BRIDGING THE GAP BETWEEN RHETORIC AND REALITY: CAN THE LAW ENFORCE QUALITY PATIENT-CENTRED CARE IN AUSTRALIA?

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 Robin Margaret Gibson                     Date
ABSTRACT

This thesis investigates a perceived gap between the medical profession’s rhetoric that the welfare of the patient is the medical practitioner’s first priority, and the reality of patient experience. The Medical Board of Australia’s *Good Medical Practice: A Code of Conduct for Doctors in Australia* mandates the duty of medical practitioners to make the care of their patients their first priority. This code also confirms that good medical practice is patient-centred.

Patient-centred care should therefore be central to patient experience. However, despite promotion of this goal by medical professional authorities, patient-centred care is not always being achieved as well as it might in practice. This thesis is an attempt to understand the reasons why this divergence between rhetoric and practice is occurring, paying particular attention to the role of the law as a potential and actual promoter of, and barrier to, practices which are recognised components of patient-centred care, and consequently of good medical practice. This aim is developed through two case studies, the way valid advance directives are observed or not, and the responses of medical practitioners to injuries to patients sustained during medical treatment.

The methodology used includes analysis of hard law regulatory processes together with the development of and increasing reliance on the soft law documented in codes, guidelines and other regulatory standards which reflect the evolving ideals of medical professionalism. In turn, an examination of disciplinary cases of tribunals and courts shows how conduct is interpreted in accordance with what is or is not professional behaviour.

There is evidence that observance by medical practitioners of patient-centred care is often being overwhelmed by the scientific and technical aspects of medical
practice and other pressures on medical practitioners, such as concerns about legal liability. The necessity for the observance of respect for the human being who is the patient is discounted to these priorities despite extensive evidence of improved outcomes for patients when patient-centred principles are implemented. The reasons for this discount are complex but a major contributor to the less than optimum observance of patient-centred principles is medical professionalism as fostered by the current methods of socialisation and training of medical practitioners. Bullying and humiliation of medical students in their training leads to desensitisation and a consequent lack of attention by medical practitioners to the necessity for patient-centred approaches to practice.

An exploration of the direct and indirect impacts of the law upon the medical profession shows the domination of medical practitioner interests over the interests of their patients. Therefore, this thesis considers whether the existing Australian legislative regime can be applied to achieving the promotion of the observance of quality, patient-centred practices by medical practitioners to the mutual benefit of doctor and patient. It argues that medical disciplinary authorities can use the provisions of the *Health Practitioner Regulation National Law* together with soft law regulation to more completely embed a patient-centred culture in medical practitioner behaviour.
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I am also grateful for the time and counsel that I have received from staff at the ANU College of Law, including Dr Kath Hall, Emeritus Professor David Hambly, Professor Peter Cain, and Anneka Ferguson. Anneka also put me into direct touch with Mary Gentile, the author of Giving Voice to Values who sent me information about her approach to the teaching of professional ethics.

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related to my thesis topic. It is sad that he is no longer here to see that his many hours of time spent with me were not wasted.

Last but not least, I must thank my wonderful and caring family, my step-daughter Frances Gibson and my son Mark Gibson, who have been with me every step along this journey, providing love and support when my confidence was at its lowest ebb. Frances is in the throes of her own thesis journey so understands the pressures on me. Mark also assisted his Luddite mother by putting this thesis into proper electronic form for submission.

Finally, I dedicate this work to my darling Frank, my husband, who died in 2008. His story was the inspiration for my embarkation on this thesis odyssey. Dear Frank – you are always with me.
PREFACE

For nearly two and a half years I watched my husband, Frank, gradually dying. A vital, intelligent man became a shell who could not walk, talk, communicate with anyone, read, watch television or turn on a radio. He just sat at the nursing home all day doing nothing. He lost his autonomy. He was subjected to constant indignities. He could manage nothing for himself. The blessing was that he seemed minimally aware of it.

Frank had, some years previously, been diagnosed with Parkinson’s Disease. On Friday 24 March 2006 he complained about pain. Our local general practitioner could not pin down what was happening and decided to have him admitted to Calvary Hospital to find out. The first hint came from the hospital’s emergency section, possible bowel blockage. I visited Frank each day but he could not communicate with me because he was so heavily sedated. Four days after his admission, I received a telephone call from a surgical registrar saying that Frank did not seem to understand what was happening - would I consent to a colonoscopy. I gave consent and twenty minutes later I was contacted again by telephone and told that there was a bowel blockage. An operation was required, with a 40% chance of survival, and no chance of survival without the operation. Would I consent? I was given no information about what such an operation would entail. I was given no time to discuss this ultimatum with my step-daughter and son. Of course, I consented – what choice was there? I had no face-to-face contact with anyone apart from a brief discussion with the surgeon afterwards who said that the operation had been completed and Frank was to be transferred to intensive care at The Canberra Hospital. The anaesthetic affected his brain disastrously and he was left with a colostomy bag.
In this situation of urgency requiring rapid decisions Frank, the patient, seemed to be the last person to be considered. We were given no information, nor the opportunity to discuss the proposed operation. There was no attempt to involve us in the decisions concerning the proposed treatment – why it was needed – what other options there might be. At that time, we did not realise that we had the right to be involved in the decision-making process. All contact was by brief telephone calls. Having made a judgement that there was only one option, the medical practitioners were only concerned to get our consent. The implication was that we should put our faith in the medical practitioners. Yes - they saved Frank’s life, but what sort of life? The net result may not have been any different if we had been involved in the decision-making process, but we would have known more and understood more, and been more prepared for the catastrophic outcome.

It has always seemed to me that there was a gross lack of sensitivity in the way the communications were made and consent obtained. This led to my attempt to discover if there could be a more compassionate way for the medical system to prioritise the patient and to involve patients and their families in making such life-changing decisions.
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Bridging the Gap Between Rhetoric and Reality: Can the Law Enforce Quality Patient-Centred Care in Australia?

Chapter I: Introduction

It is helpful to remember that the adjustments required of the medical profession in this country had their parallels elsewhere in the world. We were not unique, as those who live in Canada, the USA, Australia, Germany, and France and elsewhere all know. What was really happening was a worldwide change in the relationship between the public and doctors as traditional paternalism in all its guises began to be displaced by patient-centred care.¹

A Introduction

1 Background and Context

Until World War II, there were few reliable techniques or treatments to hold off death, or to cure illness. Whilst better nutrition, improved sanitation, inoculation against disease and public control of response to epidemics had been leading to enhanced quality of life and increased life expectancy, the prime cause of death other than wars, accidents and homicides was still infections of various kinds.² The discovery of penicillin in 1928, and subsequently other antibiotics revolutionised the treatment of infections, as killer diseases like tuberculosis, leprosy and syphilis became distant memories.

Over the ensuing decades, not only were infections being tamed, but new techniques were being developed to hold death at bay. The early iron lungs and oxygen tents gave way to modern, streamlined techniques that could maintain life

² Marshall B Kapp and Bernard Lo, 'Legal Perceptions and Medical Decision Making' (1986) 64, Suppl.2 The Milbank Quarterly 163, 165.
almost indefinitely.\textsuperscript{3} Ventilation and artificial feeding became established techniques. Efficient methods of drug delivery made treatment more certain and reduced side effects. The invention and use of artificial joints made severe arthritis a matter of history for many people. Artificial limbs gave new independence to amputees and a host of aids has made life much more acceptable for the disabled.

These medical and technical advances led to more frequent positive outcomes for patients from their medical treatment. More certain medical outcomes meant that people placed great faith in their medical practitioners and became reluctant to query their advice. The elevation in public esteem for members of the medical profession persuaded some medical practitioners that their technical knowledge and expertise should have precedence in determination of each patient’s ‘best interests’, leading to paternalistic attitudes towards their patients.\textsuperscript{4}

However, in England and Australia, commencing in the late 1990s, there was a series of high-profile and damaging medical scandals. The public began to question whether medical practitioners were always acting in their patients’ best interests.\textsuperscript{5} In some of these cases, medical practitioners were making questionable decisions that more junior medical practitioners or other health professionals like nurses were reluctant to criticise or publicise.\textsuperscript{6} In other cases, longstanding warnings from more junior health practitioners had been ignored.\textsuperscript{7} As Irvine observed, tribalism and misplaced collegiality had led to the inclination to defend clinical practices of others, except in the most egregious of circumstances.\textsuperscript{8}

\textsuperscript{3} Alan Rothschild, ‘Capacity and Medical Self-Determination in Australia’ (2007) 14 Journal of Medical Ethics 403, 411.
\textsuperscript{4} Ian Kennedy, Learning from Bristol, Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995 CM 5207(1) (July 2001) 268 [17].
\textsuperscript{5} The large number of babies dying from heart surgery at the Bristol Royal Infirmary, 'Ian Kennedy, Learning from Bristol, Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995 CM 5207(1) (July 2001) 268 [17]), the multiple murders of his patients by Dr Harold Shipman See eg, Dame Janet Smith, 'The Shipman Inquiry' (First Report Death Disguised 19 July 2002)) and other harmful conduct by medical practitioners in the United Kingdom were joined by scandals in Australia such as the King Edward Memorial Hospital in Perth (deficiencies in obstetric and gynaecology services), The Canberra Hospital (substandard neurosurgery practitioner) ‘Thomas A Faunce and Stephen N C Bolsin ‘Three Australian Whistleblowing Sagas: Lessons for Internal and External Regulation’ (2004) 181 MJA 44 and Queensland Public Hospitals (including deaths of patients of Dr Jayant Patel at Bundaberg Base hospital) (Geoffrey Davies, Queensland Public Hospitals Commission of Inquiry, Report (20 November 2005)).
\textsuperscript{7} See eg, Department of Health, Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers (Interim Report, 31 March 2016) [32]; Geoffrey Davies, Queensland Public Hospitals Commission of Inquiry, Report (20 November 2005) [1,2].
\textsuperscript{8} Donald Irvine, The Doctors’ Tale (Radcliffe Medical Press, 2003) 25.
There have been numerous reports and inquiries concerning deficient behaviour by medical professionals.⁹ For example, the Royal College of Physicians stated that publication of these reports, and their discussion in the media, were highly damaging to the medical profession and led to calls for greater independent and external scrutiny.¹⁰ As Dixon-Woods et al observed:

[The extreme nature of the transgressions, the innocence and dependency of the victims, the huge discrepancy between claims of virtue of the offenders and their actions, and the frequency with which new transgressions were reported, ...]

led to momentum to impose greater regulation on the medical profession.¹¹

The rhetoric underlying the public face of a medical profession that had expected patients to give it unquestioning trust because of its superior technical knowledge and intimate connection with questions of life and death, had been undermined — an apparent reality that this trust had frequently been misplaced. Where these scandals had occurred, not only had technical knowledge been found wanting but patients had not been fully informed about what treatment was being undertaken.¹² Public outrage generated calls for the focus of medical practice to shift from medical practitioner decision-making to a partnership of mutual respect between patient and medical practitioner in a radically-new social context,¹³ namely the traditional uneven relationship giving way to a partnership of equals. In the United Kingdom, these medical scandals also reinforced a growing realisation within the General Medical Council that a better informed public was demanding not only

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that technical competence was necessary for good medical practice, but that there must be a series of behaviours against which good medical practitioners should be judged.\textsuperscript{14}

It is tempting to consider that, following all these reports, members of the medical profession would have been galvanised into adjusting their activities and perspectives to prevent the occurrence of other situations where deficient practices could become apparent. However, more recent public scandals in the United Kingdom\textsuperscript{15} and Australia\textsuperscript{16} together with ongoing reports of bullying of juniors by senior medical practitioners\textsuperscript{17} suggest that many medical practitioners have not taken to heart the necessity to adjust their behaviours and to improve their professional conduct by promoting patient interests. For example, the charge of

\textsuperscript{14} Donald Irvine, \textit{The Doctors' Tale} (Radcliffe Medical Press, 2003) 91.
\textsuperscript{15} The Mid Staffordshire NHS Foundation Trust Investigation in 2009 — high mortality rates in patients admitted to emergency care (Healthcare Commission, \textit{Investigation into Mid Staffordshire NHS Foundation Trust} (March 2009)).
\textsuperscript{16} The Djerriwarrh Health Services Report in 2015 — high perinatal mortality rates (Professor Euan M Wallace, \textit{Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services} (Executive Summary) (an FOI request to try and obtain the full report only provided the executive summary)); The St Vincent’s Hospital cancer scandal — uniform low dosing of chemotherapy treatment for head and neck patients (Inquiry under section 122 of the \textit{Health Services Act 1997}, \textit{Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers}, Final Report (31 July 2016)).
bullying was taken seriously by the Royal Australasian College of Surgeons which convened an expert group to advise on several matters including bullying.\textsuperscript{18}

All the reports into medical scandals emphasise the prevailing medical culture in the organisation as the main characteristic that led to the problems that arose. For example, a ‘club culture’ with insiders and outsiders in the Bristol Royal Infirmary scandal,\textsuperscript{19} concern with upgrading of status of the hospital to the detriment of patient care in the Mid Staffordshire case,\textsuperscript{20} and failure to query the performance of individual practitioners rather than heed concerns expressed by nurses in the Queensland Hospitals report\textsuperscript{21} highlight concerns with status within the organisation, professional arrogance and obsession with clinical independence.

The safety issues apparent in the reports referred to above suggest the necessity for the protection of patients from inherently deficient medical practices. The more frequently that medical scandals are publicised, the clearer is the public demand for detailed regulatory oversight to minimise their occurrence.\textsuperscript{22} More detailed regulation has the object of encouraging safer behaviours and includes procuring compliance by medical practitioners with their obligations as spelled out in the Codes of Ethics promulgated by regulatory authorities.

\begin{flushright}
\textsuperscript{18} Expert Advisory Group on Discrimination, Bullying and Sexual Harassment, \textit{Report to RACS} (8 September 2015). At page 4 it stated: ‘Research results and consultation feedback confirm that discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand. The effects are significant and damaging.’ Also at page 4 it stated that the research found that:
\begin{itemize}
\item 49% of Fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment;
\item 54% of trainees and 45% of Fellows less than 10 years post-fellowship report being subjected to bullying
\item 71% of hospitals reported discrimination, bullying or sexual harassment in their hospital in the last five years, with bullying the most frequently reported issue
\item 39% of Fellows, trainees and international medical graduates report bullying, 18% report discrimination, 19% report workplace harassment and 7% sexual harassment
\item the problems exist across all surgical specialties and
\item senior surgeons and surgical consultants are reported as the primary source of these problems.
\end{itemize}\
\textsuperscript{20} Healthcare Commission, \textit{Investigation into Mid Staffordshire NHS Foundation Trust} (March 2009) 95.
\textsuperscript{21} See eg Geoffrey Davies, \textit{Queensland Public Hospitals Commission of Inquiry}, Report (20 November 2005) [1.2], [1.34].
\end{flushright}
2 From Public Safety to Quality Patient-Centred Care

As this section shows, public safety has been the primary rationale for government regulation of medical professionals commencing with the passage of the Medical Act 1858 in the United Kingdom to establish a system of registration of medical practitioners. The primary focus on safety evidenced by the legal requirement for medical professionals to be registered was joined with concerns about quality in medical practice when, in 1995, the GMC published the first edition of Good Medical Practice (the GMC Code)\textsuperscript{23}.

Likewise in Australia, safety has been joined by quality as a requirement in all healthcare settings in Australia. Since 1 July 2010, regulation of medical practitioners has fallen under the Health Practitioner Regulation National Law (the National Law), an Australia-wide system of reciprocal legislation based upon a template law first passed in Queensland, the Health Practitioner Regulation National Law 2009 (Qld).

The first objective of the National Law s3(2) is as follows:

(2) The objectives of the national registration and accreditation scheme are—

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;

Government regulation is not limited to the ‘hard law’ terms of statutes. It is accompanied by the ‘soft law’ detailed in charters, standards, codes, frameworks and guidelines, and it is through these instruments that notions of ethics and quality are developed.

\textsuperscript{23} General Medical Council, Good Medical Practice (at 22 April 2013) As a type of preamble in the latest edition, Good Medical Practice sets out ‘The duties of a doctor registered with the General Medical Council’ that are required to earn and maintain the trust of patients who commit their lives and health to them. It emphasises both maintaining technical skills and quality practice. It also states that ‘[s]erious or persistent failure to follow this guidance will put your registration at risk’ through disciplinary proceedings before the General Medical Council.
A prime example of the status of the ‘soft law’ embodied in a code is the Medical Board of Australia’s *Good Medical Practice: A Code of Conduct for Doctors in Australia* (the *MBA Code*).24 This Australian Code of Practice reflects the United Kingdom *GMC Code*25 in the requirement for medical practitioners to make the care of their patients their first concern. Both codes express this requirement as a *duty* of medical practitioners. The *MBA Code* declares: ‘Doctors have a duty to make the care of their patients their first concern and to practise medicine safely and effectively’.26 It clearly states: ‘Good medical practice is patient-centred.’ It also emphasises that ‘[medical] professionalism embodies all the qualities described [in the *MBA Code*].’27 The *MBA Code* and the *GMC Code* set out standards that must be observed by medical practitioners if they are to meet the expectations of the community and their colleagues in the medical profession.

As is apparent from the above, recurring themes in government regulation of medical practitioners are those of the medical practitioner’s *duty* to the patient (as distinct from the legal concept of duty) and what is meant by *quality*. These two concepts, together with what is encompassed in the idea of patient-centred care, will be explored at the end of this chapter.

3 Achieving Quality Medical Practice through Patient-Centred Care

The more recent focus on quality as well as safety has led to the adoption in many countries in the world, particularly those in the Western medical tradition, of the principles of ‘patient-centred care’. Patient-centred care, sometimes called consumer-centred care, is now recognised by health authorities in many countries as the best way to achieve quality clinical care and patient satisfaction with the health system.28 It is one of six ‘dimensions of quality’ listed by the World Health Organisation that are required to achieve a quality health system.29

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24 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [1.4].
25 General Medical Council, *Good Medical Practice* (at 22 April 2013) - a preamble under the heading 'The duties of a doctor registered with the General Medical Council'; also [1].
26 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [1.4].
27 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [1.4].
29 World Health Organisation, *Quality of Care* (WHO Press, 2006) 10. The listed dimensions are that the health system must be: effective, efficient, accessible, acceptable/patient-centred, equitable, safe.
In introducing the paper entitled *Patient-Centred Care*, the chairman of the Australian Commission on Safety and Quality in Health Care (ACSQHC) said:

In a large and complex health care system striving for efficiency, some busy health professionals may tend to treat patient conditions only on the basis of symptoms and scientific evidence. Scientific analysis and treatment is a foundation of modern health care, but it may lead to a reduced consideration of the patient as a person.

The patient-centred movement powerfully demonstrates that fully involving the individual patient as a person at all stages with unique needs, concerns and preferences will lead to more efficacious and satisfying outcomes.30

Patients’ experiences of patient-centred care have been shown to have positive implications for the quality and safety of their interactions with the medical system. As ACSQHC, *Patient-Centred Care* states:

[i]t is clear that patient-centred care has significant benefits associated with clinical quality and outcomes, the experience of care, the business and operations of delivering health services, and the work environment.31

The ACSQHC’s Discussion Paper on *Patient-Centred Care* comments that ‘... high quality health care is always patient focused ...’, meaning providing care that is ‘... respectful of and responsive to individual preferences, needs and values’.32

Patient focus has sometimes been missing in the past. According to Leadbeater and Garber, hospital patients and their families have been subject to a system designed around the medical profession and its procedures and hierarchies rather than accommodating the social relationships where clinicians have the skills and knowledge and can find the time to communicate effectively.33

Similarly, as Sir Ian Kennedy has observed, there is still a perception among some medical practitioners and an expectation by their patients that, because of their

30 Australian Commission on Safety and Quality in Health Care, *Patient-Centred Care* (August 2011)
31 Australian Commission on Safety and Quality in Health Care, *Patient-Centred Care* (August 2011)
33 Charles Leadbeater and Jake Garber, *Dying for Change* (Demos, 2010) 57.
knowledge, training and expertise, medical practitioners should make all medical decisions. However, paternalism is inconsistent with a patient-centred health system. As the United Kingdom Supreme Court remarked in Montgomery v Lanarkshire Health Board, there have been developments which ... point away from a model of the relationship between the doctor and the patient based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point to is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.

B THESIS PROBLEM, AIM, METHODOLOGY AND CONTRIBUTION

1 Thesis Problem and Aim

Given that patient-centredness seems to be the new paradigm, this thesis argues that the traditional legal emphasis, under the shadow of tort law, on technical skills to ensure patient safety must be joined by adoption of patient-centred quality medical practice. To this end, there is now a plethora of codes, standards, frameworks, guidelines and other directions in soft law instruments that promote the benefits of patient-centred medical practice. The primary benefits are patient safety that comes from improved communication with patients and better outcomes because of their involvement in the decision-making concerning diagnosis and proposed treatments. Likewise, attention to patient-centred principles leads to enhanced quality in medical practice. The conceptual framework upon which this

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34 Ian Kennedy, Learning from Bristol, Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995 CM 5207(1) (July 2001) 363 [22].
36 See eg, Bolam v Friern Hospital Management Committee [1957] 1 WLR 582; Whitehouse v Jordan [1981] 1 WLR 246.
37 See eg, Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014); Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012); Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013); Medical Board of Australia, Guidelines for Mandatory Notifications (at 17 March 2014); Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011).
38 See eg, Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) 23.
thesis rests is that good medical practice is not only patient-centred, but that patient-centredness equates to the ideals of medical professionalism.

A great deal of academic and regulatory effort has been put into developing regulatory structures and procedures to procure safer practice. However, little is written about the quality benefits to be reaped from the adoption by medical practitioners of patient-centred medical practice. The distinguishing characteristics of this thesis lie in its focus on its core theme and the approach it takes to that focus, to bring new perspectives to the issue. The overarching concern is the focus on professionalism as the foundation for quality. Much of the material referenced has been examined in other contexts but this thesis subjects that material to scrutiny through the lens of professionalism as the path to quality medical practice. The approach to the professionalism focus lies in the systematic and methodical survey of the material, including identification of those regulatory and legal processes that both enhance and detract from the tenets of professionalism. Therefore this thesis will focus on the theoretical foundations of medical professionalism by way of the concept of patient-centred medical practice and the assumptions upon which it rests and show how they flow through to quality medical practice. The role of law in mediating that relationship will be explored.

2 Methodology

The methodology used to answer these questions will include an analysis of the hard law regulatory processes aimed at securing safe medical practice that have been legislated by the National Law. That legislation specifies matters that must be included in registration and accreditation prerequisites. The traditional focus on safety will be exposed further through analysis of case law concerning alleged medical negligence, and the requirement for patient consent before any medical procedure is commenced. This emphasis relates back to a preoccupation with safety and to narrower aspects of what the concept of medical professionalism

40 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012); Australian Commission on Safety and Quality in Health Care, Australian Safety and Quality Framework for Health Care (at December 2010).
embraces, such as a duty of care and the respect for the patient’s autonomy inherent in the notion of consent before touching. Similarly, the traditional and historical development of the soft law documented in codes, guidelines and other regulatory standards reflects the evolving ideals of medical professionalism. To this end, this thesis also undertakes a comparison of the development of codes and other viewpoints concerning medical professionalism in the United Kingdom and the United States of America. This theoretical enquiry is bolstered by empirical evidence of outcomes of disciplinary cases heard by Australian civil and medical tribunals that refer back to what is or what is not professional behaviour.

Analysing the constituents of medical professionalism and how it underpins good quality patient-centred medical practice makes it possible to identify the gaps between the rhetoric of safe, quality, patient-centred medical practice and the medical culture that has led to the deficient practices identified in the inquiries and reports into medical scandals such as those referred to above. Medical professional culture includes ethical virtues such as compassion and altruism as well as less defensible conduct like paternalism, arrogance and the paramountcy of clinical discretion. While medical practitioner organisations assert the ongoing commitment of their members to the virtuous aspects of medical practice, there is evidence that the rhetoric is being undermined by the conduct of some individual practitioners.

3 Thesis Argument and Contribution to the Literature

What this research shows is that there can be a gap between the rhetoric of patient-centred care and the reality of patient experience. The aim of this thesis is to explain where and why this gap exists and to propose what could be done to minimise it. The issue is whether the law should only be concerned with minimum standards of clinical competence to underpin safety or whether, in addition, it can and should instigate quality by way of patient-centred medical practice. This thesis argues that the codes, guidelines and standards that comprise the soft law regulatory framework for medical practitioners include norms and aspirations beyond minimum safety standards. It concludes that regulators, through statute and disciplinary case law, are concerned to achieve and enhance quality through patient-centred medical practice. The question then is whether and how the law can be mobilised to modify the behaviour of medical professionals so as to instil
the philosophy and practices of patient-centred care, thereby leading to enhanced quality in medical practice and the assurance of patient safety.

What also will become obvious in this thesis is that there is a series of recurring dichotomies in medical practice that should be resolved in the interests of patient care. Firstly, there is the gap between the rhetoric of patient-centred care and the reality of much patient experience, as in the title to this thesis, that will be identified in more detail as this thesis proceeds. Then there is the emphasis on safety that does not necessarily or directly relate to quality. What also stands out is the need to reconcile the hard law and the soft law lying behind medical practice. In addition, there is what Jonsen calls a ‘profound moral paradox’ that pervades medicine, ‘the incessant conflict between two basic principles of morality: self-interest and altruism’. 41 It is submitted that viewing these dichotomies through the lens of patient-centred medical professionalism can lead toward their resolution. Reality may come closer to the aspirations reflected in the rhetoric, quality practice of necessity embraces safety concerns, soft law can be as effective as hard law in modifying practitioner behaviour, and altruistic actions need not be against practitioner self-interest.

C THESIS OUTLINE

In order to show how the principles of medical professionalism underpin good patient-centred medical practice, Chapter II commences by analysing what medical professionalism encompasses. It provides an outline of those factors that are common to all occupations that are termed professions. It then proceeds to examine some features of medical practice that distinguish the medical profession from other professions.

Chapter II examines the history of codes of ethics or practice from the era of the Hippocratic Oath to current statements expressed in codes of practice. This history shows the gradual shift from self-interested concerns about how medical practitioners should deal with each other and the obligations owed to them by their

patients and members of the public. The modern status of the welfare of the patient is now the primary responsibility of the medical practitioner, as confirmed in the MBA Code and in the GMC Code.42

However, as codes cannot provide answers to all ethical questions that arise in medical practice, ways of dealing with ethical dilemmas can be bolstered by training in medical ethics. Medical professionals are urged to adopt certain principles that exemplify good medical practice, principles of autonomy, beneficence, non-maleficence and justice, that appear in various guises in both the MBA Code and the GMC Code. In addition, the system of medical ethics is heavily reliant on statements that are based in philosophical principles that reflect how the medical profession sees itself and how it wishes to present itself to the public.43 These philosophical principles have been supplemented by recent interest in what has been termed ‘virtue ethics’ as a base upon which ethical decision-making in difficult medical circumstances can rest.44 Virtuous behaviour by medical professionals is an indicator of good character45 and is required because of the inherent vulnerability of the patient46 who comes seeking healing, comfort and relief of disagreeable symptoms. Regulatory bodies have recognised the importance of ethics training to rehabilitate the reputation of the medical profession that has been bruised by recurring medical scandals in recent years. One recently-developed method of training that is designed to assist in internalising medical ethics is suggested.

Codes of practice have also been supplemented in recent years by recommendations for or charters of professionalism that are intended to emphasise medical virtues.47 Much of the content of charters is contained in the codes of practice. These charters are an attempt to re-establish in public estimation the

42 General Medical Council, Good Medical Practice (at 22 April 2013).
43 Tom L Beauchamp and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 5th ed, 2001).
44 Edmund D Pellegrino and David C Thomasma, The Virtues in Medical Practice (Oxford University Press, 1993).
45 Edmund D Pellegrino and David C Thomasma, The Virtues in Medical Practice (Oxford University Press, 1993) 68.
medical profession’s reputation for trustworthiness, altruism and compassion. This reputation has been tested by revelations of medical misconduct in recent public inquiries — bullying, arrogance, a ‘club’ culture, tribalism, failure to report colleagues’ deficient activities and technical incompetence.48

However, the promotion of caring, skilled, altruistic behaviour being urged on the public is being undermined by aspects of the conduct of some medical practitioners. This conduct contradicts the efforts by medical regulators and medical associations to convince a sceptical public that medical practitioners have changed. Poor communication with patients,49 paternalism,50 disregard of patient dignity,51 bullying of colleagues52 and arrogance53 are still evident. One explanation for this behaviour can be found in the ‘hidden curriculum’ evident in training of medical students, and continued into early medical practice under supervision.54 The influence of the hidden curriculum will be explored to show how medical training can teach young doctors to stifle their emotions and to adopt uncaring approaches to patients.

The right to object to performing certain medical procedures on conscientious grounds can conflict with other provisions in codes of practice. Thus, this chapter argues that the promotion of the medical profession as compassionate, altruistic and patient-centred, is also undermined when patients are denied medical treatment, even procedures that are legal in Australia. Chapter II suggests that ways can be found to accommodate both the views of the medical practitioner and those of the patient so that the patient does not feel abandoned.

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50 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [94] (Dame Elizabeth Butler-Sloss).

51 Lynn V Monrouxe and Charlotte E Rees, "It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 *Advances in Health Science Education* 671, 683.


53 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [50] (Dame Elizabeth Butler-Sloss).

Chapter III proceeds to analyse the regulatory regime that governs the professional activities of medical practitioners. Given the priorities of quality and safety in registration of medical practitioners, there is legislation, now under the National Law, that provides for registration and re-registration of medical practitioners together with requirements for discipline for those whose conduct is found to not meet professional standards. The National Law also sets out the outlines for accreditation of health care institutions and educational bodies. However, the National Law leaves the minutiae of regulation to be developed by relevant National Boards and other bodies that are more familiar with the workings of the medical profession. Regulation is realised through policies outlined in the ‘soft’ law of codes, charters, frameworks, standards and other documentation, emanating both from National Boards and other bodies like the government-funded ACSQHC.

Soft law has become ubiquitous in regulatory environments. Soft law achieves its results mainly through voluntary compliance or through contractual obligations as, in comparison with the hard law of statutes, it is not otherwise directly enforceable. But soft law can become hard if it is given a legislative imprimatur by being adopted in a statute, or by being endorsed by the common law. Yet Aronson points out that ‘... Australia’s version of the rule against fettering statutory discretions has led its courts to decline to enforce soft law as such ... ’.

Chapter III then investigates how soft law achieves its intended outcomes when it does not have a statutory base or does not have a specific endorsement in common law. It surveys the influential theory of Responsive Regulation developed by Ayres and Braithwaite, which has been adopted to attempt to achieve safer activities of

55 National Law s 38 and Part 7.
58 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [77] (Lord Kerr and Lord Reid).
health practitioners. The Ayres/Braithwaite theory of Responsive Regulation has been widely applied in Australia and several overseas jurisdictions.

Chapter III proceeds to survey the hard and soft law by which the activities of health practitioners are ordered. The hard law is evaluated by an analysis of how disciplinary proceedings are initiated and decided. The soft law in codes, and guidelines of both government and specialist medical bodies such as the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons will be considered. The most important soft law instruments, the Australian Charter of Healthcare Rights and the National Safety and Quality Health Service Standards, will be explored to show how they promote professional ideals and patient-centred care. Then, Chapter III examines reported disciplinary cases in courts and tribunals for the three years from 1 July 2013 to 30 June 2016. This case examination extracts recurring patterns of activities of medical practitioners that have led to disciplinary proceedings and makes suggestions as to how some of these patterns might be minimised.

Two recurring problems found by Australian courts and tribunals were inadequate medical records and deficient clinical practice. Each of these problems is scrutinised and suggestions made for reducing their negative effects on patients — how to ensure more complete medical records, and how to establish that each medical practitioner is up-to-date and fit to practise.

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62 Those years have been chosen because the National Law did not commence until July 2010 and there is a lead time between the initiation report and the appearance of a matter in tribunal or court proceedings. By choosing those three years, it is anticipated that the bulk of the cases considered will be determined under the National Law. Those few cases that were still under former legislation have not been included in the summaries.
63 The cases themselves were not analysed as the point of the survey was to extract the patterns of activities rather than how each case was decided.
Chapter IV examines some structural biases in the legal system that operate in favour of medical practitioner interests and compete with patient-centred care principles. These structural biases are best understood by exploring three important, but interrelated areas of the law within the law of negligence. Firstly, in the context of an action alleging negligent conduct by a medical practitioner, the chapter reviews the law relating to the professional standard of what treatment should be provided to a patient in the patient’s particular circumstances. The Bolam standard is based on accepting the judgement of a responsible body of medical professional opinion. Over the years, the courts have moved away from an almost unquestioned acceptance of the Bolam standard as applicable to determine a patient’s ‘best interests’ and whether the alleged conduct of the medical practitioner is negligent or not because it accords with a responsible body of medical opinion. Australian courts first, and now more recently, the United Kingdom Supreme Court, have modified the Bolam principle, stating that it no longer applies to the information that must be provided to the patient before the patient can be said to have given informed consent. However, the progress made by the courts in constraining the reach of the Bolam standard has now been undermined by the reinstatement of a modified Bolam test under civil liability legislation. The Ipp Report, the Review of the Law of Negligence will be considered later in Chapter IV.

Secondly, an important legal principle is the common law requirement that the patient consent before any treatment regime is initiated. Medical practitioners are not exempt from the legal rule that any touching may be assault or trespass unless appropriate consent has first been obtained. Proper consent also involves the patient being aware of risks and benefits associated with any treatment proposed, together with risks or benefits associated with failure to undertake any treatment at all. Without this information, any consent is deficient. Thus, actions for negligence against medical practitioners can include not only allegations of deficient technical skill but also the failure to warn patients of risks. Where

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60 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
63 See eg, Civil Liability Act 2002 (NSW) s 50.
65 See eg, Airedale NHS Trust v Bland [1993] AC 789, 800 (Sir Stephen Browne P); 882 (Lord Browne-Wilkinson).
66 Rogers v Whitaker (1992) 175 CLR 479.
patients are unable to give or withhold consent, medical practitioners may treat so long as the treatment provided is in the patient’s best interests.\textsuperscript{71} However, there is ample evidence that when a patient’s refusal to consent does not accord with the medical practitioner’s view, the patient may be regarded as lacking mental capacity.\textsuperscript{72} The courts have developed detailed tests for how a patient’s capacity is to be determined.\textsuperscript{73} Yet, there is evidence that, in practice, patient autonomy is being supplanted by medical practitioner judgement, leading to these tests being evaded and, on occasion, ignored,\textsuperscript{74} derogating from patient-centred medical practice.

Thirdly, the assessment of technical competence through actions against medical practitioners where negligence is alleged has not always provided injured patients with adequate compensation for injury. The interests of patients have been subjugated to medical practitioner interests in several aspects of personal injury law. As Justice Ipp comments, injuries to patients are treated differently from injuries incurred in the workplace and, in some jurisdictions, in motor vehicle accidents.\textsuperscript{75} The ability of patients to obtain compensation has also been restricted by civil liability legislation enacted throughout the country as a consequence of the report of the Ipp Panel.\textsuperscript{76} Among other changes to the law of negligence, a three year statute of limitations now applies in contrast to a six year limitation in the case of debts or contracts.\textsuperscript{77} Quantum of damages is limited\textsuperscript{78} and, in many cases, damages are denied because the injury is not deemed severe enough.\textsuperscript{79} One way of moderating adverse effects of civil liability legislation is to take personal injuries out of the tort system altogether. Thus, this chapter asks whether the time has come for a ‘no fault’ liability system to be instituted, thereby making sure that each injured person will have proper care for the injury caused without having to prove that someone has been negligent.

\textsuperscript{71} Airedale NHS Trust v Bland [1993] AC 789, 867 (Lord Goff);
\textsuperscript{72} See eg, Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam); NHS Trust v T (Adult Patient: Refusal of Medical Treatment) [2004] 3 FCR 297; Social Development Committee, Parliament of Victoria, Inquiry into Options for Dying with Dignity (1987);
\textsuperscript{73} See eg, In re C. (Adult: Refusal of Treatment) [1994] 1 WLR 290, 292 (Thorpe J); Re MB [1997] EWCA Civ 3093 [30] (Butler-Sloss LJ),
\textsuperscript{74} Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [16]—[21].
\textsuperscript{77} See eg, Limitation Act 1969 (NSW) s 14; Limitation Act 1985 (ACT) s 11; Limitation of Actions Act 1958 (Vic) s 5.
\textsuperscript{78} See eg, Civil Liability Act 2002 (NSW) Part 2.
\textsuperscript{79} See eg, Civil Liability Act 2002 (NSW) s 16.
Chapter V is the first of two further illustrations of medical practice that examines contradictions between what the law requires and what can happen in practice, further evidence of how law and medical practice may hinder realisation of patient-centred care. This chapter looks at advance directives that have been promoted to the public by governmental and medical authorities as a way of making provision for future situations where consent to medical treatment cannot, for any reason, be given.80 Advance directives are an extension of the principle of autonomy and are recognised as such by the courts.81 Most state and territory legislatures have passed relevant provisions to establish and support their creation and use.82 Yet legislation, cases and practical factors have undermined the full realisation of their potential to guide clinicians in the types of treatment that the patient wishes or does not wish to undergo. Despite the fact that there is a great deal of hard law in statute and cases, there are some gaps in its application and interpretation.83 There is also a body of academic criticism of the validity of legally faultless advance directives.84 However, these arguments are easily countered by the legal recognition of the competent individual’s right to make provision for future events, whether in a contract, a will or some other planning device. Finally this chapter will make some suggestions that could promote acceptance of and compliance with advance directives.

Chapter VI examines the incidence of medical mishaps that may cause injury to patients. It cites research that suggests that medical injuries occur more frequently than is generally understood by the public. Not all of these injuries occur through negligence. Nevertheless, a part of medical practice that is conceivably poorly

80 Australian Health Ministers’ Advisory Council, A National Framework for Advance Care Directives (at September 2011) 1.
82 Advance Care Directives Act 2013 (SA); Guardianship and Administration Act 1990 (WA); Medical Treatment (Health Directions) Act 2006 (ACT); Advance Personal Planning Act 2013 (NT); Powers of Attorney Act 1998 (Qld); Medical Treatment Act 1988 (Vic).
83 See eg, Powers of Attorney Act 1998 (Qld) s 36(2); Medical Treatment Act 1988 (Vic) s 5(1)(c); Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam); Qumsieh v Guardianship and Administration Board [1998] VSCA 45.
understood by health practitioners is how to best deal with the aftermath, making sure that the needs of an injured patient are the prime focus and that the occurrence of an injury is used as an opportunity to learn ways to ensure it is not repeated. However, despite efforts by regulators and professional organisations to ameliorate the worst effects of adverse events on patients, many medical practitioners are failing to acknowledge their occurrence or to adequately deal with their aftermath.

Open disclosure is behaviour that is required of medical practitioners following any adverse event. The Open Disclosure Framework prepared by the ACSQHC provides details of procedures to be implemented in response to an adverse event. Open disclosure principles include patient-centred care principles such as treating patients with dignity, communicating with them and providing information and emotional support, together with access to and continuity of care, and respect for patient needs.

From the patient’s point of view, the most troubling behaviour of many medical practitioners is a failure to internalise a safety culture in day-to-day medical practice. As the MBA Code acknowledges, medical practice is inherently risky and adverse events will occur. However, despite the requirement in the MBA Code for medical practitioners to be aware of the importance of the principles of open disclosure, too often adverse events are not adequately acknowledged to an injured patient. Not acknowledging an adverse event can lead to failure to promptly initiate treatment or take other actions to minimise the harmful effects of the injury, whether physical, psychological or financial.

There is a series of actions that injured patients and their families need from medical practitioners and hospital administrators when faced with the reality of an adverse incident. Research suggests that resort to litigation may be avoided if the

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85 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [6.2.1].
87 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [6.1].
88 Ibid [6.2.1].
treating medical practitioner and responsible hospital administrators face up to the matter and provide open and honest information to those affected. The information needed by injured patients and their families is also reflected in the principles of Open Disclosure.

One way of reducing simple errors that may have catastrophic consequences is to encourage, and sometimes to mandate, the wider adoption of checklists, a simple but effective way of reducing the incidence and severity of medically-caused injuries. Chapter VI canvases arguments in favour of their adoption, together with matters that can act as barriers to their acceptance as important tools in medical practice.

Chapter VII summarises the conclusions from the previous chapters. It argues that, in light of the evidence provided there, the law can promote quality in patient-centred medical practice and is not limited to enforcing minimum standards of technical competency and safety. It also draws together the recommendations made throughout this thesis. In addition to the existing regulatory support for quality aspects of medical practice, there are some additional processes that can be implemented by regulatory authorities through their powers to direct standards.

Medical regulatory authorities also have powers such as through their approval of training by medical schools, by accreditation processes for health care facilities, by requirements to show ongoing professional development as part of annual re-registration, and by promulgation of codes and guidelines to introduce matters that can lead to better quality in medical practice. Comprehensive education in medical ethics is critical. Regular revalidation is designed to demonstrate that a medical practitioner is up-to-date and fit to practise. Simple initiatives to improve record keeping, checklists to enhance safety together with requirements that health

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90 See eg, National Law ss 35, 38, 47.
92 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012).
93 National Law s 38.
94 National Law Part 5 Division 3.
care institutions include important quality matters in their staff contracts, can also reinforce standards. As this thesis argues in Chapter III, the law can require adoption of specified quality practices through the threat of escalation of legal sanctions. The existence of and publicity surrounding disciplinary proceedings are not supposed to be punishment but are designed to act as a deterrent to members of the profession who may stray from professional norms. They also signal to members of the public that deficient behaviour will not be tolerated. 95

This chapter also summarises the contribution of this thesis to the literature, emphasising achievable initiatives that can enhance the observance of patient-centred principles by medical practitioners. Training and socialisation into the culture of medicine can emphasise technical skills over the equally important function of the medical practitioner, caring for the patient. Care in the sense of providing good medical treatment is enhanced in providing comfort and a mutually trusting relationship.

Finally, this chapter suggests some areas for future research, ranging from immediate problems such as updating the findings of the original Quality in Australian Health Care Study to some contentious issues that may benefit from a patient-centred focus, such as end-of-life decision-making.

The medical system is an important part of Australian society. Whilst most medical practitioners are conscientious in their dealings with patients, there are still aspects of medical culture that can lead to less than optimal outcomes and this thesis has identified some of these aspects. It also suggests some comparatively simple measures that can lead to greater patient satisfaction and to more rewarding interactions between those patients and their medical practitioners.

Before moving on to the substantive chapters, three important concepts, namely duty, quality and patient-centred care, will be explained. As each comprises

95 NSW Bar Association v Evatt (1968) 117 CLR 177,183–184 (Barwick CJ, Kitto, Taylor, Menzies and Owen JJ).
different shades of meaning, analysis of what is embraced in these notions can convey how they may be better understood in the context of the arguments that will be presented.

D IMPORTANT CONCEPTS

The three important concepts that require elucidation, duty, quality and patient-centred care are interrelated in various ways. This section will not only explore the concepts but will point out where these interrelationships occur. Each part in the section will examine both soft and hard law references before presenting evidence from the literature of how each concept is applied. It will then suggest how the allusions and references to each concept can be interpreted in the health law explored in this thesis.

1 Duty

Duty appears as a basic obligation in the most important soft law instruments governing medical practitioners.96 For example, the MBA Code states: ‘Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy’. 97 Similarly, the preface to the GMC Code recites ‘The duties of a doctor registered with the General Medical Council.’ Likewise, the AMA Code refers to a primary duty ‘ ... to provide ... patient(s) with the best available care.’98 The imperative to patient-centred practice is characterised as a duty, thus relating it to the ideal of patient-centred care.

In the common law, the primary reference to duty appears as an integral part of the idea of how negligence should be established when an allegation has been made that there has been a breach of a duty owed by one to another. The duty of care has been encapsulated in the famous dictum by Lord Atkin in Donoghue v Stevenson:

96 See eg. Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014); General Medical Council, Good Medical Practice (at 22 April 2013).
97 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer’s question, Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts and omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question. 99

Likewise, as McHugh stated in Vairy v Wyong Shire Council:

The present case fell within the familiar category of cases where the plaintiff was a member of a class of persons to whom the defendant had a duty – according to a body of common law precedent – to take reasonable care for the safety of members of that class. Teachers and students, doctors and patients ... 100

Macquarie Dictionary provides several meanings for the word duty. Relevant to the practice of medicine are the first three as follows — ‘1. that which one is bound to do by moral or legal obligation; 2. the binding or obligatory force of which which is morally right; moral obligation; 3. action required by one’s position or occupation: office; function’.101

The hard law of statute recognises how duty is related to function. The Health Practitioner Regulation National Law has two definitions characterised as a duty. In section 5 it states:

‘exercise a function includes perform a duty’.

Schedule 7 is headed: Miscellaneous provisions relating to interpretation. Section 12 in that part provides:

‘function includes a power, authority or duty’.

Thus, the National Law recognises that functions performed under its provisions can be termed duties. The notion of function is advanced by the Macquarie Dictionary definition above. Similarly, the duty of a medical practitioner can also be seen as relating to his or her function.

Some philosophers have attempted to clarify what is embraced in the idea of duty outside the strict legal interpretation of what the notion implies. Whitely’s suggestion is directly relevant to the trust inherent in the ideal of the doctor-patient relationship. He proposes that: ‘It cannot be a duty to do, or not to do, an action,

100 Vairy v Wyong Shire Council (2005) 223 CLR 422, 432 (McHugh J).
unless that action is covered by some commitment’. He adds: ‘The ground of my duty is always a specific feature of the situation, namely, a trust-relation between myself and some other person or persons.’

Brandt’s suggestion takes the idea further: ‘Failure to do one’s duty without suitable justification or excuse is a reflection on one, and is the object of sanctions, [or] at least unfavourable attitudes on the part of the relevant group of people.’

Johnson and Cureton in The Stanford Encyclopedia of Philosophy pick up the notions of commitment and coercion, particularly self-imposed. They suggest that: ‘Duties are rules or laws of some sort combined with some sort of felt constraint or incentive on our choices, whether from external coercion by others or from our own powers of reason.’

Thus, duty can be seen as an obligation that may or may not be compelled by the law, but that always has a moral dimension. Duties attach to medical practitioners particularly because of the trust implicit in the doctor-patient relationship. Whilst the content of the notions of obligation and duty are not necessarily always the same, Brandt suggests that, in most cases, they can be used interchangeably without ‘noticeable jar’.

In cases such as Wyong Shire Council v Shirt and March v Stramare, duty is almost invariably used in the phrase ‘duty of care’, though sometimes also as ‘breach of duty’. However, in cases such as Reibl v Hughes, Sidaway and Montgomery, the word appears in the circumstance of the doctor’s duty of disclosure, to advise of risks, to answer truthfully. Nowhere is there any judicial explanation of the concept, but in all these contexts, the notion of obligation is a clear connotation.

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105 See Vairy v Wyong Shire Council (2005) 223 CLR 422, 432 (McHugh J).
110 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871.
Thus, the dimensions of the concept of ‘duty’ can include two senses: a non-legal and primarily moral one and a legal one. It is used in negligence law in the context of the duty of care owed by a medical practitioner towards the patient when undertaking any diagnosis, treatment or advice. In its non-legal moral sense, duty is integral to the obligations of medical practitioners to their patients. Both the MBA Code and the GMC Code catalogue duties of medical practitioners to observe the behaviours they describe as professionalism.112

2 Quality

The comparatively recent establishment of bodies devoted to quality in health care113 was given impetus by evidence of unethical and deficient behaviour from health professionals and medical researchers.114 Consequently, this section aims to explain how ‘quality’ is used in the context of health care.

Notwithstanding the appearance of the word in its name, ACSQHC does not define quality but constantly refers to the necessity for its adoption by all health care professionals and health care institutions. For example, the soft law Australian Charter of Healthcare Rights ‘... describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality ...’.115 The similarly soft law Introduction to the National Safety and Quality Health Service Standards states that:

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum

112 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4]; General Medical Council, Good Medical Practice (at 22 April 2013) [1–6]. Professionalism will be examined in more detail in Chapter II.
113 The Australian Commission on Safety and Quality in Health Care was only established in 2006. <https://www.safetyandquality.gov.au/about> The Clinical Excellence Commission in New South Wales was set up in 2004. <http://www.cec.health.nsw.gov.au/about> The predecessor of the United Kingdom’s National Institute for Health and Care Excellence was the National Institute for Clinical Excellence which was set up in 1999 ‘to reduce variation in the availability and quality of National Health Service treatments and care’.
114 See eg, ‘The Tuskegee Study of Untreated Syphilis in the Negro Male’ that continued for 40 years, even for 30 years after it was confirmed that penicillin was effective in treating syphilis (Albert R Jonsen, A Short History of Medical Ethics (Oxford University Press, 2000) 108); Dame Janet Smith, ‘The Shipman Inquiry’ (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004).
standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.\textsuperscript{116}

*The Shorter Oxford English Dictionary* states that the word ‘quality’ originally came from Old French, Latin and Greek, all of which meant a particular attribute or feature. Over the years the meaning has evolved to include other meanings, such as a standard as measured against other things of a similar kind, and has also acquired an implication of high grade or inherent superiority.\textsuperscript{117}

The concept of quality is itself comprised of a variety of facets and will fluctuate depending on the context in which it is being applied. For example, the quote from the *National Safety and Quality Health Service Standards* above picks up three different nuances of the word ‘quality’ as described above from *The Shorter Oxford English Dictionary*. The first reference is to quality as a characteristic. The second reference, ‘quality assurance’ comprises the monitoring and evaluation of performance in the delivery of services, and how it affects the quality of outcomes, the context of the latter use implying a better standard. The third reference is to quality as a standard. The fourth reference is in the context of achieving high standard. Reflecting the variation in usage of the word, one conjecture concerning the phrase ‘quality of’ could suggest simply a standard, whilst ‘quality in’ might imply high quality.

The hard law of the *National Law* also refers to quality, firstly and most particularly in the context of its objectives and guiding principles. Section 3(2)(c) provides that one of the objectives is ‘... to facilitate the provision of high quality education and training of health practitioners;’ whilst one of its guiding principles is found in section 3(3)(c) that provides that: ‘restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services ... are of appropriate quality’.

When looking to cases for guidance, there are typically no discussions of what quality entails, nor any cases that elaborate a meaning of quality. When the word arises in the context of cases concerning medical situations, it is often in the situation of quality of life as compared to quantity. As Lord Kerr and Lord Reid

\textsuperscript{116} Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2012).
\textsuperscript{117} *The Shorter Oxford English Dictionary* (Oxford University Press, 3rd ed, 1973) 1724. The dictionary advises that this latter usage dated from late Middle English.
pointed out in Montgomery: ‘The relative importance attached by patients to quality as against length of life, or to physical appearance or bodily integrity as against the relief of pain, will vary from one patient to another.’

Likewise in Australia, some references in tribunal cases discussed quality as referred to in the MBA Code or the surgeons Code, but others varied by reference to ideas such as quality of life, quality of care, quality of records, quality of professional conduct.

‘Quality’ is not defined in the MBA Code either. The MBA Codes sets out the ‘qualities’ required of Australian medical practitioners. It also refers to ‘quality’ when talking of systems of quality assurance [6.2.2], making only justifiable claims about quality of outcomes [8.6.2], providing doctors who are their patients with the same quality of care as all patients [9.3.1] and human research as vital for improving quality of healthcare [11.1]. However, the code of the Royal Australasian College of Surgeons specifically advises that the ‘... nature of the surgeon-patient relationship is critical to the quality of care ...’ that implies the second meaning, quality as a standard.

Determination of what quality in health care comprises is a complex exercise but its achievement is an ideal promoted by governments, health professionals and the society in which they are located. Whilst hard and soft law instruments in Australia refer to quality in various guises, there is no specific list of the factors required as has occurred in the United States. Following the major report of the Institute of Medicine’s Committee on the Quality of Health Care documenting the

118 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [46].
119 See eg, Medical Board of Australia v Kanapathipillai [2016] ACAT 16 [57]; Medical Board of Australia v Veetill [2015] WASAT 124 [12].
120 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44. The reference in [121] is to Clause 13.1.9 of the surgeons’ Code - ‘Openness and honesty are generally relevant to the development of trust between a health practitioner and patient, a quality which is integral to the therapeutic relationship’. This provision uses quality in the sense of an attribute.
121 See eg, Medical Board of Australia v Griffiths [2017] VCAT 822 [20].
122 See eg, Medical Board of Australia v Lewis [2017] SAHPT 1 [19]–[20].
123 HCSC v Chen [2016] NSWCATOD 144 [132]; Medical Board of Australia v Fox [2016] VCAT 408 [42].
124 See eg, Medical Board of Australia v Melhuish [2016] ACAT 29 [75].
125 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014).
126 Royal Australasian College of Surgeons, Code of Conduct [2.1].
127 See eg, Australian Commission on Safety and Quality in Health Care, Australian Safety and Quality Goals for Health Care; Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012); Clinical Excellence Commission, 2013 Quality Systems Assessment (2014).
incidence of error in medical practice, *To Err is Human*,128 the Committee produced another significant report, *Crossing the Quality Chasm*.129 It proposed the following six components to define quality in health care. Examples of each of these components are reflected in the *MBA Code* and appear in square brackets after each. Quality in health care should be:

*Safe*: Avoiding injuries to patients from the care that is intended to help them. [1.4], [2.2.2], [6.2.5].

*Effective*: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively). [1.4], [2.4.4].

*Patient-centred*: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. [1.4].

*Timely*: Reducing waits and sometimes harmful delays, for both those who receive and those who give care. [4.5.1].

*Efficient*: Avoiding waste, including waste of equipment, supplies, ideas, and energy. [5.1], [5.2].

*Equitable*: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.130 [3.8.2], [5.3].

The World Health Organisation proposes that quality can be ‘measured’ against what the latest expert understanding suggests is most beneficial in achieving the desired results. Its definition is as follows

Quality: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.131

Buttell et al have taken account of proposals from a number of sources including the World Health Organisation when they submit:

Quality consists of the degree to which health services for individuals and populations increase the likelihood of desired health outcomes (quality principles), are consistent with current professional knowledge (professional practitioner skill), and meet the expectations of healthcare users (the marketplace).132

Both of these recommendations are aimed at assuring that outcomes from health related pursuits achieve optimal results. Likewise, Donabedian defines quality

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128 Institute of Medicine, *To Err is Human* (National Academy Press, 2000).
129 Institute of Medicine, *Crossing the Quality Chasm* (National Academy Press, 2001).
assurance to mean all actions taken to establish, protect, promote, and improve the quality of health care.\textsuperscript{133}

Consequently, there does not appear to be one specific use of the concept of quality in health care. ‘Quality’ is used in various senses depending on the context, a particular attribute or feature, a standard as measured against other things of a similar kind, and also as something which has a high grade or inherent superiority.

However, for the purposes of this thesis, quality will be used in the sense of a standard of excellence, of high grade or of superiority. Quality as excellence is an expectation implied in the ideals of professionalism outlined in the \textit{MBA Code} and the \textit{GMC Code}.\textsuperscript{134} The focus of this particular sense of the word ‘quality’ also accords with the aspirations repeated in important ‘soft law’ instruments governing medical practice. The \textit{Australian Charter of Healthcare Rights} describes the rights of patients and persons in their interactions with the health system. They are ‘essential to make sure [that health care] is of high quality ... ’\textsuperscript{135} Similarly, the National Safety and Quality Health Service Standards aim to provide a quality assurance mechanism which can lead to ‘quality improvement ... to realise aspirational or developmental goals’\textsuperscript{136}

3 \hspace{1em} \textbf{Patient-Centred Care}

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.\textsuperscript{137}

The achievement of patient-centred medical practice is an aspiration. However, just because it is an ideal does not mean that medical practitioners should ignore

\textsuperscript{133} Avedis Donabedian, \textit{Introduction to Quality Assurance in Health Care} (Oxford University Press, 2003).
\textsuperscript{134} Both codes also oblige medical practitioners to participate in systems of quality assurance. \textit{(MBA Code} [6.2.2] \textit{; GMC Code} [22]).
\textsuperscript{135} Australian Commission on Safety and Quality in Healthcare, \textit{Australian Charter of Healthcare Rights}.
\textsuperscript{136} Australian Commission on Safety and Quality in Health Care, \textit{National Safety and Quality Health Service Standards} (September 2012) 3. This implication of excellence is also implied in other bodies with an important role in fostering clinical improvement, see eg, the Clinical Excellence Commission and the Hunter New England Health Excellence Program in New South Wales. The motto of Women’s Healthcare Australasia is ‘Supporting excellence in health care’.
\textsuperscript{137} Francis W Peabody, ‘The Care of the Patient’ (1927) 88 (March 19) JAMA 877, 882.
the statement reflected in paragraph 1.4 of the \textit{MBA Code}, that ‘good medical practice is patient-centred’\textsuperscript{138} despite the statement of Hiley J in the Northern Territory Supreme Court. He asserted that: ‘The clause 1.4 paragraph is expressed in very general and aspiration terms. It is not couched in imperative terms and does not prescribe and identify any specific obligations. It has no clearly identifiable content’.\textsuperscript{139}

 Nonetheless, there is ample evidence that patient-centredness is entering into the lexicon of medical practice, including academic discourse.\textsuperscript{140} Therefore, this section will canvas references to patient-centred care in soft law instruments, followed by its characterisation in the hard law of cases. It will then consider how patient-centred care is represented in the literature. Out of this information, this part will propose some recurring facets of patient-centred care and note their relationship to the rights of patients expressed in the \textit{Australian Charter of Healthcare Rights}. Finally, this section will indicate the relationship between the ideal of patient-centred care and the concepts of duty and quality.

 Patient-centred care is now widely recognised\textsuperscript{141} as not only providing superior care for patients, but also enhanced morale for health care workers and business benefits for health care institutions.\textsuperscript{142} For example, ACSQHC has asserted that: ‘... [I]t is clear that patient-centred care has significant benefits associated with clinical quality and outcomes, the experience of care, the business and operations

\begin{itemize}
\item \textsuperscript{138} Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [1.4].
\item \textsuperscript{139} Nitschke \textit{v Medical Board of Australia} [2015] NTSC 39 [119]. Similarly, in Medical Board of \textit{Australia v Meluish} [2016] ACAT 29 at [65] the tribunal agrees with Nitschke that paragraph 1.3 is aspirational and states that it ‘does not consider that it [clause 1.4] creates a standard that could constitute professional conduct’.
\item \textsuperscript{141} See eg, a small sample, Institute of Medicine, \textit{Crossing the Quality Chasm} (National Academy Press, 2001); Australian Commission on Safety and Quality in Health Care, \textit{Patient-Centred Care} (August 2011); Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014); General Medical Council, \textit{Good Medical Practice} (at 22 April 2013); Donald Irvine, \textit{The Doctors' Tale} (Radcliffe Medical Press, 2003); Dame Janet Smith, \textit{The Shipman Inquiry} (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004).
\item \textsuperscript{142} Australian Commission on Safety and Quality in Health Care, \textit{Patient-Centred Care} (August 2011) 9.
\end{itemize}
of delivering health services, and the work environment’.\textsuperscript{143} Haidet et al have observed that ‘[a] growing body of empirical evidence demonstrates that patient-centered care is associated with a number of favorable biomedical, psychological, and social outcomes.’\textsuperscript{144} Likewise, Sandman points out that:

Patient centred care (PCC) is gaining ground as a leading ideology of modern medicine and health-care and is increasingly advocated as a guide for how diagnose, consultations, treatment, and care should be performed.\textsuperscript{145}

The ideal of patient-centred care is not simply a series of directions for health care professionals and organisations that deliver health care services. It involves a change of emphasis from the priorities of individual or institutional health care providers to an emphatic focus upon the patient. Everything from design of buildings to the provision of health related services should revolve around the patient who is to be included in decision-making processes.\textsuperscript{146} Proponents of patient-centred care principles see that a change in culture is necessary.\textsuperscript{147} This change in culture must permeate through all staff, from the medical specialist to the cleaner. Patient experiences are enhanced by attention to improving first the small things, like clean bed linen, prompt response to call buttons and empathic admission and discharge procedures. Any change in culture should then flow through into other aspects of the health care system. Adoption of patient-centred care principles has been recognised as the foundation for developing systems of high quality health care.\textsuperscript{148}

The \textit{MBA Code}, in describing what is good medical practice, states that professionalism embodies all the qualities described in the code. Thus, if good medical practice is patient-centred, patient-centred good medical practice equates to the qualities of professionalism, the touchstones against which all conduct of a medical practitioner are evaluated. Irvine does not bother pondering about the relationship between patient-centred care and professionalism. He asserts:

\textsuperscript{143} Australian Commission on Safety and Quality in Health Care, \textit{Patient-Centred Care} (August 2011) 9.
\textsuperscript{144} Paul Haidet et al, ‘Characterizing the Patient-Centeredness of Hidden Curricula in Medical Schools: Development and Validation of a New Measure’ (2005) 80 \textit{Academic Medicine} 44, 44.
\textsuperscript{147} Judith Healy, \textit{Improving Health Care Safety and Quality} (Ashgate, 2011) xiv.
\textsuperscript{148} Australian Commission on Safety and Quality in Health Care, \textit{Patient-Centred Care} (August 2011) Foreword.
‘Patients want doctors who are competent, respectful, honest and able to communicate with them. That is patient-centred professionalism’. 149

The notion of patient-centred care can be found in other soft law instruments. The AMA Code makes patient care its primary focus.150 The GMC Code describes its detailed provisions for making the duty of medical practitioners to the primacy of the patient as ‘professionalism in action’.151 The code of the Royal Australasian College of Surgeons (the RACS Code) refers to patient-centred practice as the priority for its members.152

Whilst patient-centred care is not specifically mentioned in the National Law, it is implied in the definition of unprofessional conduct.153 The term has also appeared in a recent Western Australian Statute. Section 4(d) of the Health Services Act 2016 (WA) proclaims the act’s purpose as including: ‘to promote a patient-centred continuum of care, including patient engagement, in the provision of health services’. An early attempt by the Commonwealth Parliament to legislate for personally controlled electronic health records documented that: ‘Since the 1990s, e-health has been increasingly seen by most developed countries as central to the provision of current and future high quality, patient-centred care.’ 154

A confirmation of the duty of the medical practitioner to make the care of his or her patient the primary concern as required by paragraph 1.4 of Good Medical Practice, was provided in the New South Wales Court of Appeal. This concern was recognised as ‘patient-centred care’ in the case of Gorman v NSW Health Care Complaints Commission155 by one of the expert witnesses, Dr Young where he said: ‘The cornerstone of good patient management in the General Practice setting

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151 General Medical Council, Good Medical Practice (at 22 April 2013) 4.
152 Royal Australasian College of Surgeons, Code of Conduct, Preamble, College Pledge, Section 2.1, Section 8.
153 National Law - paragraph (e) of the definition in section 5: unprofessional conduct, of a registered health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner’s professional peers, and includes— (e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care;

is continuous and comprehensive patient centred care.' This statement is an articulation of the statement in paragraph 1.4 that good medical practice is patient-centred. This evidence had been provided to the New South Wales Medical Tribunal when the complaint against Dr Gorman was first investigated.

Further afield, in the English case of R (on the application of Morris) v Trafford Healthcare NHS Trust, the court noted a Department of Health guidance.

**Strengthening Accountability Involving Patients and the Public** provides in its executive summary that ‘...the overall aim of section 11 is to make sure patients and the public are involved and consulted from the very beginning of any process to develop health services or change how they operate. This will lead to patient-centred care and improvement in the patients' experience.’

There are numerous references to patient-centred care in tribunal proceedings, some observing that the medical practitioner in question either did or did not practise in patient-centred manner.

The literature also abounds with references to patient-centred care. For example, Healy recognises that ‘medical culture needs to ... consider collective good practice solutions and redesign service delivery as patient-centred’.

Tallis states:

> The scientific discipline that underpins medical practice is a powerful critical force supporting the drive to a high-quality patient-centred health service and a corrective to the panic or rhetoric that has informed many changes in the organisation of healthcare.

The practice of patient-centred care involves adherence to a set of behaviours by medical practitioners and health care institutions that demonstrate the ‘... duty to

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157 HCCC v Gorman [2011] NSWMT 7 [73].
158 R (on the application of Morris) v Trafford Healthcare NHS Trust [2006] EWHC 2334 (Admin) [56].
159 See eg, a small sample: HCCC v Dr Maendel (No 2) [2013] NSWMT 10 [13]; Professional Standards Committee Inquiry in Dr Joachim Fruher [2013] NSWMPSC 7 [24]; Dr Reid v Medical Council of NSW [2014] NSWCA 152 [58]; HCCC v Quach [2015] NSWCATOD 2 [354]; Syme v Medical Board of Australia [2016] VCAT 2150 [90]; Dr A v Health District (no 2) [2014] NSWIRComm 50 [142]; HCCC v Quach (No 2) [2015] NSWCATOD 32 [399].
make the care of patients their first concern ...".162 The Institute of Medicine in the United States defines ‘patient-centered care’ as: ‘Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions’.163

The following standards appear to be to be common principles in the concept of patient-centred care adopted by many organisations world-wide. Many are expressed in different language but have the same intent.164 They are reflected in paragraphs in the MBA Code. Some examples appear in square brackets after each paragraph.

- Involving patients, families and carers in planning and undertaking all aspects of medical treatment [2.2.11], [2.3], [3.2.4], [3.6.3], [3.8.3], [3.9.1].
- Respect for patient needs, wants and values [1.4], [2.4.1], [2.1.5], [3.1], [3.2.1].
- A safety culture [1.4], [3.10], [4.2.1], [4.3.3], [4.4.3], [6], [8.4].
- Treating patients with dignity [2.4.1], [3.2.1].
- Communication, education and information [1.4], [2.2.5], [3.1], [3.2.5], [3.3], [3.8.1], [3.9.2], [3.11], [3.12.7], [3.12.10], [4.5.1].
- Designing processes for patients not for providers [2.4.3], [3.2.2].
- Access to and continuity of care [2.1.3], [4.3], [4.5].
- Emotional support [3.3.1], [3.12.6], [3.12.9], [3.12.10].
- Privacy [3.2.], [3.4.2], [3.4.5], [3.8.3].
- Rights to complain [3.10.8], [3.11], [8.10].

As can be seen from the above list, the involvement of patient, families and carers in all decision-making concerning treatments is crucial to the ideal of patient-centred care. This sense of partnership as vital is reinforced by the terms of Standard 2 of the National Safety and Quality Health Service Standards.165

In the United States the Picker Institute in collaboration with Harvard Medical School have defined what they call ‘Principles of Patient-Centered Care’. They suggest the following:

- Respect for patients’ values, preferences and expressed needs;
- Coordination and integration of care;

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162 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
163 Institute of Medicine, Crossing the Quality Chasm (National Academy Press, 2001) 3.
164 For example, Vincent and Coulter list access to care, responsiveness and empathy, good communication, clear information provision, appropriate treatment, relief of symptoms, improvements in health status, safety and freedom from medical injury, (C A Vincent and A Coulter, ‘Patient Safety: What About the Patient?’ (2002) 11 Quality and Safety in Health Care 76, 76); Little et al note exploring the experience and expectations of disease and illness, understanding the whole person, finding common ground regarding management (partnership), health promotion, enhancing the doctor-patient relationship, the realistic use of time. (Paul Little et al, ‘Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study’ (2001) 322 BMJ 1, 1).
165 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) 22–25.
• Information, communication and education;
• Physical comfort;
• Emotional support and alleviation of fear and anxiety;
• Involvement of family and friends;
• Transition and continuity;
• Access to care.166

Clearly, whilst the ideal of patient-centred care exists as an aspiration for medical practitioners to strive to achieve, it is not devoid of meaning. Patient-centred care is referred to in varying contexts as a touchstone for quality,167 each reference presuming that the term has real content. The standards referred to above and as contained in the MBA Code, exemplify the matters that will lead to patient-centred care in practice. The law can also obligate the concrete procedures that give content to the idea.168

Yet, Coulter observes that some critics see attempts to promote a more patient-centred approach as peripheral to the serious business of treatment and care, and an unnecessary and burdensome addition to a long list of demands made on health professionals.169 This is an interesting criticism. The serious business of treatment and care requires a patient who must be involved in all aspects of treatment and care. This requirement is documented in the MBA Code170 and the National Safety and Quality Health Service Standards.171 Also, this thesis argues that good patient-centred medical practice equates with medical professionalism as documented in the MBA Code. Suggesting that a patient-centred approach is unnecessary and burdensome is to insist that observing the tenets of medical professionalism is an

166 Picker Institute, The Eight Principles of Patient Centered Care (online, 15 May 2015) <http://pickerinstitute.org/about/picker-principles/>.
168 National Law s 41 (the code is ’ ... evidence of what constitutes appropriate professional conduct or practice ... ‘).
170 See eg, Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [2.2.11],[2.3],[3.2.4],[3.6.3],[3.8.3],[3.9.1].
171 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) Standard 2.
unreasonable demand. Abiding by the principles recorded in the MBA Code is one of the factors taken into account by tribunals which determine whether or not the conduct of a medical practitioner is professional.\(^{172}\) Similarly, as the commentary on patient-centred care above claims, the core principles of patient-centred care align with the elements of the Australian Charter of Healthcare Rights.\(^{173}\)

Little et al suggest two fundamental problems with the implementation of patient-centred care in practice.\(^{174}\) The first is to know which of the elements is the most important. Secondly, they see a problem with the feasibility of implementation of all the factors or whether some need to be targeted to specific patient groups. As they comment: ‘It makes little sense to try to implement each component of the patient centred approach unless they are consonant with patients’ perspectives.’\(^{175}\) They particularly comment that feasible use of time may not be possible in a busy surgery.\(^{176}\) Once again, this criticism is interesting. Surely the patient-centred factor of communication would elicit some guide to what element the patient feels important. As for the feasible use of time, what is feasible is what is practicable in the circumstances. However, the conclusions from their research in fact showed that: ‘Most patients strongly want a patient centred approach. There are likely to be at least three important domains of patient centredness from the patients’ perspective: communication, partnership, and health promotion’.\(^{177}\)

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\(^{172}\) See eg, Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [198]; HCCC v Quach [2015] NSWCATOD 2 [50]; Medical Board of Australia v Henning [2014] SAHPT 7 [691]; Medical Board of Australia v Veetill [2015] WASAT 124 [227].

\(^{173}\) Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare Rights. The right to Participation.

\(^{174}\) Paul Little et al, ‘Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study’ (2001) 322 BMJ 1, 1. They state: ‘One influential patient centred model of consultation with a doctor encompasses five principal domains: exploring the experience and expectations of disease and illness, understanding the whole person, finding common ground regarding management (partnership), health promotion, and enhancing the doctor-patient relationship; and a sixth domain, the realistic use of time.’ Their research is based on assessing the above domains which are not exactly consonant with those adopted in this thesis, though have a great deal in common. Previous research based on secondary care suggested that older patients and those with a serious illness may not prefer patient centred approaches (at page 2) and the research in this article is an attempt to find out what patient centredness means for primary care.

\(^{175}\) Paul Little et al, ‘Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study’ (2001) 322 BMJ 1, 1.

\(^{176}\) Paul Little et al, ‘Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study’ (2001) 322 BMJ 1, 1.

\(^{177}\) Paul Little et al, ‘Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study’ (2001) 322 BMJ 1, 6.
Thus, patient-centred medical practice now seems to be more and more widely adopted with research cataloguing the benefits both to patient care and to morale among health practitioners. Patients are entitled to expect that their interactions with the health system will make them better not cause injury or death. There are numerous ways in which patient safety can be compromised but close attention to patient-centred principles minimises risks.

Adoption of a patient-centred culture entails close attention to quality as a way to ensure patient safety. Healy observes that the quality movement promotes the concept of patient-centred care, that is designing health care around the interests of patients, not just those of providers. Research by Little et al into whether patients’ perceptions of patient centredness predict outcomes, showed that measurement of patients’ perceptions in these circumstances ‘... provide a marker of the quality of care. If doctors don’t provide a positive, patient centred approach patients will be less satisfied, less enabled, and may have greater symptom burden and use more health service resources.’

Patient-centred care is also the result of the observance by medical practitioners of their duty to make their patients their first priority, the centrality of the patient as confirmed by the MBA Code.

4 SUMMARY OF RELATIONSHIP BETWEEN THE CONCEPTS

The aspirational character of the MBA Code is reflected in its description as: ‘... set[ting] out the principles that characterise good medical practice and mak[ing] explicit the standards of ethical and professional conduct expected of doctors .... ’. To reiterate, Clause 1.4 states: ‘Doctors have a duty to make the care of their patients their first concern, ...’. Similarly, as Good Medical Practice refers to professionalism as embodying all the qualities described in that code, the concept of duty as an obligation is thereby connected to the idea of quality as excellence.

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178 Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011) 9.
179 Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011) 91.
180 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 8.
182 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
183 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.1].
As stated above, the conceptual framework upon which this thesis rests is the equivalence of patient-centred principles to the ideals of medical professionalism. The concept of quality, in its sense of a standard of excellence, is integrated with professionalism by the terms of Clause 1.4 of the MBA Code quoted earlier in this chapter — ‘Professionalism embodies all the qualities described here ... ’. Patient-centred care is also one of the facets of quality listed by the United States Institute of Medicine as outlined above.

The relationship of quality with duty appears in Clause 1.4 of the MBA Code that sets out ‘Professional values and qualities of doctors' and Clause 8.1 that emphasises ‘ ... the core qualities and characteristics of good doctors ... ’ and that includes the duty to the patient.  

The duty to patient priority is a duty to patient-centred medical practice, the priority of the patient being the primary task of the medical practitioner. In addition, adoption of a patient-centred culture entails close attention to quality as a way to ensure patient safety. There are numerous ways in which patient safety can be compromised but close attention to patient-centred principles minimises risks. Healy observes that the quality movement promotes the concept of patient-centred care, that is designing health care around the interests of patients, not just those of providers. Research by Little et al into whether patients’ perceptions of patient centredness predict outcomes, showed that measurement of patients’ perceptions in these circumstances ‘ ... provide a marker of the quality of care. If doctors don’t provide a positive, patient centred approach patients will be less satisfied, less enabled, and may have greater symptom burden and use more health service resources’.

Having explored the concepts of duty, quality and patient-centred care in medical practice, it is now time to move on to showing how rhetoric and reality can part company.

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184 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
185 Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011) 91.
186 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 8.
As Audet, Davis and Schoenbaum point out:

> Our results point to a gap between knowledge and practice, between what physicians say they want to achieve (patient-centered practice attitudes) and what they are able to do (patient-centered practice adoption).\(^{188}\)

The following chapters will identify some elements of medical practice that undermine the necessity to prioritise patient-centred care as the essential standard in medical practice for achieving safer and better quality medical care.

\(^{188}\) Anne-Marie Audet, Karen Davis and Stephen C Schoenbaum, 'Adoption of Patient-Centred Care Practices by Physicians' (2006) 166 Archives of Internal Medicine 754, 758.
CHAPTER II: PATIENT-CENTRED CARE AND THE LIMITS OF MEDICAL ETHICS AND MEDICAL PROFESSIONALISM

The first step on the way to understanding modern medicine ... is to unravel the rhetoric of medicine.¹

A INTRODUCTION

This chapter explores what underlies the notion of medical professionalism. The principles of medical ethics and the ideals of medical professionalism provide the foundations for the assertion by the medical profession of its trustworthiness and its right to self-regulate. From its earliest days, medicine has seen itself as a moral enterprise;² a consciousness partly explained by differing religious traditions.³

¹ Ian Kennedy, The Unmasking of Medicine (George Allen and Unwin, 1981) 2.
³ Jonsen describes precepts of compassion, honesty, humility, mercy, humanity and learning underlying the conception of medicine from Christianity (Albert R Jonsen, A Short History of Medical Ethics (Oxford University Press, 2000) 13), Islam (Ibid 19), Judaism (Ibid 21) Buddhism and Confucianism (Ibid 38).
Medical professionalism is underpinned by a strong focus on the ethical values that medical practitioners proclaim and that are emphasised as necessary to build and sustain the trust that the public has in its doctors.\textsuperscript{4}

This chapter commences by describing what is encompassed in the concept of medical professionalism. It outlines what is common to all occupations that term themselves professions, a body of specialised knowledge, a strong emphasis on ethical values and the obligation to serve the community in which it functions. In exchange, the community grants the profession the right to regulate itself.

The rhetoric of codes obliges medical practitioners to adhere to the principles of professionalism and patient-centred care and their message of integrity, trustworthiness, altruism and respect for patient autonomy. But there are some features that are closely associated with medical professionalism, that may detract from the medical profession’s rhetoric enshrined in its codes.\textsuperscript{5}

This chapter continues by exploring how codes of practice have developed as a way of demonstrating, both to the public, and to members of the medical profession themselves, the ethical values by which the profession identifies itself. It shows how codes have evolved from an emphasis on inter-professional concerns, to acknowledge and prioritise the well-being of the patients that are the justification for medical practice.

However, codes and guidelines issued by professional bodies cannot provide the answers to all ethical problems that arise. This chapter explores what medical ethics encompasses, the broad principles to guide medical practitioners who are confronted, from time to time, by problems that cannot be resolved by strictly

\textsuperscript{4} For example, the Australian Medical Association (AMA) identifies the following as core values of the medical profession:

\begin{itemize}
  \item respect,
  \item trust,
  \item compassion,
  \item altruism,
  \item integrity,
  \item justice,
  \item accountability,
  \item protection of confidentiality,
  \item leadership, and
  \item collegiality.
\end{itemize}


\textsuperscript{5} These features include a government-granted monopoly, arrogation of the entitlement to define illness, paternalism, arrogance, hierarchy and the assertion of the right to self-regulate.
technical expertise. The two most influential theoretical streams of medical ethics are, firstly, principlism, and secondly, virtue ethics. Each of these approaches will be scrutinised to identify both their good points and their deficiencies.

In addition, some eminent medical bodies, aware of adverse publicity surrounding medical scandals in recent years, have supplemented codes. They have promulgated charters of professionalism in an attempt to re-kindler the former good reputation of the medical profession.

Yet, behaviours like poor communication, arrogancy, paternalism, disregard of patient dignity and autonomy and bullying of patients and colleagues are still prevalent. These behaviours have often been observed in the process of being trained, both at an undergraduate level and during clinical experiences. The ‘hidden curriculum’ is known to be as influential as the formal instruction provided. The way the ‘hidden curriculum’ influences attitudes is explored. This exploration shows how medical students can be conflicted by inconsistent messages conveyed by both good role models and some questionable behaviours of persons charged with their instruction.

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11 Medical students absorb ways of acting by exposure to the activities of lecturers, fellow students and other instructors. They also take in subtle messages concerning acceptable conduct, conveyed by the priorities of medical schools.
Thus, this chapter suggests that what may be required in efforts to encourage the assimilation of ‘virtuous’ behaviour and to inculcate the principles of medical ethics and medical professionalism in patient-centred medical practice, is to identify ways of reducing the influence of the ‘hidden curriculum’ and other entrenched attitudes that can lead to offhand attitudes to patients. What is in issue is a conflict between the explicit commitments to professional values inherent in good medical practice like compassion, altruism and respect for patient dignity and autonomy and the tacit learning of detachment, self-interest and privilege. Sir Donald Irvine sees medical education as the best way of ‘... internalising the values and standards of the new professionalism’. He recognises the negative impacts that accompany the ‘hidden curriculum’ and argues that ‘[w]hat we need now are individual medical schools to take responsibility, and to be sure, at least, that their teaching faculty members are all exemplars of good doctoring.’ This chapter will propose that teaching of medical ethics should assume a higher priority in education of medical students.

Finally, this chapter notes some internal conflicts in codes of ethics. It will criticise provisions that permit medical professionals to decline on conscience grounds to perform a medical procedure, even one that is legally available in Australia. It will suggest ways that could be adopted to reconcile the interests of those medical practitioners and their patients.

B THE IMPORTANCE OF MEDICAL PROFESSIONALISM

As the practice of medicine is not a business and can never be one, the education of the heart — the moral side of the man — must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals in corn and coal; “the human heart by which we live” must control our professional relations.

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15 William Osler, ‘On the Educational Value of the Medical Society’ in Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine (Blakiston, 1904) 349–350.
Medical professionalism should lie at the heart of all encounters between medical practitioners and their patients. The need for professionalism in medical practice has received much attention in practice journals and academic writings.16

This section commences by giving a brief account of the development of medicine into a profession in its own right. It describes the features of those occupations that call themselves professions to distinguish themselves from what were trades or crafts. It then scrutinises certain characteristics of medical professionalism that arguably distinguish it from other professions such as monopoly, defining illness, hierarchy, self-regulation, arrogance and paternalism. Whilst these characteristics may also exist in some measure in other professions, they manifest themselves in particular ways in the medical profession reflecting the power imbalance between practitioner and patient.17

As a general conclusion, the status of the medical profession has, in the past, allowed it to resist the addressing of a range of problems that detract from its claim to professionalism.18 The law has provided many protections for the activities of medical practitioners and has respected and endorsed the medical privileges and discretions of members of the medical profession. The profession wants to retain this virtually unquestioned recognition of its clinical prerogatives by non-members.19


18 For example, it has been resistant to permitting supervision and scrutiny of its activities by ‘outsiders’ such as lawyers or bureaucrats. (Roger S Magnusson, Angels of Death (Melbourne University Press, 2002) 103; Eliot Freidson, Professional Dominance (Aldine Publishing, 1970) 98; Ian Kennedy, The Unmasking of Medicine (George Allen and Unwin, 1981) 125).

1 The Meaning of Professionalism

Macquarie Dictionary’s first meaning for a profession is as ‘... a vocation requiring knowledge of some department of learning or science, especially one of the three vocations of theology, law and medicine, (also known as the learned professions)’. 20 MacKenzie argues that the learned professions also see themselves as using this specialised knowledge in the service of others, commitments to various ideals and a social contract with the community in which it works. 21 The mark of any profession is socialisation to its attitudes and philosophies and the devotion to the learning and skills of that profession. In turn the community grants the profession autonomy in practice, 22 a monopoly over the use of its particular knowledge and skills 23 and the right to regulate itself. 24

Professions have acquired a dominant position in society. 25 Their members are the repositories of specialised knowledge acquired through many years of academic and practical training. 26 At the end of basic training, aspiring professionals are subject to a rigorous examination process to prove that they have the knowledge and skills necessary for admission to the profession. 27

27 This examination process is crucial to demonstrate that the professional can be allowed to 'practise' on members of the public, both as a way to confirm acquired expertise and to gain the experience to enhance that expertise.
2 The Evolution of Medicine as a Profession

Healers have been present in human societies for millennia. In the middle ages, persons pursuing similar occupations joined into guilds to assert their common interests. Universities began to train physicians. Both guilds and universities provided a public profile for physicians that gave them the basis for their standing in the community. The Royal College of Physicians of London was established in 1518 by a charter from King Henry VIII that gave it the authority to determine who could legally practise medicine thus exemplifying the modern idea of a profession as a self-regulating body. Physicians began to term themselves a profession to distinguish themselves from surgeons and other health practitioners and also to emphasise their superiority as university trained practitioners.

The precursor for the British Medical Association, the Provincial and Medical Surgical Association, was founded in 1832 as a forum for physicians to exchange scientific information related to the practice of medicine. It adopted the name, British Medical Association in 1855 and provided an impetus for the 1858 legislation establishing the General Medical Council and the Medical Register, both of which are still operating today. The American Medical Association was founded in 1847.

3 Features of Medical Professionalism

Professionalism cannot be imposed by governments or by regulatory culture. It must emerge from and be sustained by doctors themselves.

Medical professionalism underlies good patient-centred medical practice. Whilst members of all professions are permitted to learn their skills as a way of earning a good living, the society also expects that they will use their skills for the benefit of

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29 Eliot Freidson, Profession of Medicine (Dodd, Mead and Company, 1970) 19.
30 Jeffrey Lionel Berlant, Profession and Monopoly (University of California Press, 1975) 130.
35 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
their society, thus ensuring their high prestige and authoritative voice in public life. However, some commentators have observed that the medical profession has features that can detract from the observance of patient-centred care principles. Those characteristics of the medical profession that do not reflect the duty of the medical practitioner to make the care of the patient the practitioner’s first concern, can detract from the patient-centred objective of a partnership between medical practitioner and patient in achieving optimum health outcomes. They may also add to a public perception that the medical profession is not keeping its side of the social contract that grants prestige in exchange for service to society.

(a) Monopoly

By restricting, in the name of public safety, the practice of medicine to those who have shown their technical competence, the state has conferred a practical monopoly on the medical profession. The law forbids non-registered persons from performing medical procedures and may prosecute those who do. As Jonsen observes,

[in] essence it comes down to a social tolerance for a monopoly in return for a promise of social benefit in the form of competent and dedicated medical care. The monopoly exists because physicians set the standard of competence, educate the candidates, and examine their skills.

However, the existence of a monopoly also gives the medical practitioner the power to grant or deny access to medical care on irrelevant grounds like bias or discrimination. Denying patients access to medical care on moral or religious grounds is also forbidden under codes of practice, though medical practitioners can decline to personally provide that care. As Charo contends, the fact that abortion, birth control and in vitro fertilisation are, by the terms of the monopoly given to the medical profession, restricted to medical practitioners, makes the medical profession a form of public utility, obliging its members to provide those services to all who want them.

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37 Eliot Freidson, Profession of Medicine (Dodd, Mead and Company, 1970) 53.
39 See eg, Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [2.4.7]; General Medical Council, Good Medical Practice (at 22 April 2013) [59].
40 R Alta Charo, 'The Celestial Fire of Conscience - Refusing to Deliver Medical Care' (2005) 352 NEJM 2471, 2473.
The medical profession’s connection with increasingly predictable and positive outcomes of treatment for illness or disease based on scientific observation and experience has meant that the public has been prepared to put its trust in medical practitioners. It ought therefore be permitted to regulate which persons should be permitted to practise medicine. It also argues that the safety of members of the public is dependent on excluding other persons who purport to practise some form of healing. As Frenk and Durán-Arenas comment, by confirming a monopoly for the medical profession, the state creates the conditions for pricing some segments of the population out of the market.

The profession’s technical knowledge is publicly recognised so this practical monopoly has been officially approved. The medical practitioner alone can provide to a patient a certificate of illness that gives the patient the right to be absent from work, eligible for compensation or requiring specialist attention. Only a medical practitioner can prescribe restricted drugs and authorise tests.

(b) Defining Illness

However, in addition to these features of the medical monopoly, Freidson’s research suggests that medicine has arrogated to itself the right to determine what is illness or not and the right to treat illness. Kennedy agrees by commenting that the first decision that he is ill is made by the patient but he needs confirmation before the benefits of being ill can be accessed. The monopoly power to confirm or deny illness is in the hands of the doctor. Kennedy further comments that the monopoly of licensure gives the medical practitioner the sole right to declare, and if necessary, certify that an individual is or is not ill: ‘If illness is a judgment, the practice of medicine can be understood in terms of power. He who makes the

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judgement yields the power"49 thus reinforcing the disparity between medical practitioner and patient.

Confirmation of the status of being ill can mean that the sufferer is looked after by others and is relieved of responsibility for the duration of the illness. As Illich observes:

The physician has increasingly abandoned his role as moralist and assumed that of enlightened scientific entrepreneur. To exonerate the sick from accountability for their illness has become a predominant task, and new scientific categories of disease have been shaped for the purpose.50

The process of defining illness requires the medical practitioner to locate the situs of the illness, try to explain what caused it and to suggest what is required to free the patient of the illness as diagnosed.51 If the illness is severe, it may require the patient to be dependent on others for all manner of assistance from feeding to mobility, from pain relief to personal functions.52

The existence of the medical profession’s legal and practical monopoly — as Kennedy comments ‘power’53 — over illness and its incidents also leads to an expectation by practitioners that they should be accorded respect by patients and the community.54

(c) Hierarchy

In addition to the high power and status of the medical profession is the internal hierarchy apparent in team settings, particularly in hospitals.55 Senior clinicians expect to be obeyed by more junior medical practitioners, by students and by other health professionals like nurses.56 To a certain extent, hierarchy is necessary in the education of students who expect to learn from more experienced practitioners.57 However, the pervasiveness of hierarchy in the medical profession can lead to

49 Ibid 7.
50 Ivan Illich, Limits to Medicine (McClelland and Stewart, 1976) 120.
54 Jack Coulehan and Peter C Williams, ‘Vanquishing Virtue: The Impact of Medical Education’ (2001) 76 Academic Medicine 598, 600.
57 Eliot Freidson, Profession of Medicine (Dodd, Mead and Company, 1970) 166.
unprofessional conduct, to the ostracism of whistle blowers, to forgiving mistakes of their fellows, to the diffusion of responsibility for adverse events and to the rejection of the expertise of the lower ranking. It can also lead to bullying of ‘inferiors’ and to their reluctance to complain about it.

(d) Self-Regulation

Despite unprofessional behaviour as outlined above, the medical profession has always claimed the right to regulate itself. One of the distinguishing features of any profession is the right to discipline its members as they see fit. Professions argue that only they have the technical skills and the knowledge of ethical principles relevant to the profession concerned. Ayres and Braithwaite comment that to some extent there is a symbiosis between state regulation and self-regulation. Chapter III will show that much regulation is based on the premise that the internal features of an industry are best understood by those within it. Yet, self-regulation can insulate professions such as the medical profession from searching external scrutiny. Chapter III also provides further details about the limitations of self-regulation for medical practitioners.

Because of the widespread preference for individual private practice by medical practitioners, the opportunities to scrutinise the work of individual medical practitioners are limited. Unlike the profession of law where the bulk of work

66 Ian Ayres and John Braithwaite, Responsive Regulation (Oxford University Press, 1992) 3.
involves interactions with other practitioners, the work of a medical practitioner is, more often than not, concealed from external scrutiny. The medical practitioner is usually dealing one-on-one with the patient. Unless some dramatic adverse event occurs, other medical practitioners are not normally in a position to evaluate the work of the medical practitioner.

This lack of regular and open scrutiny can lead to the concealment of deficient practices. Assessment of performance is limited by the lack of technical knowledge of those outside the profession. The profession has been trusted to keep its own house in order and to discipline those that stray outside the bounds of competence or ethics. Braithwaite, Healy and Dwan point out that the medical profession has a long tradition of self-regulation but that the ‘... complacent approach of “leaving it to the doctors” is now under challenge’.

The option to self-regulate may be abused if there is reluctance to investigate too deeply the activities of another member of the profession. The record of the medical profession shows numerous failures to deal with either incompetence or with medical practitioners whose ability to practice is impaired by drugs, illness or temperament.

Braithwaite, Healy and Dwan have also observed that regulation in the health sector has traditionally been ‘soft’, essentially non-interventionist. Similarly, Healy has commented that medical boards are reluctant regulators except in egregious cases. Reluctance by regulators to deal with even demonstrated cases of unprofessional behaviour was exemplified by English cases such as that of Dr Harold Shipman. Dr Harold Shipman was among many other practitioners who were dealt with leniently by the GMC. Shipman was addicted to pethidine and was

67 Eliot Freidson, Profession of Medicine (Dodd, Mead and Company, 1970) 152.
68 Ibid 156.
69 Ibid 137.
71 David J Rothman, ‘Medical Professionalism — Focusing on the Real Issues’ (2000) 342 NEJM 1284, 1284. For example, Dame Janet Smith’s fifth report of the Shipman Inquiry catalogues disciplinary proceedings brought against medical practitioners where seriously aberrant behaviour has been treated by the General Medical Council as necessitating rehabilitation rather than discipline by supervision or conditions. (Dame Janet Smith, ‘The Shipman Inquiry’ (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004) [96], [15.12], [16.60], [16.176].)
73 Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 129.
convicted of forgery, fraud and possession of pethidine. The GMC seemed to be less interested in the safety of patients than in the rehabilitation of medical practitioners.\textsuperscript{75} Shipman was permitted to continue in practice receiving only a warning letter.\textsuperscript{76} The GMC process relied on psychiatric reports from medical practitioners who were nominated by and known to the medical practitioner who had been convicted of drug offences. There was no independent inquiry as to whether patients were being put at risk.\textsuperscript{77}

Failures in self-regulation have led to greater external scrutiny by regulators, even if they have been reluctant on occasion. But the fact that there are still so many facing disciplinary proceedings suggests that many medical practitioners are not observing professional norms of conduct. Disciplinary cases are analysed in more depth in Chapter III.

\textit{(e) Arrogance}

Several commentators have suggested that arrogance is a hallmark of the medical profession. Turner comments that the medical profession sees itself as somehow superior to other learned professions.\textsuperscript{78} Magnusson sees the drive to preserve ‘clinical discretion’ and the designation of decisions as doctors’ ‘turf’ as a mark of medical arrogance.\textsuperscript{79} Kass contends that this arrogance derives from physicians’ own attitudes and prejudices that colour their activities with respect to their patients.\textsuperscript{80} He argues that physicians need to be protected against their own arrogance and weakness, precisely because they have the power of life and death over their patients.\textsuperscript{81} Pellegrino maintains that arrogance born of self-importance and a sense of infallibility can demean patients and add to the indignity of the illness itself.\textsuperscript{82}

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\textsuperscript{75} Dame Janet Smith, 'The Shipman Inquiry' (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004) [98].
\textsuperscript{76} Dame Janet Smith, 'The Shipman Inquiry' (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004) [16.156].
\textsuperscript{78} Bryan S Turner, Medical Power and Social Knowledge (Sage Publications, 1987) 141.
\textsuperscript{80} Leon R Kass, "I Will Give No Deadly Drug": Why Doctors Must Not Kill" in Kathleen Foley and Herbert Hendin (eds), The Case against Assisted Suicide (Johns Hopkins University Press, 2002) 17, 29.
\textsuperscript{81} Ibid 30.
\textsuperscript{82} Edmund D Pellegrino, 'The Lived Experience of Human Dignity' in President's Council on Bioethics (ed), Human Dignity and Bioethics (President's Council on Bioethics, 2008) 513, 530.
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Any arrogance towards patients and other health care professionals is contrary to the ethical requirement to treat both patients\(^83\) and colleagues with respect.\(^84\) Any arrogant behaviour can also undermine the profession’s insistence that it is caring and trustworthy and derogate from good patient-centred medical practice.

\((f)\) **Paternalism**

An adjunct to arrogance exhibited by some medical professionals is the expectation that patients should observe their directions without question. Medical paternalism is a function of the power differential between the medical practitioner and the patient, where the vulnerable patient needs the medical expertise.\(^85\) Strong forms of paternalism have been based on the assumption that the medical practitioner knows what is best for the patient and can make decisions without informing the patient of the facts, alternatives or risks.\(^86\) As Gawande relates, doctors used to make the decisions and patients did what they were told.

> Doctors did not consult patients about their desires and priorities and routinely withheld information — sometimes crucial information, such as what drugs they were on, what treatments they were being given, and what their diagnosis was. Patients were even forbidden to look at their own medical records ...\(^87\)

The requirement that the patient consent to medical treatment is now well-established, a recognition of patient autonomy in the face of medical power. However, the requirement for consent to medical treatment is not necessarily a bulwark against medical paternalism. Coulehan reports the surgeon who has boasted that consent is a farce, as he can get a patient to agree to anything he wants — ‘It’s not what you say, it’s how you say it’.\(^88\) Furthermore, the case of *Medical Board of Australia v Adams* saw the practitioner suspended for six months and imposition of conditions.\(^89\) In a 12 month period he had forged consent forms for 37 patients\(^90\) on the grounds that consent forms were complex, required completion on admission\(^91\) and created too much work for himself and his staff.\(^92\) These cases

\(^{83}\) See eg, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [2.4], [3.2.1].

\(^{84}\) Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [4.2].


\(^{89}\) Medical Board of Australia v Adams [2017] VCAT 796.

\(^{90}\) Medical Board of Australia v Adams [2017] VCAT 796 [8].

\(^{91}\) Medical Board of Australia v Adams [2017] VCAT 796 [35].

\(^{92}\) Medical Board of Australia v Adams [2017] VCAT 796 [41]. ‘I decided to cut out the middle man and fill in the form myself’. [41].
illustrate that patient autonomy can be illusory as the medical practitioner may have the final say.\textsuperscript{93}

Courts have recognised a ‘therapeutic privilege’ that may entrench medical paternalism. Whilst the medical practitioner has a duty to give the patient complete information so that the patient can determine whether or not to go ahead with a procedure,\textsuperscript{94} ‘therapeutic privilege’ permits the medical practitioner to withhold information about risk if it can be shown that a reasonable medical assessment of the patient would suggest to the medical practitioner that there would be a serious threat of psychological detriment to the patient.\textsuperscript{95}

The judgement of the medical practitioner as to what to tell the patient also takes into account the medical practitioner’s assessment of the character and emotional condition of the patient. Thus it is proper that a medical practitioner acting in the best interests of the patient would be concerned that a warning about the outcome of a surgical procedure may frighten the patient into refusing an operation that, in the view of the medical practitioner, is best treatment for the patient in the circumstances. As Lord Scarman said in Sidaway:

There is no evidence to justify an inference that this careful and compassionate man (the history of the case, which I have related, shows that he merited both adjectives) would have failed to consider what was in the best interests of his patient. He could well have concluded that a warning might have deterred her from agreeing to an operation which he believed to be the best treatment for her.\textsuperscript{96}

Notwithstanding, the United Kingdom Supreme Court has held that the therapeutic exception should not be abused.

It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.\textsuperscript{97}

However, medical paternalism, while still occurring on occasion, is no longer the problem it used to be. In his judgement in Chester v Afshar, Lord Steyn

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\textsuperscript{93} Edmund D Pellegrino, ‘Compassion is not Enough’ in Kathleen Foley and Herbert Hendin (eds), The Case against Assisted Suicide (Johns Hopkins University Press, 2002) 41, 48.
\textsuperscript{94} See eg, Rogers v Whitaker (1992) 175 CLR 479.
\textsuperscript{95} Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 887 (Lord Scarman).
\textsuperscript{96} Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 883 (Lord Scarman).
\textsuperscript{97} Montgomery v Lanarkshire Health Board [2015] UKSC 11 [91] (Lord Kerr and Lord Reid).
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commented: ‘In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed ... ’.  

Similarly, the Supreme Court of the United Kingdom in Montgomery, confirmed that recent ‘ ... social and legal developments point away from a model of the relationship between the doctor and the patient based upon medical paternalism.’

Likewise in Australia, in Breen v Williams, Gaudron and McHugh JJ observed that ‘ ... recent decisions of Australian courts have rejected the attempt to treat the doctor-patient relationship as basically paternalistic ... ’.

The principle is clear as is borne out by recent cases cited above — that paternalism is no longer acceptable within the doctor-patient relationship and the courts will, if necessary, penalise a failure to respect patient autonomy. Professionalism dictates that failure to acknowledge and respect patient autonomy is both legally and ethically unacceptable.

(g) Conclusion
The status of the medical profession has allowed it to resist the addressing of a range of problems such as those outlined above that can detract from its claim to professionalism. The vulnerability of the patient created by the power differential in the doctor-patient relationship necessitates personal reference by the medical practitioner to ethical principle.

C CODES OF ETHICS AND PRACTICE – ACKNOWLEDGING THE PATIENT

The critical sense and sceptical attitudes of the Hippocratic school laid the foundation of modern medicine on broad lines and we owe to it: first, the emancipation of medicine from the shackles of priestcraft and of caste; secondly, the conception of medicine as an art based on accurate observation, and, of man and nature; thirdly, the high moral ideals expressed in that most memorable of human
documents, the Hippocratic oath; and fourthly, the conception and realization of medicine as a profession of a cultivated gentleman.\textsuperscript{104}

Medical codes of ethics or codes of practice set out a series of behaviours to which medical practitioners must adhere. They declare what the medical bodies that prepare them consider to be professional behaviours based on lists of principles and virtues. Some of these principles and virtues recur in most codes.

In the United Kingdom, the General Medical Council’s \textit{Good Medical Practice} (the \textit{GMC Code}) commences by saying that ‘[p]atients must be able to trust doctors with their lives and health’.\textsuperscript{105} In Australia, the \textit{MBA Code} declares that all the qualities it describes, including self-awareness and self-reflection, are embodied in professionalism.\textsuperscript{106} As Pellegrino and Thomasma argue, medicine is a moral community because of the nature of illness, the nonproprietary nature of medical knowledge and the nature and circumstances of the professional oath.\textsuperscript{107} Codes are intended to reassure patients. The aspirations expressed in codes form part of the rhetoric of patient-centred medical practice. Yet, as Brazier and Cave have observed, in the past, codes of practice have often seemed to be more concerned with the ethical obligations of medical practitioners to each other and reference to patient concerns has been limited.\textsuperscript{108} Similarly, Beauchamp and Childress observed that few codes have been subjected to scrutiny by patients.\textsuperscript{109}

Codes of ethics have now evolved from standards governing etiquette between medical practitioners into a body of principles directed to both the public and the profession that underpin society’s trust in and expectations of its doctors. Wynia asserts that members of professions should adhere to the ideals articulated in codes of ethics or practice because they are designed to create trust between the professional and members of the society.\textsuperscript{110} Cruess and Cruess note that these

\textsuperscript{104} William Osler, ‘Chauvinism in Medicine’ in \textit{Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine} (Blakston, 1904) 280.
\textsuperscript{105} General Medical Council, \textit{Good Medical Practice} (at 22 April 2013).
\textsuperscript{106} Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [1.4].
\textsuperscript{107} Edmund D Pellegrino and David C Thomasma, \textit{The Virtues in Medical Practice} (Oxford University Press, 1993) 37.
\textsuperscript{108} Margaret Brazier and Emma Cave, \textit{Patients, Medicines and the Law} (Penguin Books, 2007) [3.7].
codes detail the behaviour expected of professionals as the demonstration to the community of the ideals that underpin their social contract with the community.\textsuperscript{111}

However, these declarations of principles were not always so extensive. The \textit{Hippocratic Oath} sets out some currently recognisable principles but the background to modern codes, both in England and Australia, shows a strict focus on inter-personal relations between medical professionals. It is only in recent years that codes have evolved to place the care of the patient at the core of the doctor’s attention.

This section commences by an examination of the \textit{Hippocratic Oath}. It is still called upon in the 21\textsuperscript{st} Century as the model for ethical medical practice. Yet its shortcomings are now apparent and will be outlined below. A series of modern codes of conduct grew out of the writings of a number of early physicians who were concerned to reduce the degree of infighting between members of the profession. The background to modern codes will be considered, noting the comparatively recent emergence of the patient as the prime object of the medical practitioner’s concern.

1 The Hippocratic Oath

The Hippocratic Oath \(^{112}\) has been lauded by Dowbiggin as setting out worthy ideals of a person who professes competence, is utterly trustworthy and who puts the needs of those who consult him before his own needs.\(^{113}\) However, some writers have observed that this oath is not based upon any altruistic concern for the patient. It reflects more the hypocritical altruism that disseminates the message that if a patient gives the physician his business, he will not take unfair advantage of the privilege of being invited into the patient’s house. By subscribing to the Hippocratic Oath, the group of physicians concerned was declaring to the public that there were particular activities that might be considered unwelcome by a stranger that they would not do, thus distinguishing themselves from others who were not prepared to subscribe to those limitations.

As Jonsen comments, examination of text and the context of Hippocratic medicine suggests that altruism was missing in the Hippocratic practitioner who was a skilled craftsman and whose objective was a good living.\(^{114}\) Pellegrino and Thomasma agree by noting that, whilst the Hippocratic Oath appears to recognise that its adherents are members of a moral community who have certain

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\(^{112}\) I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract:
To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.
I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them.
I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.
In purity and according to divine law will I carry out my life and my art.
I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.
Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.
Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.
So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

\(^{113}\) Ian Dowbiggin, A Concise History of Euthanasia (Rowman & Littlefield, 2005) 11.

responsibilities, the oath itself is morally defective in having the purpose of protecting the guild.\(^{115}\)

The *Hippocratic Oath* asserts that those who strictly observe its principles will earn the respect of all men. Some of those principles are reflected in codes of practice to this day.\(^{116}\) This oath is often quoted by contemporary medical practitioners arguing against medically assisted suicide or abortion, both of which are forbidden by the terms of the *Hippocratic Oath*. Yet, it requires its adherents to forswear surgery, a requirement no longer heeded by medical practitioners. Again, it is unlikely that the provision that the physician’s teacher be held in the same esteem as the physician’s parents and supported for his life would be observed today.\(^{117}\)

### 2 Historical Codes of Medical Ethics as Codes of Etiquette

It was only in the eighteenth century that the idea of medicine as a profession was conceived by John Gregory, a Scot and Thomas Percival, an Englishman.\(^{118}\) The medical profession had previously been considered a ‘merchant guild’.\(^{119}\) As McCullough remarks, medical practitioners were primarily concerned with etiquette in response to the ‘intensely competitive entrepreneurial world’ of medicine pertaining at the time.\(^{120}\)

Gregory’s *Observations on the Duties and Offices of a Physician*\(^{121}\) emphasised both scientific and clinical competence, cautioned against physician self-interest and developed the idea of medicine as a public trust. According to Gregory, gentlemen from the best families applied to study medicine.\(^{122}\) Physicians were


\(^{116}\) For example, it requires the healer to treat all contacts with the patient as confidential, and to avoid any impropriety in the homes he visits including seduction of any man or woman, free or slave. Patient orientation is included in the obligation to enter a home only for the benefit of the sick. The physician should also do no injustice or harm to his patients.

\(^{117}\) Mason and Laurie speculate that the *Hippocratic Oath* actually predates Hippocrates (J K Mason and G T Laurie, *Law and Medical Ethics* (Oxford University Press, 8th ed, 2011) 3); The *Declaration of Geneva* is its modern incarnation (Declaration of Geneva (1948). Adopted by the General Assembly of World Medical Association at Geneva Switzerland, September 1948).


\(^{119}\) Ibid.

\(^{120}\) Laurence B McCullough, ‘The Discourse of Practitioners in Eighteenth-Century Britain’ in Robert B Baker and Laurence B McCullough (eds), *The Cambridge World History of Medical Ethics* (Cambridge University Press, 2008) 403. In England and the United States, early codes of ethics were promoted as a way of setting out the boundaries of practice between medical practitioners rather than emphasising the priority of the patient.


\(^{122}\) Ibid 6.
expected to act like gentlemen\textsuperscript{123} and, as such, their behaviour would lead to ethical solutions for any dilemmas that could arise in medical practice.\textsuperscript{124}

In 1792, Thomas Percival put together a code of ethics in a treatise that he called \textit{Medical Jurisprudence}. He noted that the work was undertaken as a request from physicians and surgeons in the Manchester Infirmary.\textsuperscript{125} Jonsen comments that the request was made in response to a dispute between the governors of the infirmary and its staff.\textsuperscript{126}

The first clause epitomises the dichotomy between the self-interest in professional reputation and patient concerns when it states:

\begin{quote}
§1. Hospital. Physicians and Surgeons should minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity. They should study, also, in their deportment, so as to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.
\end{quote}

Reflecting the etiquette to be observed in medical practice at that time, subsequent clauses are concerned with the relationships between medical practitioners, and the strict priorities governing which medical practitioner is to attend patients in hospitals. Patients in hospitals cannot be allowed a choice of physician or surgeon because it upsets the ‘... regular and established succession of medical attendance.’\textsuperscript{127} It is not until Chapter II of \textit{Medical Jurisprudence} that there is a single reference to the patient’s good as the prime focus of the medical practitioner.\textsuperscript{128}

\section{The Development of Current Codes of Practice}

Historical preoccupations with medical etiquette can still be found in quite modern medical codes of ethics. The dichotomy between professional interests and patient concerns is on stark display in the development of the current codes of ethics in England, the United States and Australia. They address professional reputation and

\begin{thebibliography}{99}
\bibitem{123} Ibid 50.
\bibitem{124} Margaret Brazier and Emma Cave, \textit{Patients, Medicines and the Law} (Penguin Books, 2007) [3.2].
\bibitem{125} Thomas Percival, \textit{Medical Ethics} (John Henry Parker, 3rd ed, 1849) 22.
\bibitem{126} Albert R Jonsen, \textit{A Short History of Medical Ethics} (Oxford University Press, 2000) 58.
\bibitem{127} Thomas Percival, \textit{Medical Ethics} (John Henry Parker, 3rd ed, 1849) 27.
\bibitem{128} Ibid 48.
\end{thebibliography}
behaviour as well as acknowledging that awareness of patient concerns underlies good medical practice.

(a) England

As stated above, the precursor for the British Medical Association, the Provincial and Medical Surgical Association, was founded in 1832. Formulation of the medical practitioner’s code of practice and ethical conduct is now the responsibility of the General Medical Council (the GMC). The first edition of the current code, Good Medical Practice, was not prepared until 1995\(^{129}\) the expectation being that ‘gentlemen’ did not need to be told how to practise medicine.\(^ {130}\) Before 1995, the GMC provided all medical practitioners, at the time of their qualification, with a copy of the ‘Blue Book’.\(^ {131}\) The ‘Blue Book’ described disciplinary processes of the GMC and set out those behaviours that would lead to the initiation of disciplinary proceedings against them for serious professional misconduct. These behaviours included the disallowance of advertising, forbade deprecation of other medical practitioners and prohibited sexual relationships with patients or their wives, personal abuse of alcohol or drugs and neglect of patients.\(^ {132}\) However, the ‘Blue Book’ did not outline the attributes of a good doctor and there was no agreement between the GMC or the deans of medical schools at that time as to what those qualities were. In other words, as Sir Donald Irvine relates: ‘... how could the profession know what was expected of it?’\(^ {133}\)

The GMC Code labels its substantive provisions as ‘Professionalism in Action’ and commences with the duty of doctors to make the care of their patient their first concern.\(^ {134}\) The GMC also promulgates guidelines for ethical conduct by medical

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\(^ {131}\) Donald Irvine, The Doctors’ Tale (Radcliffe Medical Press, 2003) 89.
\(^ {132}\) See eg, General Medical Council, Professional Conduct and Discipline: Fitness to Practise (April 1985).
\(^ {133}\) Donald Irvine, The Doctors’ Tale (Radcliffe Medical Press, 2003) 90.
\(^ {134}\) General Medical Council, Good Medical Practice (at 22 April 2013) 4.
practitioners, sets standards for their registration and is in charge of disciplinary processes.


(b) United States of America

The American Medical Association was founded in 1847 when it approved a founding code of ethics and laid the foundations for standards for the training of medical practitioners. The Percival Code became the basis for the first code of medical ethics of the American Medical Association when adopted at a National Medical Convention in Philadelphia in May 1847.

Embroidering §1 of Percival’s Medical Ethics, Chapter 1 Art.I §1. provided as follows:

A physician should not only be ever ready to obey the calls of the sick, but his mind ought to be imbued with the greatness of his mission, and the responsibility he habitually incurs in its discharge. Those obligations are the more deep and enduring, because there is no tribunal other than his own conscience, to adjudge penalties for carelessness or neglect. Physicians should, therefore, minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge, depend on their skill, attention and fidelity. They should study, also, in their deportment, so to unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence.

The emphasis on the rights of the medical practitioner continues in Chapter 1 Art.II. – Obligations of Patients to their Physicians. The first clause, §1 provides:

The members of the medical profession, upon whom are enjoined the performance of so many important and arduous duties towards the community, and who are required to make so many sacrifices of comfort, ease, and health, for the welfare of those who avail themselves of their services, certainly have a right to expect and require, that their patients should entertain a just sense of the duties which they owe to their medical attendants.

The duties of patients as outlined in Article II include never wearying the physician with tedious details that do not relate to the illness (§5), being promptly and implicitly obedient to prescriptions of the physician (§6) and always sending for the physician in the morning (§9). Whilst every case should be treated by the

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135 See eg. General Medical Council, Consent: Patients and Doctors Making Decisions Together (2 June 2008); General Medical Council, Treatment and Care Towards the End of Life: Good Practice in Decision Making (at 1 July 2010).
136 General Medical Council web site <http://www.gmc-uk.org/about/role.asp>. By contrast, the British Medical Association acts as the professional association for medical practitioners and medical students and is their registered trade union. It publishes the British Medical Journal, a respected source of scientific and medical knowledge.
138 Thomas Percival, Medical Ethics (John Henry Parker, 3rd ed, 1849).
physician with ‘... attention, steadiness and humanity’, ‘[r]easonable indulgence should be granted to the mental imbecility and caprices of the sick.’ Amendments were made in 1903, 1957 and 1980 that slowly began to acknowledge patients’ concerns over professional concerns as the basis of good medical practice. By 2001, the focus had firmly fallen on the patient. Article VIII of the 2001 Principles of Medical Ethics — that is Item 1 in the American Medical Association’s Code of Medical Ethics — advises physicians that: ‘A physician shall, while caring for a patient, regard responsibility to the patient as paramount’ and, in addition, Article II confirms that the physician must ‘... uphold the standards of professionalism ...’.

(c) Australia

The first identifiable Australian version of a code of ethics was published in 1859 by a group calling itself the ‘Australian Medical Association’. It was at that time a New South Wales organisation formed in 1844 to ‘... maintain and secure the dignity and the privileges of the medical and surgical profession in this colony ...’ and to seek legislation to ‘... put down quackery ...’ by preventing unqualified people from practising medicine. That organisation, like many other early attempts at establishing medical associations in the various colonies of Australia, fell by the wayside through internal squabbling.

This particular code was, like the 1847 code of the American Medical Association, based upon the Percival code of 1792. Chapter I Article I §1 was in almost identical terms to the first article in the 1847 American Medical Association Code as quoted above. Until 1962 when the modern AMA was formed, following the early difficulties in establishing medical associations in the Australian colonies, medical practitioners had been grouped into state branches of the British Medical Association.

The first code of ethics of the AMA appeared in 1965. It called upon the prayer of Maimonides — Moses ben Maimon who lived from 1135–1204, principles of the Hippocratic Oath, the Declaration of Geneva and the 1949 World Medical

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139 Code of Medical Ethics of the American Medical Association (American Medical Association Press, 1847) Article I §2.
141 Australian Medical Association, More Than Just a Union (June 2012) 23.
142 Ibid 17.
Association (WMA) *International Code of Medical Ethics.* This 1965 code acknowledged the basis of the doctor-patient relationship to be one of ‘... absolute confidence and mutual respect.’ The personal responsibility of the doctor was to observe ethical standards at all times and give advice and take action always in the patient’s best interests. Other than the obligation of secrecy, the remainder of the code was concerned with dealings between medical practitioners and their obligations to each other. The 1989 code was in substantially similar terms to the 1965 code. It was not until 1992 that more focus was put on the patient though even this code was still largely concerned with inter-personal relations between medical practitioners.

By 2004, another code of ethics had been drafted. This code was revised in 2006 and was the version in force at the time of the legislation that brought all health practitioners in Australia under a national registration and regulatory scheme. Whilst being in similar form to the 1992 code, it expanded the focus upon patient care, commencing with the obligation to ‘[c]onsider first the well-being of your patient,’ and to ‘[t]reat your patient with compassion and respect.’

Upon enactment of the *Health Practitioner Regulation National Law* and its commencement in 2010, the AMA Code of 2004 was overtaken by the *MBA Code.* This code is authorised by the *National Law* and is an integral part of the armoury of standards that underpin the regulation of medical practitioners in Australia. The obligations to observe patient confidentiality, to refrain from improper conduct including sexual relationships with patients or any member of the patient’s household and to act in the best interests of the patient — all specified in the *Hippocratic Oath* — are reflected in the *MBA Code.* The *MBA Code*

> describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.

143 Australian Medical Association, *Code of Medical Ethics* (at 1965) 9.
144 Ibid, Article 6.1.1.
145 That code was revised again in 2016.
147 Ibid [1.1b].
148 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at 2009). There is now a 2014 version of the *MBA Code.* Chapter III will describe the background to the passing of the *National Law.*
149 *Health Practitioner Regulation National Law* s 39.
150 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at 2014) [1.1].
It firmly places the patient in the forefront of medical practice: ‘Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy’.\footnote{151}{Ibid [1.4].}

However, despite the duties specified in codes, Chapter III argues that there is evidence that adherence to those obligations has not always been honoured. Therefore, this thesis contends that negative outcomes as a consequence of these lapses may be mitigated by inculcating an ethical sense in medical practitioners and it is to an analysis of theories of medical ethics to which this chapter now turns.

D MEDICAL ETHICS - THE ASPIRATION FOR COMPASSIONATE AND PATIENT-FOCUSED MEDICAL PRACTICE WHERE CODES HAVE NO ANSWERS

As noted above, the mark of a profession is a body of specialised knowledge used in the service of society, deference to ethical ideals and a social contract with its community. The vulnerability of the patient when seeking care of the medical practitioner, leads to the necessity for the medical profession to exhibit the ethics upon which society grants it special status.

In Australia, the \textit{MBA Code} ‘... sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors ...’\footnote{152}{Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [1.1].} whilst the \textit{AMA Code of Ethics} ‘... articulates and promotes a body of ethical principles to guide doctors’ conduct in their relationships with patients, colleagues and Society.’\footnote{153}{Australian Medical Association, \textit{AMA Code of Ethics} – 2004 (at November 2006) Preamble.} However, recognition of the need for medical practitioners to be guided by ethical principle is a relatively recent occurrence. Evidence before Dame Janet Smith in the Shipman Inquiry observed: ‘Medical ethics were not taught, as they ought to be, as part of the undergraduate course; nor were they usually taught during the post registration year.’\footnote{154}{Dame Janet Smith, \textit{The Shipman Inquiry} (Fifth Report Safeguarding Patients: Lessons from the Past – Proposals for the Future 9 December 2004) [10.38].} Goldie remarks that despite a 2500 year history, it is only
in the last 30 years that medical ethics has been included in the formal medical curriculum.\textsuperscript{155} Similarly, Coulehan comments:

>[p]rofessional ethics, based on virtue and duty, ... confined itself to the special interests and obligations of physicians. In fact, [professional ethics] ... acquired a bad reputation as being more a set of rules to protect the interests of physicians than a code of moral conduct to protect patients.\textsuperscript{156}

Jonsen notes that medical ethics had previously been learned by young doctors following the example of senior practitioners.\textsuperscript{157} Likewise, Coulehan observed that in the past, teaching about ‘good’ doctors focused on ethics teaching together with assuming that

>[p]hysicians-in-training would acquire professional values by osmosis from mentors and role models as they progressed through their training, just as generations of physicians had presumably done in the past.\textsuperscript{158}

However, professional and regulatory bodies now recognise the centrality that medical ethics plays in the doctor-patient relationship and good medical practice and are concerned to find ways to inculcate the values of medical ethics into both undergraduate and post-graduate medical training. The importance of medical ethics training for trainees lies in developing medical practitioners whose ethical approach to their patients contributes to a public perception that medical practitioners deserve the prestige and reputation that had been dented by past and continuing reports of deficient behaviour.\textsuperscript{159} As Stern and Papadakis observe: ‘What is at stake is nothing less than the privilege of autonomy in our interactions with patients, self-regulation, public esteem, and a rewarding and well-compensated career’.\textsuperscript{160}

1 Approaches to Medical Ethics

As not every contingency can be documented in codes and guidelines, medical professionals need some broad principles to guide them in their ethical decision-making. As Huddle has argued

Inculcating medical ethics is often held to play an important part in the teaching of professionalism. As with the rest of the clinical curriculum, ethics is generally

\textsuperscript{156} Jack Coulehan, ‘Teaching Professionalism: Engaging the Mind but not the Heart’ (2005) 80 Academic Medicine 892, 892.
\textsuperscript{157} Albert R Jonsen, A Short History of Medical Ethics (Oxford University Press, 2000) 97.
\textsuperscript{158} Jack Coulehan, ‘Teaching Professionalism: Engaging the Mind but not the Heart’ (2005) 80 Academic Medicine 892, 892.
\textsuperscript{159} See eg, the St Vincent’s Hospital Off-protocol prescribing scandal, the Bristol Royal Infirmary case, Graeme Reeves (the Butcher of Bega).
taught as offering students a skill ... a set of conceptual tools with which to clarify and respond to moral difficulties that arise in the practice of medicine.161

There are two highly regarded and important approaches to medical ethics. The first, principlism, is based on a set of principles of bioethics, whose function is to ‘ ... provide ... a framework for identifying and reflecting on moral problems’162 that arise in medical practice. The second major theory, virtue ethics, argues that simple adherence to rules is not sufficient to internalise ethical behaviour. Rather, an emphasis on the habitual exercise of the virtues expected of medical practitioners goes to the heart of being a good physician163 who will act appropriately for the good of the patient.164

Coulehan declares that: ‘Values, beliefs, and community are ... essential components of medical professionalism.’165 Similarly, Huddle observes: ‘ ... “professionalism” has come to designate the ethical obligations towards patients and society that are entailed in the physician’s role ... ’.166 He continues:

[i]n asking for professionalism, that is, for just, altruistic, conscientious, and compassionate physicians ..., medical educators are asking for morality, which is at bottom asking for more than just expertise. The bread and butter of morality in medicine is not the “hard cases”, where the right way forward is difficult to see; it is in acting rightly when the right path is clear before us but other pressing needs and desires pull us away from that path in the midst of day-to-day medical routine ...

(a) Principlism

This approach has been influential in recent years. It incorporates theories from the writings of several prominent 20th century philosophers168 together with ideals extracted from the *Universal Declaration of Human Rights*, the *Hippocratic Oath* and the *Declaration of Geneva*.

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164 Ibid 23.
167 Ibid 886.
This part commences by analysing the most important exposition of principlism by Beauchamp and Childress in their *Principles of Biomedical Ethics*. Its four principles have been adopted by the World Medical Association as representing the most important standards for ethical decision making in medical practice. Beauchamp and Childress promote a set of principles that should ‘... function as an analytical framework that expresses the general values underlying rules in the common morality.’ They suggest four moral ideals as principles to ‘... function as guidelines for professional ethics’:

1. respect for autonomy (respecting the decision-making capacities of autonomous persons)
2. nonmaleficence (avoiding the causation of harm)
3. beneficence (providing benefits and balancing benefits against risks and harms)
4. justice (distributing benefits, risks and costs fairly).

Their work has been highly commended by a number of commentators. Mason and Laurie refer in their book, *Law and Medical Ethics* to *Principles of Biomedical Ethics* as a ‘classic’ in the field of applied ethics despite accusations of pro-Western bias. They also compliment the approach of Beauchamp and Childress and their four principles as providing an example of how any discussion of ethical questions benefits from reflection that refers to accepted values.

Medical practitioner and ethicist, Raanan Gillon maintained that these four principles together with reflection about the scope of their reach should be adopted by all health care workers and will encompass most of the moral dilemmas that they encounter. He suggests that this approach can be applied whatever the personal philosophy, religion or political views of the health care worker in question. He continues that whilst we can agree about moral commitments to respect for autonomy, beneficence, non-maleficence and justice, it is still possible to disagree about those to whom these commitments are owed. However, it is easy for health practitioners to know to whom they owe these moral obligations because

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172 Ibid.
174 Ibid 1, fn 1.
175 Ibid 6.
176 Ibid.
178 Ibid.
of the special relationship to their patients that requires the health practitioner to provide help without causing injury.\textsuperscript{179}

Similarly, in discussing professionalism in medical practice, MacKenzie refers to these four elements as the ethical underpinnings of medical practice.\textsuperscript{180} Brazier and Cave also adopt these four principles as underlining ethical obligations of medical practitioners.\textsuperscript{181} Jonsen refers to them as entering the vocabulary of medical ethics\textsuperscript{182} when the public was shocked by medical research scandals such as the Tuskegee revelations in the USA (leaving syphilis untreated for 40 years after knowing it was treatable)\textsuperscript{183} and the New Zealand cervical cancer scandal (deliberately failing to treat some women with cervical carcinoma in situ).\textsuperscript{184}

The review by Beauchamp and Childress of medical codes of ethics notes that codes are full of principles that are of concern to medical practice and its traditions but they sometimes clash with more general moral norms.\textsuperscript{185} Beauchamp and Childress also query whether these codes are not designed more to protect the interests of the medical profession than to provide wide and impartial moral guidance to its members.\textsuperscript{186} The apparent lack of consultation with patients is exemplified by the challenge made by Burke to guidelines issued by the GMC in the United Kingdom.\textsuperscript{187}

However, despite this broad support, this approach has its critics. For example, Gillon acknowledges that there does not appear to be a method of resolving conflicts between the principles. Pellegrino and Thomasma have also criticised this ‘four principles’ approach on the ground that it does not take into account either the internal morality of medicine or the clinical realities of the doctor-patient relationship, so it should be replaced by alternative theories based on virtue\textsuperscript{188} to which this thesis now turns.

\textsuperscript{179} Ibid 187.
\textsuperscript{181} Margaret Brazier and Emma Cave, Patients, Medicines and the Law (Penguin Books, 2007) [3.4-6].
\textsuperscript{182} Albert R Jonsen, A Short History of Medical Ethics (Oxford University Press, 2000) 116.
\textsuperscript{183} Ibid 108.
\textsuperscript{185} Tom L Beauchamp and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 5th ed, 2001) 7.
\textsuperscript{186} Ibid.
\textsuperscript{187} R (Burke) v General Medical Council [2005] QB 424.
\textsuperscript{188} Edmund D Pellegrino and David C Thomasma, The Virtues in Medical Practice (Oxford University Press, 1993) 52.
Core values of the medical profession as listed by the AMA, include virtues such as trust, compassion, integrity, justice and altruism. To these, Pellegrino and Thomasma add prudence, \(^{189}\) temperance\(^ {190}\) and fortitude.\(^ {191}\) Faunce lists trust, competence, integrity, compassion, prudence and loyalty to patient suffering.\(^ {192}\) McCammon and Brody refer to honesty, trust, beneficence and altruism.\(^ {193}\)

Eighteenth century Enlightenment physician John Gregory lauded the virtues as a way of distinguishing medical practitioners who are dedicated to the art of medicine from those who consider it as a mere article of trade\(^ {194}\) on the grounds that only morals guided by sympathy can engage patients and enhance the probability of a cure.\(^ {195}\)

As with principlism, several commentators have espoused the need for virtue ethics as a way of providing doctors with tools to deal with moral questions that arise in practice. Huddle comments that: ‘Medical educators and patients alike want physicians who are “professional” ... : just, altruistic, conscientious, compassionate, honest, and scrupulous about financial conflicts of interest.’\(^ {196}\) McCammon and Brody claim that what Jonsen called the medical profession’s “profound moral paradox”\(^ {197}\) of self-interest as juxtaposed against the societal expectation of altruism and compassion from their physicians, has led to the recent interest in the significance of virtue ethics for the medical profession.\(^ {198}\)

McCammon and Brody also argue that: ‘[I]deally, virtue ethics combines two important tasks of ethics, to serve as both an inspiration and a practical guide.’\(^ {199}\)

They maintain that the recent interest in virtue ethics is a way of re-introducing the

\(^{189}\) Ibid 84.
\(^{190}\) Ibid 117.
\(^{191}\) Ibid 109.
\(^{195}\) Ibid 18–19.
\(^{199}\) Ibid 269.
physician’s character into medical ethics.\textsuperscript{200} There needs to be more open
discussion of professional and unprofessional behaviour in medical schools,
including dealing with mistakes and near-misses as a tool for learning.\textsuperscript{201} Coulehan
comments that whilst the explicit curriculum focuses on teaching the virtues, the
process of internalising the virtues is undermined by the hidden curriculum’ with
its emphasis on detachment and self-interest.\textsuperscript{202} The problem is how to instil the
virtues into trainee medical practitioners so that they are embraced and become
part of the medical practitioner’s lived experience. Training along the lines of the
‘Giving Voice to Values’\textsuperscript{203} system may address any disconnect between learning
ethical rules and internalising their requirements. The ‘Giving Voice to Values’
process for teaching ethical behaviour will be considered further in Part 2 of this
section.

The most frequently-cited core values of the medical profession are the virtues of
trust, altruism and compassion. Similarly, they are cited by advocates of the need
for virtue ethics in medical practice as fundamental moral standards. This section
will analyse why their adoption is seen by so many commentators as underpinning
good, patient-centred medical practice.

(i) Trust

Medicine concerns the experiences, feelings, and interpretations of human beings in
often extraordinary moments of fear, anxiety, and doubt. In this extremely
vulnerable position, it is medical professionalism that underpins the trust the public
has in doctors.\textsuperscript{204}

This section shows how fundamental the medical virtue of trust is to the
achievement of patient-centred care principles by medical practitioners. As the
first statement in the GMC Code declares: ‘Patients must be able to trust doctors
with their lives and health’.\textsuperscript{205} Mason and Laurie remark that trust works better in
an atmosphere of morality rather than by an imposition of rules that can be
inflexible.\textsuperscript{206}

\textsuperscript{200} Ibid 258.
\textsuperscript{201} Ibid 262.
\textsuperscript{202} Jack Coulehan, ‘Teaching Professionalism: Engaging the Mind but not the Heart’ (2005) 80
Academic Medicine 892, 894.
\textsuperscript{203} Mary C Gentile, Giving Voice to Values (Yale University Press, 2010).
\textsuperscript{204} Royal College of Physicians, Doctors in Society: Medical Professionalism in a Changing World
\textsuperscript{205} General Medical Council, Good Medical Practice (at 22 April 2013).
\textsuperscript{206} J K Mason and G T Laurie, Law and Medical Ethics (Oxford University Press, 8th ed, 2011), 28.
On occasion, patients need to provide to their medical practitioners sensitive information and to expose their bodies for examination. They are also reliant on the medical practitioner to provide advice and treatment with due care. As Pellegrino and Thomasma explain, trusting another person also means being vulnerable to the person trusted, and the necessity of having confidence that this vulnerability will not be exploited even if the one trusted has motives for doing so.

The vulnerability of the patient inherent in the doctor-patient relationship has led to courts working towards recognising fiduciary duties. In law, a fiduciary relationship has traditionally arisen in the context of property held by a trustee on behalf of a beneficiary. However, in Breen v Williams, Brennan CJ said: ‘... the relationship of doctor and patient is one where the doctor acquires an ascendancy over the patient and the patient is in a position of reposing trust in the doctor.' Gaudron and McHugh JJ have also confirmed that the categories of fiduciary relationship are not closed as the courts have identified various circumstances that point towards the existence of a fiduciary relationship.

These circumstances, which are not exhaustive and may overlap, have included: the existence of a relation of confidence; inequality of bargaining power; ... a dependency or vulnerability on the part of one party that causes that party to rely on another.

However, the medical practitioner must also trust the patient. Kennedy argues that confidence and trust can only prosper when the patient is treated as a partner. Kass claims that trust is a necessary ingredient in the therapeutic relationship and has a connection to the healing process. Fletcher criticises the former inclination of medical practitioners to hide information from their patients as demonstrating a lack of trust in the patient. The medical practitioner needs the patient’s trust for co-operation once they have, together, determined the treatment plan. Similarly, as Honneth observes, the patient requires the dignity of being trusted by the medical practitioner.

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211 Ian Kennedy, Treat Me Right (Clarendon Press, 1988) 188.
212 Leon R, Kass, "I Will Give No Deadly Drug": Why Doctors Must Not Kill' in Kathleen Foley and Herbert Hendin (eds), The Case against Assisted Suicide (Johns Hopkins University Press, 2002) 17, 28.
The medical practitioner’s virtue of being trustworthy permits the vulnerable patient to rely on the practitioner for guidance when treatment regimes are being planned. But the complementary trust in the patient by the doctor strengthens the partnership between equals that is fundamental to professionalism and quality patient-centred care.

(ii) Altruism

High among the moral virtues that are adopted by the champions of medical professionalism is altruism. Barondess asserts that medical professionals are expected to be moral and altruistic and to use their skills for the benefit of the community.\(^{215}\) But underlying medical practice is, as mentioned previously, Jonsen’s ‘profound moral paradox’ of the persistent conflict between altruism and self-interest.\(^{216}\) Whilst these terms need not be mutually exclusive, Jonsen suggests that altruism has sometimes been seen as a disguised form of self-interest.\(^{217}\) McCammon and Brody have observed that as care of the patient is the first priority in the job description, attributing altruism to the physician is not only unfounded\(^{218}\) but unnecessary. Cruess, Johnston and Cruess comment that there is an expectation that because of the trust that the community places in physicians, they should be altruistic and place the interests of patients first.\(^{219}\) Yet, as they remark, public mistrust, because of the profession’s failure to self-regulate, has sometimes led to a perception that the medical profession has put its own interests above those of patients; and that the medical associations have protected unprofessional colleagues.\(^{220}\)

Yet, the AMA has placed altruism high among the core values underpinning the medical profession so, despite the above scepticism, the public is entitled to expect its medical practitioners to be altruistic. Altruism is also expected as part of the social contract whereby medical practitioners will use their professional skills for the benefit of members of the community. But as Cruess and Cruess observe:

\[\text{[t]here are ... both written and unwritten portions [of the social contract] entailing moral commitments that are fundamental to both the social contract and to}\]


\(^{217}\) Ibid.


professionalism. One cannot legislate altruism, commitment, or independent professional judgement; they must come from within the individual physician.221

(iii) Compassion

Nussbaum sees compassion as having three strands - a belief in the observer that the suffering is serious rather than trivial, that the suffering person does not deserve that suffering and that the observer experiences the emotion of the suffering person.222 The ability to look outward from oneself and to focus on the sufferings of others is a virtue that should be reflected in all decisions of medical professionals.

The MBA Code lists ‘compassion’ as one of the ‘[P]rofessional values and qualities of doctors’223 and requires ‘Being courteous, respectful, compassionate and honest’ as part of the high standards of professional conduct required in a good doctor-patient partnership.224

Compassion has been identified as an essential virtue in medicine since earliest times.225 Newton talks of medical professionalism, essential to maintain the integrity of the profession, as demonstrating compassion.226 Faunce lists compassion as one of the professional virtues together with loyalty and competence.227

Whilst the compassion of the medical practitioner provides a measure of extra comfort to patients who are subjected to the sometimes dispassionate workings of the medical system, it must be held in perspective. Beauchamp and Childress maintain that too much emotional involvement from the medical practitioner may derogate from rational, practical decision-making.228 Nevertheless, contemporary decision science argues the importance of recognising both an emotional and a rational aspect to decision-making. Kahneman points out that the emotional/intuitive feature of our decision-making processes has an evolutionary

basis, as a way to determine how to solve the problems that are needed to survive.\textsuperscript{229} The recognition that our minds first look at a heuristic, that is ‘... a simple procedure that helps find adequate, though often imperfect, answers to difficult questions. ...’\textsuperscript{230} before the rational asserts itself, has been used in the decision-making processes of many fields, including medical diagnosis, legal judgment, finance and military strategy.\textsuperscript{231}

2 \hspace{1cm} \textit{Giving Voice to Values}

According to Stern and Papadakis: ‘Until the late 1970s, the formal teaching of ethics, professionalism ... was not part of the medical school curriculum’.\textsuperscript{232} They proceed to state that most medical schools now have a formal ethics course.\textsuperscript{233}

Burack et al have observed that:

Contemporary medical ethics education has concerned itself with teaching either facts or moral reasoning processes, but not with the motivational network of values, attitudes, and feelings that underlies moral behaviour.\textsuperscript{234}

One possible method of ethics teaching, the \textit{Giving Voice to Values} (GVV) system has been used to assist in the process of internalising ethical values. The GVV system is based on experience gained in the context of business ethics. However, this approach is being adapted for use in varying contexts including medicine, nursing, engineering, law and accounting.\textsuperscript{235}

The philosophy of this approach is to move away from what is forbidden to what is possible. Mary Gentile’s book\textsuperscript{236} noted that, rather than an emphasis on externally-imposed rules, the internalisation of ethics could be based upon values that people already have. It is not a question of right or wrong but what each person experiences ‘... deeply and internally ...’ about particular behaviour.\textsuperscript{237} Whilst we can recognise and name the reality, rather than try to change it we have choices about how we respond.\textsuperscript{238} Gentile identifies four sets of conflicting values and

\begin{thebibliography}{99}
\bibitem{229} Daniel Kahneman, \textit{Thinking, Fast and Slow} (Farrar, Strauss and Giroux, 2011) 90.
\bibitem{230} Ibid 98.
\bibitem{231} Ibid 8.
\bibitem{233} Ibid.
\bibitem{234} Jeffrey H Burack et al, 'Teaching Compassion and Respect : Attending Physicians' Responses to Problematic Behaviors' (1999) 14 \textit{JGIM} 49, 49.
\bibitem{235} Mary C Gentile, 'Values-Driven Leadership Development: Where We Have Been and Where We Could Go' (2012) 9 \textit{Organization Management Journal} 188, 194.
\bibitem{236} Mary C Gentile, \textit{Giving Voice to Values} (Yale University Press, 2010).
\bibitem{237} Ibid 27.
\bibitem{238} Ibid 210.
\end{thebibliography}
asserts that most ethical dilemmas fall into one or other of these categories – truth versus loyalty, individual versus community, short-term versus long-term and justice versus mercy.239

The process commences with becoming aware of an issue, analysing it and then developing an action plan to deal with the issue.240 The traditional approach has been to identify what the problem is and work out what the right thing in response may be. The GVV approach is that once the right thing to do has been identified, it is necessary to decide how the ‘right’ approach can be implemented. Consequently, the GVV approach is deeply involved in solving problems and this is achieved by discussion of problem scenarios to determine what action should be taken. In addition, the GVV approach is concentrated on ‘... enhancing effectiveness by repeated practice in delivering responses and providing peer feedback and coaching.’241 The GVV approach also calls upon research that shows how human beings are subject to biases242 that can affect how problems are dealt with and teaches the necessity for awareness of these biases before decisions are made.

A pilot study of the GVV approach in the context of nursing found that ‘... the educational power of simulation, experiential or scenario-based learning that is central to the GVV methodology is clearly a valuable pedagogical initiative, one that ought to take a more prominent place in our educational endeavours’,243 Thus, the GVV approach has been found to be effective in instilling ethical approaches in nursing and could clearly be adapted to ethics training for medical students, and periodic ethics reinforcement for medical practitioners.

As the high numbers of boundary violations identified in Chapter III, particularly sexual indiscretions, will show, enhanced ethics education is important, both during undergraduate training, and for ongoing professional development obligations. The numbers of boundary violations suggest that current systems of ethics education are not necessarily having the desired impact. Whilst not

239 Ibid 176.
240 Ibid 190.
suggesting that the GVV system is necessarily superior to the current system, it is offered as an adjunct that may improve outcomes.

3 Conclusion

McCammon and Brody have declared that: ‘Regardless of whether it is virtue-based or principle-based or duty-based, medicine is a moral enterprise’. Thus, adherence to a set of strong ethical principles is fundamental to the concept of medical professionalism. Medical ethics lies at the heart of the social contract between the medical profession and the society. It is partly because of the declaration of the medical profession’s strong ethical values that the society is prepared to grant the profession its high prestige and its place at the policy table when healthcare funding decisions are being made.

The professed principles and virtues are not simply aspirations. They are deeply embedded in the ideals of medical professionalism. The Royal College of Physicians’ Working Party on Medical Professionalism remarked in its Foreword that it began its task with the ‘assumption that at the heart of good medical care is a set of values, attitudes and behaviours called medical professionalism’. It continued ’ ... medical professionalism lies at the heart of being a good doctor. The values that doctors embrace set a standard for what patients expect from medical practitioners’ Similarly, as will be shown in Chapter III, in disciplinary proceedings, the behaviour of medical practitioners is assessed against a standard referable to what the profession and the public considers to be professional.

E MEDICAL PRACTITIONER VIEWS OF MEDICAL PROFESSIONALISM

Cruess, Johnston and Cruess report that some eminent medical practitioners have been concerned about how doctors can provide quality care, preserve their clinical autonomy and adhere to the values of the Hippocratic Oath. This soul-searching led to distinguished medical bodies in USA and United Kingdom undertaking their own reviews of what medical professionalism means in the 21st Century.

246 Ibid xi.
Following well-publicised medical scandals of recent years, some eminent members of the medical profession called for a revisiting of what medical professionalism comprises in light of the way changes in health care were threatening the nature and values of medical professionalism.

1 United States and Europe

In 1999, the European Federation of Internal Medicine, the American College of Physicians-American Society of Internal Medicine and the American Board of Internal Medicine, having agreed that physician views were similar even in quite different health care systems, met to initiate a project to define the principles of medical professionalism. The resulting Charter on Medical Professionalism, published at the same time in The Lancet and Annals of Internal Medicine, is based on three principles. The principles are Primacy of patient welfare, Primacy of patient autonomy and Primacy of social justice. The principle of the Primacy of patient welfare emphasises altruism as contributing to the trust central to the physician-patient relationship. These principles are supplemented by ten Professional Responsibilities. As the committee concluded:

To maintain the fidelity of medicine’s social contract ... we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

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248 See eg, the St Vincent’s Hospital Off-Protocol Inquiry, the Shipman Inquiry, the Bristol Royal Infirmary Inquiry, the Djerriwarrh Health Services Investigation.
250 ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine, Medical Professionalism in the New Millennium: A Physician Charter (2002).
255 Ibid 246.
2 United Kingdom

Professionalism cannot be imposed by governments or by regulatory culture. It must emerge from and be sustained by doctors themselves.256

A few years later, a working party of the Royal College of Physicians undertook its own review into how medical practitioners should be dealing with changes in the way medicine was being practised. The review was undertaken following several inquiries into medical scandals that had questioned and criticised long-held views about the balance of power in the doctor-patient relationship.257 In 2006, the Report of the Working Party on Medical Professionalism commented that the medical profession had been slow to adapt to changing social expectations.258 It declared that the medical profession had discarded notions of mastery, practitioner autonomy, privilege and self-regulation.259 It noted that both the King’s Fund260 and the Picker Institute261 were recommending that medical practitioners change to adopt patient-centred care principles.

The Working Party defined medical professionalism as signifying ‘ ... a set of values, behaviours, and relationships that underpins the trust the public has in doctors ... ’.262 The report described how medical professionalism achieves these values, behaviours and relationships as follows:

Medicine is a vocation in which a doctor’s knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.263

The centrality of the notion of a partnership between medical practitioner and patient is embedded in the ideals of patient-centred care. The report looked forward to entrenching the ideals of professionalism within medical culture. However, these charters and reviews did not address a significant difficulty preventing their adoption, unfortunate attitudes of some medical practitioners absorbed during their medical training, to which this chapter now turns.

259 Ibid [2.9].
260 Ibid [1.16].
261 Ibid [1.17].
262 Ibid xi.
263 Ibid [2.6].
F   LEARNING TO BE A PROFESSIONAL – TRAINING THE DOCTORS OF THE FUTURE

1   Introduction

The requirement for professionalism pervades every aspect of doctors’ interface with the patients committed to their care. Previous sections have outlined how concern with what medical professionalism entails has been approached through theories of medical ethics, through codes and guidelines and through charters promulgated by bodies of distinguished medical practitioners. These approaches have adverted to the damage done to the reputation of the profession particularly through damaging reports of irregularities in various medical treatment settings. However, despite the good intentions of medical regulators, professional medical associations and bodies of distinguished medical practitioners, some unacceptable and deviant behaviour is still occurring. One factor that can undermine these efforts to instil professionalism among doctors lies in the way that the doctors of the future are trained and socialised.

The purpose of this section is to examine the hidden influences on medical students and trainees. However, not all influences are malign. This section commences by showing how important good role models are in training and socialisation of young medical graduates. As Wear et al comment: ‘Role modeling is not new to medical education, but is becoming increasingly called for as perhaps the most important factor in students’ ongoing professional development’.264

Whilst learning from teaching faculty is not the only way that medical students are socialised, the effect is significant because of their early exposure to its influences. Students also absorb behaviours of fellow students. However, there is a substantial body of literature that documents a disconnect between positive and negative influences and shows how socialisation of students in their process of learning to become medical professionals has, in a number ways, detracted from the adoption of patient-centred care principles.

The following parts of this section outline how hidden influences, for good or ill, play a part in shaping the attitudes of trainee medical practitioners towards professionalism and their behaviours towards their patients and more junior health practitioners. As Ozolins, Hall and Peterson report, students in Queensland felt that the notion of ‘being’ a doctor was ‘... at the heart of the informal and hidden curriculum. It serves a purpose of teaching them “how to be” and think like doctors.’

Firstly, this section considers the positive aspects of the ‘hidden curriculum’ whereby good role models can instil such positive traits as patient-centredness, and compassion and respect. However, to show how patient-centred practice can be undermined by the socialisation process, this section will look secondly at examples of unprofessional behaviour by those charged with medical education and training, and will move on to explore the gap between what is being taught and what is being learned, including how humiliation is used as an educational tool. The following part briefly considers the subtle messages that can discount the importance of disclosure when adverse events occur. More importantly, the ‘hidden curriculum’ can detract from reflective practice so that the opportunity, as Kenny et al observe, ‘to learn effectively from experience and develop the affective aspect of professional practice may not be realised. To conclude, as Levinson et al suggest, work needs to be done to: ‘(1) change the actual practice behaviors[sic] of the physician role models that trainees will encounter during their clinical experiences; and (2) alter the conditions under which these physicians carry out their work.’

266 Jennifer Laura Johnston et al, ‘Medical Students’ Attitudes to Professionalism: An Opportunity for the GP Tutor?’ (2011) 22 Education for Primary Care 321, 322.
268 Andrew H Brainard and Heather C Brislen, ‘Learning Professionalism: A View from the Trenches’ (2007) 82 Academic Medicine 1010, 1010. As they remark: ‘The academic study of medical professionalism is becoming very common, and there are several reviews, articles, and books on teaching professionalism. However, as current medical students immersed in learning professionalism, it is our observation that most of the current literature on this topic misses the mark. We propose that the chief barrier to medical professionalism education is unprofessional conduct by medical educators’.
2 Role Modelling as a Positive Influence on Medical Training

The first requirement for a sea change in professionalism is to increase dramatically the number of physicians who are able to role-model professional virtue at every stage of medical education.271

According to Burack et al, traditionally medical students learned about professionalism by absorbing ‘the way things are done’ from their lecturers in medical school and their exposure to more senior practitioners.272 Harden et al point out that there were, in fact, two traditional ways of education for medical students:

- the classroom model, where students learn through attendance at lectures, at practical classes, or by working independently;
- the apprenticeship model, where students or young doctors work in the clinical setting with the consultant or other member of staff serving as a role model.273

Levinson et al recognise these two traditional methods of teaching medical students but caution that there may be a conflict between the messages imparted in each context.274 Hogg has observed that: ‘Teachers and trainers set an example to new students and provide role models for them both in the classroom and placements in hospital and community when they are most impressionable.’275

Kenny et al note that enhancing role modelling is a recent concern in medical education.276 They observe that: ‘Role models are central to enculturation because professional behaviour is learned in the experience of practice’.277 Johnston et al also observe that attitudes and actions of those teaching are significant as they are the role models observed by students.278 They point out the benefits of mentoring by primary care physicians who are adept at imparting, communication skills, and the holistic approach and person-centredness. These skills that are so integral to

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275 Christine, Hogg, Patient-Centred Care - Tomorrow’s Doctors (23 March 2004) Education Committee Discussion Document Number 0.2 General Medical Council 9.
277 Ibid 1204.
278 Jennifer Laura Johnston et al, ‘Medical Students' Attitudes to Professionalism: An Opportunity for the GP Tutor?’ (2011) 22 Education for Primary Care 321, 322.
general practice, are transferable to wider medical practice.\textsuperscript{279} Similarly, Newton et al comment that ‘[p]hysicians who are role models should work more closely with medical students to develop an empathic relationship with ... patients’ but also note that there is a chronic lack of clinical role models and perhaps a lack of positive role models.\textsuperscript{280}

Yet, research carried out by Sloan, Donnelly and Schwartz has found that there are good surgical role models. Students canvassed by them chose the most important factors that they saw as differentiating ‘better preceptors from the poorer ones’, one of the factors being ‘the degree to which the preceptor served as a positive role model’.\textsuperscript{281}

These observations also apply when the teaching method is problem based learning during clinical exposure in hospitals. Hill points out the centrality of the preceptor-student relationship. ‘A one-to-one relationship between a senior faculty member and a student ensures an appropriate role model exists for future professional development’.\textsuperscript{282}

Abu et al also noted that students recognised the need for positive role models in teaching professionalism because it leads to deeper and more experiential learning.\textsuperscript{283} A survey by Lempp and Seale of a single medical school in the United Kingdom suggested that many staff members were positive role models.\textsuperscript{284}

Stern and Papadakis observe that teaching in the hidden curriculum happens through role modelling and the telling of parables (stories about cases) as well as through more formalised teaching. Some teachers in medical faculties see themselves as role models, a prime method of teaching professionalism to their

\textsuperscript{279} Ibid 326.
\textsuperscript{281} David A Sloan, Michael B Donnelly and Richard W Schwartz, ‘The Surgical Clerkship: Characteristics of the Effective Teacher’ (1996) 30 Medical Education 18, 22.
\textsuperscript{284} Heidi Lempp and Clive Seale, ‘The Hidden Curriculum in Undergraduate Medical Education: Qualitative Study of Medical Students’ Perceptions of Teaching’ (2004) 329 BMJ 770, 771.
students. But a role model is just that — a model. Consequently, as they continue, teachers must provide an environment that is consistently professional, both in medical schools and in clinical contexts.

However, whilst good medical professionalism can be taught to medical students by their observation of the conduct of positive role models, it is also possible to absorb the negative behaviours of some role models and carry them into medical practice. As Karnieli-Miller et al note: ‘Experiences with both negative and positive behaviours shape students’ perceptions of the profession and its values’.

### 3 Examples of Unprofessional Behaviour

Some medical professionals who were training students do not appear to have been aware of the promulgation of the charters in US and the United Kingdom outlined above. Monrouxe and Rees in 2012 documented unprofessional behaviour in teaching of some Scottish medical students. Brainard and Brislen in 2007 described some American students as disclosing gross breaches of professionalism in their medical training in 2007. In both studies, students reported unprofessional behaviour, as documented below, by those who were supposed to be teaching and evaluating them in the tenets of medical professionalism.

Brainard and Brislen referred to a report by a third year medical student:

> A student was asked to forge an attending’s signature on a discharge order. When she protested, stating that forgery was likely unprofessional, her supervising resident promised her an “A” in professionalism in exchange for the signature. She complied.

Abu et al tell of students who ‘... felt they learned negative values and unprofessional behaviours because this was what they witnessed in real world

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286 Ibid 1797.
288 Lynn V Monrouxe and Charlotte E Rees, "It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 Advances in Health Science Education 671, 671.
settings and because their mentors sometimes treated both them and their patients unprofessionally.’  

Faunce contends that the student may learn ethical and unethical principles by way of osmosis through contacts with cynical staff members in informal settings. As Brainard and Brislen report: ‘[Students] seem to adopt an implicit set of rules that place hospital etiquette, adherence to academic hierarchy, and subservience to authority above patient-centred virtues.’ What is absorbed can include the dismissive behaviour detailed below and as observed and reported by numerous writers.

(a) Undermining Patient Dignity

As Monrouxe and Rees record, unannounced inspections of 100 hospitals in England found 40 to be sub-standard in their recognition of patient dignity. The English study has been confirmed by students in USA, Brainard and Brislen, who have told of unprofessional conduct by medical faculty that continues and is protected by an established hierarchy.

Brainard and Brislen comment that whilst the formal professionalism curriculum places the patient at the centre of the ethical order by exalting the virtues of altruism, respect, honour, integrity, excellence and accountability, there is another, ‘hidden’ curriculum that emerges in the practical learning environment that ‘...
encourages the learning of an opposing set of values.” Students reported that patients continue to be ‘... examined, disrobed, or treated without respect for their dignity and without their consent.’ In the same study, students also noted that their medical educators have made derisive comments about their patients’ weight, ethnicity and diseases.

Monrouxe and Rees reported one student as saying:

I had a surgeon trying to goad me into calling a patient ‘fat’ basically which was pretty uncomfortable he asked me to examine the patient ... and he said ‘no- no step back, stay by the end of the bed and describe what you see’ and so he started saying something and she was a really big lady, he was dying for me to call her you know call her ‘fat’ and he was saying ‘She’s fat just say it’.

Levinson et al reported that both ‘[r]esidents and medical students had observed, and also admitted to participating in unprofessional behavior including ... engaging in disrespectful comments ... about others. Between one fourth and one half of residents surveyed described witnessing multiple incidents ... of disrespect of patients ... by other residents’. Similarly, Karnieli-Miller et al’s research showed that: ‘The most common theme in the students’ stories was denoted manifesting ... disrespect in clinical interactions with patients ... ’

Monrouxe and Rees comment that students learn behaviour from physicians trained when paternalism by medical practitioners was more acceptable and they imbibe the culture of treating patients dismissively.

\textbf{(b) \textit{Trivialising the Patient}}

The result of negative role models is that medical students are sometimes socialised rather than instructed about dismissive attitudes to patients and other

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300 Lynn V Monrouxe and Charlotte E Rees, "It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 Advances in Health Science Education 671, 681
303 Lynn V Monrouxe and Charlotte E Rees, "It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 Advances in Health Science Education 671, 695.
health professionals. Cribb and Bignold maintain that medical students, as a
strategy for coping with the stresses of ‘demanding academic and clinical
challenges’, trivialise and joke about patients and their bodies and cadavers, and
thereby distance themselves from the reality of medical practice. Coulehan and
Williams argue that these dismissive attitudes also lead to cultivation of an attitude
of them and us, inferior patients and superior medical practitioners, weak
patients and strong physicians. Hafferty and Franks observe that patients are
seen by these students not as recipients of faithful attention but as objects described
by the use of derogatory language.

Wear et al’s research evaluated the contention that ‘[i]t has long been known that
students become more cynical as they move through their training’. They
investigated ‘one dimension of this phenomenon: how medical students perceive
and use derogatory and cynical humour directed at patients’. They found that the
objects of cynical and derogatory humour were those patients whose conditions the
students categorised as being ‘their own fault’ such as obesity, smoking, excessive
drinking or drugs, driving recklessly, unsafe sex or other ‘own fault’ behaviours.
These patients were considered to be ‘fair game’. Wear et al suggested that
humour is a form of cultural insider knowledge that endows ‘native speakers’ with
a sense of their own cultural distinctiveness or even superiority.

Coulehan and Williams comment that an adjunct to an attitude of superiority is the
sense of entitlement. This sense of entitlement is inspired by the accepted rigour of
the process of learning the technical aspects of medical practice and the
consciousness that healing the sick is a highly esteemed occupation. They also

304 Delese Wear et al, ‘Making Fun of Patients: Medical Students’ Perceptions and Use of Derogatory
305 Alan Cribb and Sarah Bignold, ‘Towards the Reflexive Medical School: the Hidden Curriculum
306 Jack Coulehan and Peter C Williams, ‘Vanquishing Virtue: The Impact of Medical Education’
(2001) 76 Academic Medicine 598, 600.
307 Alan Cribb and Sarah Bignold, ‘Towards the Reflexive Medical School: the Hidden Curriculum
308 Frederic W Hafferty and Ronald Franks, ‘The Hidden Curriculum, Ethics Teaching, and the
Structure of Medical Education’ (1994) 69 Academic Medicine 861, 865. A similar point is made in
Jeffrey H Burack et al, ‘Teaching Compassion and Respect: Attending Physicians’ Responses to
309 Delese Wear et al, ‘Making Fun of Patients: Medical Students’ Perceptions and Use of Derogatory
310 Ibid.
311 Ibid 457.
312 Ibid 455.
313 Ibid.
remark that this sense of entitlement extends to the expectation of high status and a substantial income.\footnote{314}{Jack Coulehan and Peter C Williams, 'Vanquishing Virtue: The Impact of Medical Education' (2001) 76 Academic Medicine 598, 600.}

Other writers also document trivialising the patient as part of the training of many medical students. For example, Burack et al identified that ‘referring to patients in disparaging or derogatory ways, or otherwise showing disrespect’ was seen by some attending physicians as one sort of behaviour that "‘rais[ed] red flags’ about possible deficiencies in concern, respect or compassion for patients'.\footnote{315}{Jeffrey H Burack et al, 'Teaching Compassion and Respect : Attending Physicians' Responses to Problematic Behaviors' (1999) 14 JGIM 49, 51.}

Karnieli-Miller et al found that some students were using inappropriate humour or comments behind the patient's back, thus showing disrespect for the patients concerned.\footnote{316}{Orit Karnieli-Miller et al, 'Medical Students' Professionalism Narratives: A Window on the Informal and Hidden Curriculum' (2010) 85 Academic Medicine 124, 127.}

Hafferty outlines three different curricula that shape the medical professional. Firstly there is the formal curriculum of lectures and clinics aimed at providing the student with information about the human body, diagnosis of illnesses, drugs and treatments and the other matters that are ‘offered and endorsed’. Second comes the informal curriculum that is not formally stated and occurs on an interpersonal level between faculty members and students, in the corridors and the ‘tea room’. Finally there is the hidden curriculum that Hafferty specifies as the ‘influences that function at the level of organizational structure and culture’, those hidden messages


\footnote{318}{David T Stern and Maxine Papadakis, 'The Developing Physician — Becoming a Professional' (2006) 355 NEJM 1794, 1797.}
that are conveyed even while the formal curriculum is being taught.\textsuperscript{319} Frequently the terms ‘informal curriculum’ and hidden curriculum’ are used as though they are both part of the hidden curriculum of unscripted influences on medical students.\textsuperscript{320} On other occasions, they are referred to together as influencing medical students on an informal basis.\textsuperscript{321}

Hafferty was concerned to emphasise that medical training is a process of ‘moral enculturation’ whereby the transmission of normative values and emotions saw the medical school function as a ‘moral community’.\textsuperscript{322} Coulehan and Williams comment that whilst some medical schools teach medical ethics and humanities, the impact of these courses is generally limited.

Because the tacit value system of the hospital is so potent in forming the student’s view of doctoring, the explicit values embodied in ethics and humanities courses may have little impact. For example, in their medical ethics courses, students may have learned the components of informed consent and the ethical and judicial standards by which consent is judged. Furthermore, in their courses on physician-patient communication, students may have learned the appropriate methods of facilitating or negotiating informed consent. These topics are in the explicit curriculum. However, in their surgical clerkships they may encounter a culture in which none of this material is relevant.\textsuperscript{323}

As Jones observes, the perception that consent is obtained merely for medico-legal purposes can trivialise the practical importance of an ethical viewpoint by reducing ethical principles to formalised processes such as consent forms.\textsuperscript{324} Coulehan and Williams argue that students consider that what they learn in the clinical hot house is what is the best for the patient. The students thereby purport to be placing the patient first when in reality they are emphasising practices that benefit the medical practitioner.\textsuperscript{325}

Hafferty contends that ‘… a great deal of what is taught — and most of what is learned — in medical school takes place not within formal course offerings but

\begin{itemize}
\item \textsuperscript{320} See eg, Alan Cribb and Sarah Bignold, 'Towards the Reflexive Medical School: the Hidden Curriculum and Medical Education' Research' (1999) 24 Studies in Higher Education 195.
\item \textsuperscript{321} see eg, Ieva Ozolins, Helen Hall and Ray Peterson, 'The Student Voice: Recognising the Hidden and Informal Curriculum in Medicine' (2008) 30 Medical Teacher 606.
\item \textsuperscript{322} Frederic W Hafferty and Ronald Franks, 'The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education' (1994) 69 Academic Medicine 861, 861.
\item \textsuperscript{323} Jack Coulehan and Peter C Williams, 'Vanquishing Virtue: The Impact of Medical Education' (2001) 76 Academic Medicine 598, 602.
\item \textsuperscript{324} Michael A Jones, 'Informed Consent and Other Fairy Stories' (1999) 7 Medical Law Review 103, 130.
\item \textsuperscript{325} Jack Coulehan and Peter C Williams, 'Vanquishing Virtue: The Impact of Medical Education' (2001) 76 Academic Medicine 598, 601.
\end{itemize}
within medicine’s “hidden curriculum”. He identifies structural issues as at the heart of the hidden curriculum. He says that much of what is valued or not in medical education can be discerned by how the medical school ‘sells’ itself. Thus, if the curriculum only has ethics teaching as a minor subject fitted amongst the more ‘important’ subjects, the message is conveyed that ethics is of low significance. If the school is seeking funding and advises that any funds received will be directed into new buildings or into research, the message is clear that those are the priority areas.

The experiences of unprofessional behaviour by practitioners as role models charged with educating medical students in professionalism, demonstrate the dichotomy between the professionalism rhetoric and the practice of medical practitioners. McCammon and Brody argue that where students have seen their superiors violating moral norms, they can perceive this as a betrayal.

5 The Use of Humiliation in the Hidden Curriculum

Lempp and Seale contend that much of the teaching at the medical school they surveyed involved humiliating students particularly on clinical rounds. They maintain that humiliating students is one way that the hierarchy that is a feature of

the medical profession is conveyed to medical students. The use of humiliation as a way to teach and socialise medical students has been widely reported.

Another result of the use of humiliation in the hidden curriculum appears to be the desensitisation of students in anticipation of the forthcoming rigours of medical practice. Students are being taught skills such as how to break bad news and how to communicate with their patients but research has indicated that over time, students become desensitised and ‘... lose a measure of their humanity ...’. Behaviour leading to desensitisation can be absorbed by students as they observe interactions between clinicians and patients. According to Karnieli-Miller et al, their research suggests that the socialisation process has resulted in some medical students suppressing their emotions to an extent that has detached them from their humanity. Cribb and Bignold claim that professional socialisation of medical practitioners ‘... requires a distancing from, and in some respects an “alienation” from the everyday world’. They refer to consistent findings from sociological researchers into medical education that there is a ‘... loss of idealism amongst medical students as they move from articulating humanistic ideals upon entry to an increased pragmatism and sometimes cynicism’. Newton et al suggest that one reason for a decline in empathy of some students is related to students ‘learning to

333 Lynn V Monrouxe and Charlotte E Rees, 'It's Just a Clash of Cultures': Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 Advances in Health Science Education 671, 695.
assume an authoritative role in providing care’ while simultaneously seeing themselves as being abused by their mentor/role models.338

Students are usually aware of the right thing to do but can feel helpless because of the hierarchies endemic in medical practice,339 from medical professionals teaching in medical schools to the hierarchies observable in hospitals and other medical institutions. McCammon and Brody describe some students as reporting feelings of moral distress when feeling powerless to change a situation that they perceive as unprofessional.340 According to McCammon and Brody: ‘Moral distress is generally defined as “when you know what the right thing to do is, but you are unable to do it”.’ 341 They suggest that moral distress in medical students includes three elements:

First, the betrayal of the moral value is committed by someone with legitimate, respected power and authority. Second, the fact that the moral value has been violated is clear; the case does not admit of ethical ambiguity or reasonable differences of opinion (as would be true in many real-life cases of moral distress). Finally, the authority figures who violate the moral value may have been the same who earlier taught the importance of that moral value to the trainee.342

McCammon and Brody remark that there is a tendency by educational institutions to ‘fix or diffuse’ moral distress by referring the student to therapeutic measures. Instead, they should ‘... admit that there really might be wrong things going on out there and that some form of corrective action is required.’343 However, as Hafferty points out: ‘Redesigning the “learning environment” of a medical school is a vastly different ... undertaking than redesigning a curriculum alone’. 344

6  Adverse Events and the Hidden Curriculum

Another aspect of the of the hidden curriculum lies in the way a particular medical practitioner or institution deals with adverse events in medical practice. Berlinger claims that

... the hidden curriculum teaches students and residents how to compose and contribute to successful narratives about mistakes, when success is measured in terms of personal or institutional protection from litigation or in terms of transmitting tribal norms. What we do not learn from these stories is whether the hidden curriculum is capable of teaching early-career physicians how to tell injured patients, and their families, what happened, why it happened and who is responsible, with clarity, candour, and compassion.

Faunce and Bolsin observe that, in some institutions, what has been learned in the hidden curriculum may actually obstruct any disclosure. Bolsin et al comment that the medical profession is experienced and adept at promoting bad behaviour around reporting poor care, and attributes these behaviours to the hidden curriculum.

Berlinger comments that medical students have learned that their teachers believe in, practise and reward the concealing of errors. The hidden curriculum makes sure that they learn that if the patient does not ask, then the physician does not tell. Some physicians do not regard this conduct as lying.

Halbach and Sullivan recommend that there should be explicit teaching about how to prevent errors and how to handle the aftermath. They consider that there is a need to address the hidden curriculum in medicine to facilitate a change of culture. Similarly White et al suggest that students need disclosure training after medical error rather than be expected to rely on the hidden curriculum to teach disclosure skills.

348  Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005 41.
7 Non-Reflective Learning

Several writers have commented upon the problem of non-reflectivity concerning the accepted values of medical ethics. Treadway and Chatterjee report that junior medical practitioners will consciously follow the accepted and traditional values of medical professionalism but not realise that their behaviour conveys values that are diametrically at variance with the received wisdom that the medical profession is compassionate and caring. Sociologists, Hafferty and Franks have reflected that medical education as it now occurs is concerned with establishing a distinct medical morality. Yet, medical students should learn not only what ought to be done but why it should matter. As Cribb and Bignold argue:

Discussion of rights and duties or ‘principles’ — or some other framework underpinning ethics — may provide ethics ‘knowledge’ but it does not necessarily provide ‘ethical attitudes’ or generate ethical doctors. If we are interested in moral education we need to be concerned not only with clarifying what ought to be done but also how and why people come to care about doing what ought to be done ...

Students also learn from observation of and contact with their teachers that requires attention not only to what messages are being revealed but how these messages are conveyed. As Phillips observes:

[Despite] lofty, formal institutional values, what students learn suffers from the often unintended missteps of faculty, staff, colleagues and environment that can never be cleansed of all ‘bad’ elements. If, however, we demonstrate a willingness to see the hidden disavowed curriculum ... then we can use contradictory messages as a starting point for the discussion of values with students, rather than pretending that medicine is value-free.

Similarly, Mossop et al comment that: ‘The power of role-modelling should be harnessed to provide reflective learning experiences for students’.

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352 Katherine Treadway and Neal Chatterjee, ’Into the Water — The Clinical Clerkships’ (2011) 364 NEJM 1190, 1192.


The necessity for doctors to learn reflection in their attitudes to being medical professionals has been emphasised by the GMC which has instituted a system for revalidation of medical professionals. The GMC makes clear in its framework that simply gathering information is not sufficient. Each medical practitioner must reflect on the information collected as the appraiser will want to know how the doctor will develop or modify practice as a result of that reflection.357

Similarly, the Medical Board of Australia’s Expert Advisory Group on Revalidation emphasises that use of multi-source feedback in continuing professional development programs ‘... has been shown to identify gaps in both clinical and professional performance, to trigger self-reflection and to improve practitioner performance.’358 This report emphasises the necessity for reflection and self-awareness as factors in learning during the continuing professional development process.359

7 Conclusion

This section has shown that, despite the positive aspects of role modelling in teaching professionalism, too often the negative aspects of the hidden curriculum overwhelm the positive and leave students either disappointed in their instructors or cynical about how they should treat their patients.360 Some teachers actually consider that they should abuse their students as a way of reinforcing learning.361 However, some commentators contend that use of abuse against students can be equated with child abuse, where victims later become perpetrators.362 Therefore, success of the effort to instil an ethical sense into medical practitioners and ensure that it is internalised to the extent that it outweighs contrary pressures in medical practice, is closely dependent on the training provided to medical students. The unspoken can overwhelm formal instruction concerning the professional tools students need to assist them in navigating the

357 General Medical Council, The Good Medical Practice Framework for Appraisal and Revalidation (March 2013) 1.
358 Medical Board of Australia, Expert Advisory Group on Revalidation (Interim Report, August 2016) 11.
359 Ibid 22.
360 Paul Haidet et al, ‘Characterizing the Patient-Centeredness of Hidden Curricula in Medical Schools: Development and Validation of a New Measure’ (2005) 80 Academic Medicine 44, 44.
ethical minefield that confronts them in daily practice. Medical regulators must supervise the accreditation process for training institutions to guard against lack of attention to informal influences that derogate from internalising ethical values. The Medical Board of Australia could, through its accreditation processes, mandate the sort of ethics training required and supervise its implementation to minimise the detrimental aspects of the hidden curriculum. It can also make sure that ethics is taught in a way that encourages reflection by medical students, not just a mere learning of rules.

While professionalism is the key to quality patient-centred medical practice, there is one aspect of the professional expectations outlined in the codes that should be closely monitored. Recourse to conscientious objection as a way of denying some patients access to legally available medical procedures should be managed to make sure that the patients concerned are not abandoned by their medical practitioners. The next section scrutinises the exercise of conscientious objection and proposes ways to satisfy the interests of both medical practitioner and patient.

G CONSCIENTIOUS OBJECTION — PROFESSIONALISM IN ISSUE

Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busy-bodies. The robber baron’s cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.363

Whilst codes of ethics such as the MBA Code and the GMC Code describe the behaviours expected of medical practitioners, there may be occasions where their provisions conflict. This section analyses provisions in codes of practice that excuse medical professionals from performing a procedure on conscientious objection grounds. Allowing medical practitioners to give a blanket refusal can deny patients access to legally permitted practices and conflicts with the priority of the care of the patient. Courts, codes of ethics and legislation have almost universally recognised conscientious objections by medical practitioners. Whilst there is no community expectation that medical practitioners should always be required to act against conscience, medical professionalism and the principles of patient-centred care demand that alternative arrangements — such as referral to

another practitioner or health service organisation — be made so that patients are not abandoned. Refusal to make alternative arrangements depreciates the duty to practise the patient-centred care expected of medical professionals.

Dickens complains that the monopoly of licensure prevents some people from access to legally available procedures when the medical practitioner has a personal religious objection to providing it. Government legislation restricts particular functions such as performing an operation or prescribing restricted drugs to registered medical practitioners. If the practitioner objects on conscientious grounds to performing a legally-available procedure such as a termination of pregnancy, the patient may have to find another practitioner who will perform the procedure. The restriction of the procedure to registered medical practitioners and the criminalisation of its performance by non-registered persons means that the patient has no alternatives. This could have devastating consequences for a patient whose life is at risk.

If the first priority of the medical practitioner is the care of the patient, any legally-sanctioned procedure that is necessary for the health and well-being of a patient should be provided. The most common procedures to which medical practitioners may object are abortion, sterilisation, contraception and in vitro fertilisation techniques, all of which are legally permitted in Australia. In USA, objection has been made to circumcision, artificial insemination and even to pain-killing drugs for terminally-ill patients, all of which are legally permissible in Australia. As Dickens comments, any indiscriminate appeal to conscience may be in violation of the rights of others.

1 Conscientious Objection in Codes of Ethics

There is no mention in either the Hippocratic Oath or the Declaration of Geneva that a medical practitioner may refuse to treat a patient based on religious or moral beliefs. Nor does the World Medical Association’s

365 Ibid 337.
366 Martha S Swartz, "Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities (2006) 6 Yale Journal of Health Policy, Law, and Ethics 269, 276.
368 Hippocratic Oath - Classical Version.
International Code of Medical Ethics\textsuperscript{370} make any mention of a physician’s choice to refuse to undertake a legally permitted medical procedure. However, recognition of conscientious objections appears in the codes of practice that apply in Australia and the United Kingdom.

(a) Australia

The MBA Code\textsuperscript{371} provides in paragraph 2.4.6 that the medical practitioner has the ‘... right to not provide or directly participate in treatments ... ’ to which he or she has a conscientious objection but directs that the medical practitioner inform the patient and colleagues and not impede access to treatments that are legal. This provision is bolstered by paragraph 2.4.7 where the medical practitioner is told to not allow moral or religious views to deny a patient access to medical care but is advised that he or she is free to ‘... decline to personally provide or participate in that care.’ There is no requirement to facilitate transfer of a patient and the patient’s records to another medical practitioner who will provide the treatment denied. The only mention of transfer of records is in the context of a sale or relocation of practice\textsuperscript{372} though there is reference to facilitating transfer of health information when requested by the patient.\textsuperscript{373}

The AMA Code\textsuperscript{374} is even less specific. It advises that when ‘... a personal moral judgement or religious belief alone prevents you from recommending some form of therapy ... ’, the medical practitioner should advise the patient who can then seek care elsewhere.\textsuperscript{375} There is no requirement for the medical practitioner to facilitate the transfer nor to pass on medical records. In the section on professional independence, the medical practitioner has the ‘... right to refuse to carry out services ... ’ that he or she considers professionally unethical or against his or her moral convictions,\textsuperscript{376} but again there is no requirement to facilitate transfer of the patient and the patient’s medical records to another medical practitioner. The only mention of records is the requirement to ‘[m]aintain accurate contemporaneous clinical records’.\textsuperscript{377}

\textsuperscript{371} Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at 2014).
\textsuperscript{372} Ibid [3.15.2].
\textsuperscript{373} Ibid [8.4.7].
\textsuperscript{374} Australian Medical Association, AMA Code of Ethics - 2004 (at November 2006).
\textsuperscript{375} Ibid [1.1p].
\textsuperscript{376} Ibid [3d].
\textsuperscript{377} Ibid [1.11].
The AMA *Position Statement on Conscientious Objection* recognises sincerely-held beliefs and moral concerns, but not self-interest or discrimination.\(^{378}\) It counsels the medical practitioner to continue to provide treatment in an emergency even if it conflicts with personal beliefs.\(^{379}\) This statement also provides that the medical practitioner must continue to treat the patient with dignity and respect despite having an objection to the proposed procedure and may continue to provide other treatment.\(^{380}\) Once again, there is no requirement that the doctor should facilitate transfer to another practitioner, though patients must be advised that they have the right to see another doctor.\(^{381}\) There is also no mention of transfer of medical records.

Acceptance of the medical practitioner’s right to decline to provide a medical service on account of a conscientious objection that is documented in Australian codes and position statements protects the medical practitioner but can leave the patient without access to legal procedures. This may not be a major problem in larger communities where there are more practitioners, but may cause great hardship in smaller centres without alternatives. Even where other practitioners are available, the lack of assistance to transfer to another practitioner can leave a vulnerable patient without necessary treatment. Lack of assistance to transfer throws the responsibility on the patient to try to determine in advance what the attitude of the medical practitioner is going to be, not easy for a patient who is less than self-reliant and who is conscious of the power differential in the doctor-patient relationship.

In these circumstances it would be sensible for the *MBA Code* to require medical practitioners to put up a notice making clear those procedures that the medical practitioner will not perform on conscientious grounds. Similarly, a requirement for a doctor to facilitate transfer of a patient, and the patient’s medical records, to another doctor would assist the patient to have access to legally-available medical procedures. The main problem with a requirement to transfer would be if there were an emergency situation. As mentioned above, the AMA *Position Statement on Conscientious Objection* makes clear that appropriate emergency treatment must be provided even if that treatment conflicts with the personal beliefs and values of the medical practitioner. However, once there is a requirement in the

\(^{379}\) Ibid [4].
\(^{380}\) Ibid [6].
\(^{381}\) Ibid.
**MBA Code**, either or both to put up a notice or to facilitate transfer of patient and medical records then that requirement becomes part of medical professionalism.

(b) **United Kingdom**

The **GMC Code** is more specific. Paragraph 52 provides that a doctor with a conscientious objection to a particular procedure must advise the patient of the right to see another doctor and provide sufficient information for the patient to exercise that right. The doctor must not express disapproval of the patient’s ‘... lifestyle, choices or beliefs ...’ and must assist the patient by arranging for another ‘suitably qualified colleague’ to take over where it is not practicable for the patient to arrange to do so. There is no mention of transfer of records, but the clause could be interpreted such that where a colleague takes over ‘... your role ...’ this would include access to medical records.

This procedure has the advantage of giving equal weight to the rights of each party. The practitioner is relieved of an obligation to treat against conscience and the patient is not abandoned.

(c) **International**

Following ‘heated debate’ about whether health professionals had the right to refuse to carry out medical procedures to which they object on moral or religious grounds, a survey of medical practitioners in USA reported by Curlin et al found that most believe that it is ethically permissible to explain moral objections to patients and to assist in referring the patient to another medical practitioner who does not object to the proposed procedure. However, there is a substantial number of physicians who do not see that they have any obligation to advise patients about their objection, nor to refer them to another physician. This throws the onus on patients to initiate discussions to determine the attitude of the doctor and to find further information. The findings of this study were that male physicians and those who were religious were most likely to express objections to morally controversial medical treatment and least likely to advise their patients of this, nor refer them to physicians who might undertake these procedures. In the

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382 General Medical Council, *Good Medical Practice* (at 22 April 2013).
384 Ibid 597.
385 Ibid 600.
wake of the Canadian Supreme Court’s *Carter v Canada* ruling\(^3\) that denial of physician-assisted suicide contravenes the *Canadian Charter of Rights and Freedoms*,\(^2\) the Canadian parliament has now passed legislation to permit medical assistance for suffering patients who wish to die. Christian medical practitioners there have been agonising about their responsibility to refer patients where personal conscience will not permit them to provide assistance in dying.\(^3\)

Conscience clauses have been legislated in nearly all states in the USA, permitting health practitioners to refuse to participate in procedures to which they have a religious or moral objection.\(^4\) In addition the Federal Hyde-Weldon Amendment does not even require the objection to be based on personal belief or conscience, any reason being permitted.\(^5\) These clauses permit health professionals to refuse to provide services they find objectionable. They may also refuse to refer the patient to someone else without a similar moral objection and may even refuse to inform the patient of alternative legal options.\(^6\) Swartz tells of a pharmacist who, when presented with a prescription for an oral contraceptive, not only refused to dispense the medication, he failed to ask the patient if she had any medical conditions where pregnancy might prove dangerous. He refused to inform her of other pharmacies that might dispense the medication. When the patient located another pharmacy, he refused to transfer the prescription. This conduct led to a complaint being made to the relevant disciplinary body.\(^7\) Judges subsequently determined that ‘... the state’s interest in assuring that professionals practice [sic] their professions in a competent manner and that patients have access to requested care outweighed the pharmacist’s constitutional rights to exercise his religion freely’.\(^8\)

\[^{3}^{3}\] *Carter v Canada* (Attorney General) [2015] 1 RCS 331.
\[^{2}\] *Canadian Charter of Rights and Freedoms*, s 7.
\[^{3}\] ‘Canada’s Upcoming Assisted Death Law Puts Christian Doctors Under "Great Pressure"’ *The Huffington Post Canada* (Online) (3 February 2016) <http://www.huffingtonpost.ca/2016/02/03/christian>.
\[^{6}\] Martha S Swartz, “Conscience Clauses” or “Unconscionable Clauses”: Personal Beliefs Versus Professional Responsibilities’ (2006) 6 *Yale Journal of Health Policy, Law, and Ethics* 269, 274.
\[^{7}\] Ibid 291.
\[^{8}\] Ibid 269.
\[^{9}\] Ibid 305–306.
2 Arguments Against Conscience Clauses

Health professionals are entitled to monopoly practice yet assert the right to deny patients access to alternative providers on the grounds that giving patients information about alternatives makes those health professionals complicit in the objectionable practice.\textsuperscript{394} Charo criticises this attitude whilst recognising that health professionals do not have to violate their own consciences. She suggests that a valid referral to another practitioner respects the conscience of the refusing medical practitioner while similarly respecting the views of the patient. They should not be at odds when the convictions of both can be accommodated.\textsuperscript{395}

A similar point has been made by Dickens\textsuperscript{396} who argues that conscientious objection has now become a sword rather than a shield against having to perform medical procedures against the religious beliefs of the medical practitioner. Assertion by a medical practitioner (as noted above, mainly males) of a right to refuse a procedure where the reproductive health of a woman may be at risk is a denial of her right to safe, competent medical care. Like Charo, Dickens considers that referral is a sound way of accommodating the beliefs of both medical practitioner and patient.\textsuperscript{397}

Swartz maintains that courts have been less willing than legislators to grant blanket refusal rights, especially to institutional bodies that can be characterised as public or quasi-public.\textsuperscript{398} The problem for many patients is that, in a particular area, the only provider may be a religious body. Yet, Swartz reports that some state courts have characterised private hospitals as ‘quasi-public’ so that they were not entitled to refuse to perform legally available abortions.\textsuperscript{399} However, courts have been more sympathetic to individuals who have been dismissed for religiously-based refusals to participate in abortions.\textsuperscript{400}

Swartz also tells of a medical practitioner who refused to perform an abortion on a pregnant woman with an infection in her amniotic fluid, the recommended

\textsuperscript{394} R Alta Charo, ‘The Celestial Fire of Conscience - Refusing to Deliver Medical Care’ (2005) 352 NEJM 2471, 2471.
\textsuperscript{395} Ibid 2473.
\textsuperscript{397} Ibid 345.
\textsuperscript{398} Martha S Swartz, “Conscience Clauses” or “Unconscionable Clauses”: Personal Beliefs Versus Professional Responsibilities’ (2006) 6 Yale Journal of Health Policy, Law, and Ethics 269, 297.
\textsuperscript{399} Ibid 299.
\textsuperscript{400} Ibid 303.
preferred therapy. In consequence of the refusal, the woman suffered septic shock and had to have a hysterectomy. \(^{401}\) The result was the prioritising of the moral objection over the patient’s health. \(^{402}\) Swartz takes the view that medical codes of ethics should specify that the professional is professionally obligated to provide the necessary care ‘... so long as it is not medically contra-indicated, prohibited from the standpoint of professional ethics, or illegal’. \(^{403}\) She considers that this is especially true for medical professionals who, because of their state-granted licences ‘... hold a monopoly on the type of care they provide’. \(^{404}\)

Likewise, both Dickens\(^ {405}\) and Charo\(^ {406}\) argue that the existence of a monopoly of medical practice in the hands of medical practitioners means that they should not be able to hold their patients hostage. As Dickens remarks, the physician receives the licence or registration to practise based upon mastery of medical science, not upon personal religious beliefs. \(^ {407}\)

Savulescu contends that the doctor’s conscience has no place in public medicine and goes as far as to state that any doctor who compromises the delivery of medical services to clients on conscience grounds should be punished by removal of his or her licence to practise. \(^ {408}\)

It should be noted in passing that conscientious objection to performing a particular legally available procedure could be seen as one extreme of a continuum where patient-centred care lies in the centre. The opposite extreme to refusals based on moral or religious grounds, is the over-zealous advocacy of treatment forcing a particular moral perspective on the patient by depriving the patient of information about alternative options. As will be seen in Chapter IV, in the Scottish case of Montgomery, \(^ {409}\) the medical practitioner’s moral judgement that vaginal birth is superior to a caesarian section, even in an anxious diabetic mother, led to a catastrophic outcome.

\(^{401}\) Ibid 271.  
\(^{402}\) Ibid 270.  
\(^{403}\) Ibid 278.  
\(^{404}\) Ibid 279.  
\(^{409}\) Montgomery v Lanarkshire Health Board [2015] UKSC 11.
In the landmark case of *R v Bourne*\textsuperscript{410} where the legality of access to an abortion for a young rape victim was in question, Macnaghten J criticised the circumstances where obstetricians might refuse to perform an abortion based upon personal religious sentiments, saying:

> On the other hand, there are people who, from what are said to be religious reasons, object to the operation being performed under any circumstances. That is not the law either. On the contrary, a person who holds such an opinion ought not to be an obstetrical surgeon, for if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of his religious opinions and the woman died, he would be in grave peril of being brought before this Court on a charge of manslaughter by negligence.\textsuperscript{411}

As can be seen, the professional obligation to make the patient the medical practitioner’s first priority is not only undermined, but can be repudiated where a medical practitioner refuses a ‘legal’ procedure and fails to compromise by referring the patient to a doctor who does not object to the procedure proposed. Consequently, the Medical Board of Australia should amend the MBA Code to adopt similar provisions to those in the GMC Code, that require the medical practitioner to facilitate transfer of the patient to another practitioner who has no moral objection to the procedure in question. Obliging medical practitioners to display a notice where particular ‘legal’ procedures will not be performed, would also assist patients who may not want to ask.

**H CONCLUSION**

This chapter has shown that despite medicine’s fundamental notion of the centrality of the care of the patient, the drive for professionalism has not been able to eliminate behaviours of some medical practitioners that undermine this principle. Charters of medical professionalism and codes of ethics spell out the way that doctors must deal with their patients. Yet, as this chapter has detailed, medical practice is pervaded by such things as occurrences of dismissive behaviour towards patients, students being humiliated and the perfunctory observance of the principles of patient-centred care, all brought about by pressures on medical practitioners that detract from adherence to ethical and professional norms.

Responses that are contrived to overcome these derogations from the primacy of patient-centred care may be many. However, the emphasis on professionalism returns, time and time again, to the need for enhanced education of medical

\textsuperscript{410} *R v Bourne* [1939] 1 KB 687.

\textsuperscript{411} *R v Bourne* [1939] 1 KB 687, 693 (Macnaghten J).
practitioners in the fundamental tenets of medical ethics and medical professionalism. This enhanced education process should lead to the internalising of principles that can sustain medical practitioners who are faced with ethical dilemmas in practice. The accreditation processes for medical training established by the Medical Board of Australia could be brought to bear upon accredited educational institutions to amend their curricula to insist upon the promotion of the status of medical ethics in the education of future doctors. The Board should also make sure that, when re-registering medical practitioners, medical ethics are dealt with in continuing professional education modules, even to the extent of insisting that each medical practitioner should have to revisit the subject at least every few years. Constant reinforcement should lead practitioners to reflect and internalise the tenets of medical ethics and professionalism.

The elevation of the status of medical ethics as a subject within medical schools must also be accompanied by adoption of medical ethics principles by those teachers whose behaviour has led to disrespectful and dismissive behaviour both towards patients and more junior medical practitioners. The Medical Board of Australia has the power to discipline teachers and practitioners who are found to have shown dismissive behaviour towards patients, thus providing bad examples for medical students.

Last but not least, the acceptance that medical practitioners can decline to perform a procedure because of a conscientious objection is a major derogation from the professional norm of the priority of the care of the patient. The registration system designed to lead to safer patient care can have the perverse effect of detracting from patient care when the practical and legal monopoly given to medical practitioners leads to denial of treatment based upon the practitioner’s conscientious objection.

The content of medical professionalism has been explored in this chapter. Chapter III now turns to consider both the hard and the soft law underlying regulation of medical practitioners. Statute and case law, particularly in disciplinary processes, both call on concepts of medical professionalism as the standard by which medical practitioners are to be judged. Details of what professionalism comprises is to be found in codes, guidelines, charters and frameworks most of which are soft law instruments. Chapter III argues that soft law can be as authoritative as the hard law that underpins it.
CHAPTER III: THE LEGAL REGIME UNDERPINNING MEDICAL PRACTITIONERS — HOW ‘HARD’ LAW AND ‘SOFT’ LAW CONVERGE TO GOVERN MEDICAL PRACTICE

A INTRODUCTION

The primary purpose of this chapter is to provide the background to the legal regime that regulates the professional activities of medical practitioners in Australia. This chapter’s secondary purpose is to scrutinise the Australian disciplinary regime for medical practitioners. In all health systems based on the Western medical tradition, the first priority is the safety of individual members of the public. The necessity to protect members of the public by making sure that its medical practitioners were properly trained led to the Medical Act 1858 (UK) that provided for a system of registration and a body to supervise its implementation. Likewise in Australia, legislation to ensure that medical practitioners had appropriate training and to establish the bodies to oversee implementation of this requirement, was passed in each jurisdiction.1

However, since 2010 there has been a uniform system for registration and regulation of medical practitioners in Australia under the Health Practitioner Regulation National Law (the National Law).2 Firstly, medical practitioners are governed under the ‘hard law’ of the National Law. The National Law lays down the structure of, and the bodies that must implement, the regulatory scheme.3 However, the National Law does not specify all necessary regulatory provisions but it sets out broad parameters for accreditation of educational institutions and health care providers4 and for registration and renewal of registration of health practitioners.5 The National Law also institutes the regulatory arrangements for

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1 See eg, Medical Practitioners Act 1930 (ACT); Medical Practice Act 1992 (NSW); Medical Practice Act 2004 (SA); Medical Practice Act 1994 (Vic); Medical Act 1894 (WA).
2 Health Practitioner Regulation National Law. (The background to this legislation will be discussed in Section C below).
3 Health Practitioner Regulation National Law Parts 2–5.
5 Health Practitioner Regulation National Law Part 7.
monitoring of conduct and for disciplining of health practitioners. Apart from these specific provisions, it then gives to ‘industry’ bodies, including the relevant National Board, the power to develop the ‘soft law’ comprised in charters, codes, guidelines, frameworks and standards that provide the more detailed specification of both technical and ethical conduct. These regulatory instruments are intended to secure co-operation from members of the regulated profession and their compliance to achieve the outcomes desired.

This chapter commences by analysing what is comprised in the idea of soft law as the way in which complex regulatory environments can be effectively and efficiently monitored. Soft law is intended to influence behaviour and can be as effective as statute in securing compliance with specified norms of conduct.

As soft law is not directly enforceable under the terms of a statute, how does this vast array of instruments intended to have regulatory effect actually affect behaviour? This chapter grounds its analysis on features of the influential theory of effective regulation developed by Ayres and Braithwaite in their well-known book, Responsive Regulation. A range of reports aimed at enhancing safety in the Australian health system has used the Responsive Regulation approach. Responsive regulation influences behaviour by way of a process of persuasion backed by the threat of escalating sanctions. This chapter examines the features of responsive regulation as applied to health care and shows it to be an efficient and effective but relatively cheap technique for securing regulatory compliance.

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6 Health Practitioner Regulation National Law Part 8.
7 Health Practitioner Regulation National Law Part 5 Division 3.
The chapter then scrutinises the hard and soft law that directly affect the way medical professionals practise in Australia. After that, this chapter analyses the disciplinary system in place for health practitioners, exploring the rationale behind any decision to discipline and its outcomes.

The chapter continues by summarising the complementary roles of both hard and soft law in the regulation and discipline of medical practitioners. In this context, the dichotomy between hard and soft law is sometimes clear. However, this chapter will demonstrate how the two can converge. The total elimination of disciplinary proceedings is virtually impossible, as the determinations of disciplinary cases attest. The conduct of many medical practitioners undermines the profession’s efforts to demonstrate to a sceptical public that the welfare of the patient is truly the first priority of the medical profession. Scepticism has been generated by recurring reports of medical scandals in both Australia and the United Kingdom.

This chapter also examines reported cases in courts and tribunals for the period from 1 July 2013 to 30 June 2016. Chapter I pointed out the reasons for choosing this time frame. This investigation calls attention to the recurring patterns of conduct of some medical practitioners that has led to the proceedings. As tribunals constantly reiterate, disciplinary proceedings are primarily concerned to protect the public from substandard practice and to provide a deterrent to other practitioners. Two of the recurring behaviours identified by tribunals are the inadequacy of medical records and deficiencies in clinical standards. Each of these behaviours is then scrutinised and suggestions made concerning ways that these behaviours might be remedied.

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B QUASI-REGULATION AND THE HEALTH CARE SYSTEM

1 Introduction

This section examines the way in which soft law has emerged as the dominant method of regulation. This examination does not consider soft law as applied to the activities of government bodies such as the Department of Health. Rather, it is concerned with the impact of soft law on individuals and organisations in the private sector and those that provide services subject to government supervision or financing, such as public hospitals. The Report of the Commonwealth Interdepartmental Committee on Quasi-regulation, the *Grey Letter Law* report refers to ‘the principle that mandatory regulation should be the minimum necessary to achieve the set objectives’.

Yet in the context of health and safety, regulation may need to be more stringent than the minimum.

2 Definition of Soft Law

As will be observed shortly, the idea of ‘soft law’ is an oxymoron. Nevertheless, regulation by way of soft law is now more pervasive in modern society than specific legislation in influencing and controlling the behaviour of individuals and organisations. As Weeks maintains: ‘Soft law is best understood as occupying a space between instruments so soft as not to be law on the one hand and hard law of the positivist variety on the other’. Weeks also comments that: ‘Soft law instruments occupy a broad section of the spectrum between unstructured discretion and legislation.’

The idea of soft law first arose in the context of international law rather than as an adjunct to statutes and regulations. As Creyke and McMillan observe: ‘... international law rules often appear in the guise of soft law ...’ as they lack the enforcement processes that underlie domestic legal systems. Creyke and McMillan also point out that the term soft law is a non-sequitur. Law is either hard because it is enforceable by the state, or it is not law. However, the term has now become

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18 Sometimes called quasi-legislation or quasi-regulation.
20 Ibid xxii.
22 Ibid.
24 Ibid 378.
part of the language of domestic law. As the Administrative Review Council declared: ‘“[S]oft law” refers to a vast and varied range of instruments, among them codes of practice ... guidelines and rules of conduct ... ’. Because there is such a huge variety of instruments that could potentially be considered ‘soft law’, there was a need for further delineation. In the circumstances, the Council adopted the following:

Soft law has been described in terms of rules of conduct or commitment that are set out in instruments that are without legal force although not devoid of all legal effect and that are intended to have some practical effect on behaviour.25

The Administrative Review Council’s report, in its Pyramid of Business Rules, recognised some legislative instruments as soft law.26 However, Weeks expressly rejects that classification.

To the extent that the Complex Regulation Report might be understood as including delegated legislation within the definition of soft law, this book will respectfully depart from its reasoning, regardless of whether such instruments are registered under the Legislation Act 2003 [sic].27

The Legislation Act 2003 (Cth) provides for registration of legislative instruments as defined. The First Parliamentary Counsel may include in the Register any information he or she considers ‘likely to be useful to users of the Register’.28 A legislative instrument is described in section 7 as follows:

Generally the following are legislative instruments:

• an instrument described or declared by a law (including this Act) to be a legislative instrument;
• an instrument registered on the Federal Register of Legislation as a legislative instrument;
• an instrument made under a power delegated by the Parliament that determines the law or alters its content.

However, an instrument is not a legislative instrument if an Act (or a regulation under this act) so provides.

Section 15K(1) of the Legislation Act 2003 provides that: ‘a legislative instrument is not enforceable by or against any person (including the Commonwealth) unless the instrument is registered as a legislative instrument’. Consequently, a great number of instruments of a ‘legislative character’ has been registered including some with administrative content that might otherwise be considered to be soft law.

26 Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) 5.
27 Ibid x.
29 Legislation Act 2003 (Cth) s 15A(4).
3  **Rationale for Government Regulation**

Governments identify problems such as health or safety concerns, or defective market mechanisms before deciding how risks should be handled.\(^{29}\) Regulators have to decide whether explicit legislation is required, or whether soft law regulation will achieve the regulatory object. Indeed, resolution of the problem can largely be handed over to the industry concerned to self-regulate. Sometimes a soft law response should be instituted while a longer term solution to the identified problem can be found.\(^{30}\)

However, according to the Administrative Review Council, whatever regulatory arrangements are instituted, they should comply with the ‘... administrative law values of lawfulness, fairness, rationality, openness ... and efficiency’.\(^{31}\) Any associated accountability mechanisms must be both efficient and effective.\(^{32}\)

4  **Advantages and Disadvantages of Soft Law Regulation**

Soft law regulation has several advantages over explicit legislation. Whilst legislation has the advantage of enforceability, quasi-legislation can be developed or amended quickly to provide the greatest flexibility in changing circumstances.\(^{33}\) One of the reasons for this is that development of soft law regulations is not subject to the intense scrutiny of the parliamentary process.\(^{34}\)

Soft law regulation provides the adaptability to deal with the broad range of situations that arise in day-to-day activities of bodies being regulated. It can be ‘... helpful in fleshing out broad legal principles and clarifying regulatory requirements’.\(^{35}\) Soft law provisions can be relatively easy to amend if they are found not to be operating in the manner envisaged when they were promulgated.\(^{36}\) Soft law can also produce innovative solutions to perceived problems at the least

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\(^{30}\) Ibid xxii.

\(^{31}\) Administrative Review Council, *Administrative Accountability in Business Areas Subject to Complex and Specific Regulation* (November 2008) 16.

\(^{32}\) Ibid 4.


\(^{36}\) Ibid 31.
cost, especially where governments can secure co-operation with the affected industry.\textsuperscript{38}

However, some of the perceived advantages of soft law regulation may, on occasion, turn out to disadvantage some industry players. The advantage of speed and flexibility may be offset by lack of detailed scrutiny leading to a failure to take adequate care to consider all possible contingencies.\textsuperscript{39}

Likewise, the compliance burden of some standards may be excessive on small operators, who may not have the resources to comply with some highly technical rules.\textsuperscript{40} Sometimes there is a perception in an industry that regulators have acquired too much discretion.\textsuperscript{41} In addition, challenges to soft law rules can be difficult and expensive.\textsuperscript{42}

Increasingly, governments are incorporating external materials such as standards into delegated legislation, acknowledged by the Administrative Review Council as a species of soft law.\textsuperscript{43} Section 14 of the Legislation Act 2003 (Cth) authorises the incorporation into legislation by government regulators of instruments prepared outside of government. This section is a recognition that industry bodies are more familiar with the concerns of their particular operations and can bring industry expertise to the regulatory table. Standards promulgated by Standards Australia, or guidelines prepared by industry bodies can be adopted into legislation and be registered as legislative instruments making them enforceable.

\textsuperscript{37} Ian Ayres and John Braithwaite, \textit{Responsive Regulation} (Oxford University Press, 1992) 5.
\textsuperscript{38} Commonwealth Interdepartmental Committee on Quasi-regulation, \textit{Grey Letter Law}, Report (December 1997), 26. For example, in the context of medical practice, soft law regulation can call upon the huge reservoir of technical expertise only available when the industry is consulted (Ian Ayres and John Braithwaite, \textit{Responsive Regulation} (Oxford University Press, 1992) 38).
\textsuperscript{40} Commonwealth Interdepartmental Committee on Quasi-regulation, \textit{Grey Letter Law}, Report (December 1997) 1, 31.
\textsuperscript{42} Administrative Review Council, \textit{Administrative Accountability in Business Areas Subject to Complex and Specific Regulation} (November 2008) 14; see generally also, Greg Weeks, \textit{Soft Law and Public Authorities} (Hart Publishing, 2016).
As Abetz states: ‘There are very sensible and practical reasons for incorporating standards in delegated legislation’.\(^{44}\) Advantages include less cumbersome legislation, uniformity of standards both nationally and internationally. Where the legislation adopts the standard as in force ‘from time to time’, amendments are more simply made than having to totally remake the regulation.\(^{45}\) However, whilst according to the *Legislation Act 2003* (Cth), a legislative instrument may incorporate ‘... any matter contained in any other instrument or writing as in force or existing at the time when the first-mentioned instrument commences’\(^{46}\) it must not incorporate ‘... any matter contained in an instrument or other writing as in force or existing from time to time’.\(^{47}\)

Yet, adoption into delegated legislation by government agencies of Australian Standards\(^{48}\) without thorough assessment to determine whether they are apposite for the purpose for which they are being applied can be heavy-handed, when a lighter touch might have been adequate.\(^{49}\) In addition, because of the assignment by Standards Australia in 2003 of its copyright to a company called SAI Global Limited, access to the standards even by governments and libraries is strictly limited.\(^{50}\) The ‘Rule of Law’ principle that ‘... the law must be accessible, as well as clear and intelligible’ is thereby compromised.\(^{51}\)

5 Self-regulation and Co-regulation

The Commonwealth Interdepartmental Committee on Quasi-regulation defined ‘regulation’ as follows: ‘Regulation includes any law or “rule” that influences the way people behave. Regulation is not limited to government legislation; and it need not be mandatory’. It views the various forms of regulation on a spectrum running from self-regulation, through quasi-regulation to explicit government regulation via statutes, rules, regulations and other legislative instruments.\(^{52}\)


\(^{45}\) Ibid.

\(^{46}\) *Legislation Act 2003* (Cth) s 14(1)(b).

\(^{47}\) *Legislation Act 2003* (Cth) s 14(2).

\(^{48}\) Developed by Standards Australia, a non-governmental, not-for-profit, standards body.


\(^{51}\) Ibid, 4.

Self-regulation is the method by which an industry can be regulated with minimum intrusion by government. Self-regulation can be achieved by voluntary agreement between industry members that a specific set of principles will apply. Failure to adhere to these principles may lead to expulsion from an industry association or other disciplinary processes. Industry players may also commit themselves to varying review mechanisms, such as peer review, industry-based dispute-resolution mechanisms and internal complaint-resolution.

Co-regulation can come about when governments are involved with industry bodies in setting minimum standards by legislation and co-operating with the expertise of the industry concerned in preparing industry codes or other mechanisms. Co-regulation through quasi-regulation provides detailed guidelines for furthering the broad objectives of government policies and provides any industry being regulated with greater certainty and consistency. As the Administrative Review Council commented: ‘...[c]o-regulation seeks to combine the advantages of the predictability and binding nature of legislation with a more flexible self-regulatory approach’.

6 The Theory behind Responsive Regulation

Because of the complexity of modern governmental regulation, Ayres and Braithwaite contend that good regulatory policy is based on the recognition of the interdependence between private and public regulation. If government regulators want to achieve a particular policy outcome, the industry will be more amenable to regulation if it is consulted about the intended outcome and how best to get there. However, regulators are also concerned that industry participants actually comply

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55 Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) 14.
56 Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) 9.
58 Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) 9.
59 Taskforce on Reducing Regulatory Burdens on Business, Rethinking Regulation, Report (January 2006) xii.
60 Ibid xii.
with the regulatory landscape that has been developed. It is here where the well-known Ayres and Braithwaite theory of responsive regulation can be effective.

Responsive regulation rewards ‘good’ behaviour by permitting a high level of self-regulation, or at least by minimising controls, but punishes non-compliant behaviour by gradually increasing punitive sanctions. Government regulators have extensively relied on self-regulation of industries. There is more likely to be compliance when an industry group is involved in and accepts the regulatory scheme, because the industry has been deeply involved in its preparation.\(^{61}\) Responsive regulation is based upon appealing to the enlightened self-interest of individual and corporate players who see that they ultimately benefit from observance of regulatory requirements.\(^{62}\) According to Ayres and Braithwaite, persuasion is cheaper than punishment.\(^{63}\)

Ayres and Braithwaite argue for a ‘speak softly but carry a big stick approach’.\(^{64}\) By that, they mean that the regulator has to have a broad series of escalating sanctions that can be implemented when compliance is deficient. Having only a few sanctions, so stringent that courts and regulators are reluctant to use them,\(^{65}\) reduces their regulatory impact. By being willing to escalate up the pyramid of sanctions for ‘bad’ behaviour, and equally to reward compliance by implementing a softer form of regulation, they argue that it is possible to achieve satisfactory regulatory obedience at the least cost and aggravation to all parties.\(^{66}\)

7 The Limits to Self-Regulation of Medical Practitioners

In keeping with the Ayres and Braithwaite theory, industry self-regulation in the medical profession is the preferred strategy. ‘When self-regulation works well, it is the least burdensome approach from the point of view of both taxpayers and the regulated industry’.\(^{67}\) Self-regulation in the medical profession turns on the fact that it is the profession itself that is most familiar with its unique technical and practical features. As outlined in Chapter II, the medical profession has historically claimed the right to self-regulate in exchange for the expectation that it


\(^{63}\) Ibid 26.

\(^{64}\) Ibid 40.

\(^{65}\) Ibid 36.


\(^{67}\) Ian Ayres and John Braithwaite, *Responsive Regulation* (Oxford University Press, 1992) 38.
will use its specialised knowledge in the service of the community. As Dame Janet Smith commented:

[t]here was a strong belief, apparently shared by Government, that the medical profession itself provided the best (indeed the only) means of imposing high standards of clinical care and professional conduct on doctors and of monitoring those standards. It was believed it would do so rigorously. Hence, matters of professional concern were left to be determined ... with the GMC [General Medical Council] as ultimate arbiter of fitness to practise. This belief, which was fostered by the profession, was difficult to challenge in an area involving questions of professional expertise.

However, despite the undoubted benefits of involving members of a specific industry in developing and managing their own regulatory system, governments in Australia have chosen to closely monitor regulation of medical practitioners. A tradition of comprehensive self-regulation by the medical profession in the past was not able to prevent aberrant behaviour by a small group of medical practitioners and has led to their regulation becoming more prescriptive. The recurring ‘scandals’ affecting medical practice, including in Australia, have led the public and government regulators to consider that the medical profession cannot be trusted to preside over a totally self-regulatory system. Faunce and Bolsin commented that, in a series of three ‘whistleblowing sagas’ in Australia, in each case ‘... the problems were exacerbated by a poor institutional culture of self-regulation ... ’.

As Dixon-Woods et al observe in the United Kingdom context, public trust in the profession to regulate itself to provide safe outcomes to patients by singling out and removing ‘bad apples’ has been substantially dented. There is evidence that the profession has been more interested in shielding its members from disciplinary actions than demonstrating zero-tolerance towards serious infractions. Similarly, Dame Janet Smith reported:

[the GMC was ‘doctor-centred’. It appeared to assume that all doctors were good, competent and conscientious until proved otherwise. It would deal with the profession’s ‘bad apples’ for the sake of the profession. It would do so in its own way and did not welcome scrutiny. Its procedures were designed to be fair to doctors and to ensure that no doctor would lose his/her right to practise without very good cause. It did not focus on the reasonable expectations of the public and it did not see

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69 See eg, the Bristol Royal Infirmary, the Shipman Inquiry, Djerrwarrh Health Services, Graeme Reeves, Jayant Patel, Off-Protocol Prescribing at St Vincent’s Hospital.
itself as having a duty to ensure that all members of the medical profession were willing and able to provide a proper professional service.\textsuperscript{72}

In Australia, Judith Healy has written extensively about regulation of health care professionals.\textsuperscript{73} Healey concurs with Mary Dixon-Woods and her colleagues and with Dame Janet Smith by saying:

The limited use of stern disciplinary sanctions by medical boards can be interpreted in three ways. First, most patients’ complaints may be on minor matters that do not warrant a stern response to doctors; second, the boards apply a responsive approach that aims to remediate, rather than punish doctors; or third, the medical boards are ‘soft on doctors’. The registration boards rightly aim to correct rather than cull poorly performing health professionals, have developed a hierarchy of options to respond proportionately to complaints, and can direct practitioners down a ‘health pathway’ as well as a ‘disciplinary pathway’. While revoking the licences of doctors who engage in gross infractions clearly is necessary, some argue that there is no evidence that culling a few bad apples acts as a deterrent and so improves the general quality of medical care. As medical boards have been reluctant regulators except in egregious cases, the public suspect [sic] they are more concerned to protect professionals than to protect patients.\textsuperscript{74}

Kennedy was an early critic of the medical profession in the United Kingdom, where in his Reith lectures he declared that

[professional self-regulation is always open to the criticism that it is not sufficiently energetic, that ranks will be closed to protect a fellow member, rather than opened to admit that questioning outsider. Certainly, the medical profession can never be expected to become the champion of the consumer’s cause.\textsuperscript{75}

Furthermore, when analysing why the United Kingdom medical profession was no longer wholly self-regulating, Dixon-Woods et al noted:

The organising collegial principle of the medical profession was that all fully qualified members were equal in authority, self-directing and self-disciplined, and sufficiently conditioned by norms of conduct and their individual consciences, to ensure that all members would conduct themselves honourably. In effect, it was assumed that there were no “bad apples”.\textsuperscript{76}

Thus, the medical profession provides a prime example of the need for more intrusive regulation by government regulatory authorities than is suggested by its former insistence upon its right to wholly self-regulate. However, whilst self-regulation by the medical profession has often been shown to be deficient,

\textsuperscript{73} Healy has written both on her own and with collaborators in the Regulatory Institutions Network at The Australian National University.
\textsuperscript{74} Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 129.
\textsuperscript{75} Ian Kennedy, The Unmasking of Medicine (George Allen and Unwin, 1981) 125.
\textsuperscript{76} Mary Dixon-Woods, Karen Yeung and Charles L Bosh, ‘Why Is UK Medicine No Longer a Self-Regulating Profession?’ The Role of Scandals Involving "Bad Apple" Doctors (2011) 73 Social Science and Medicine 1452, 1455.
government regulators who wish to be more prescriptive have needed to call upon the expertise of the medical profession to determine the detail of regulation.77

In the context of the United Kingdom, Dame Janet Smith, referring to the expertise in the General Medical Council, commented:

I would like to believe that the GMC's culture will continue to change in the right direction by virtue of its own momentum. However, I do not feel confident that it will do so. I am sure that there are many people within the GMC, both members and staff, who want to see the regulation of the medical profession based on the principles of 'patient-centred' medicine and public protection. Indeed, I think it is likely that all members are theoretically in favour of those principles. The problem seems to be that, when specific issues arise, opposing views are taken and, as in the past, the balance tends to tip in favour of the interests of doctors.78

8  Responsive Regulation in Health Care

Because of the limitations on self-regulation by medical professionals as outlined above, the responsive regulation model has been promoted by Braithwaite, Healy and other colleagues to improve safety in the health care system.79 They have extensively researched ways to reduce the alarming incidence of injuries and death to patients, particularly in hospitals. They deal with mandatory reporting of sentinel events, benchmarking in accordance with clinical protocols and continuous quality improvement.80 Whilst these matters are critically important, there is an equally important deficit in information about how individual medical practitioners should respond to their overarching obligation to good patient-centred medical practice and how a safety culture can be instilled at the individual level.

Most medical practitioners work in or are employed by private practices that charge a fee for service.81 The choice to practise as a private practitioner is particularly appealing where the medical practitioner has acquired advanced degrees or recognition by one of the prestigious specialist colleges of medicine. The preference for private practice is bolstered by a constitutional guarantee in the

77 National Law s 33 where National Boards are appointed. As National Law s 35 provides, one of the functions of a National Board is to ‘develop or approve’ standards, codes and guidelines. See Section C below.
social services power under section 51(xxiiiA) of the *Australian Constitution*.82 The overall effect of cases against the Commonwealth under section 51(xxiiiA) is now a practical guarantee that medical practitioners who choose to do so, can carry on a private practice on their own account and cannot be forced to become employees of the Commonwealth to provide medical services.83 As so many do practise on their own account, the opportunities to use regulatory tools like contractual performance obligations is limited. In addition, private work like this reduces the possibility that colleagues can observe inadequate behaviour.84

Healy has designed a regulatory pyramid85 following her more recent research, as a modification of one used by Braithwaite, Healy and Dwan in their discussion paper for the Australian Commission on Safety and Quality in Health Care (ACSQHC).86 Her pyramid is reproduced below.87

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82 The terms of s51(xxiiiA) of the Constitution provide that the Commonwealth of Australia has power to make laws for the peace, order, and good government of the Commonwealth with respect to the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances. It is the words in brackets that have been interpreted by the cases as providing a constitutional guarantee of private practice.


As quoted above,¹ Healy comments that medical regulators have been ‘reluctant regulators’ except in egregious cases leading members of the public to suspect that they are more concerned to protect the professionals concerned than the public.²

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Likewise, in the United Kingdom, the General Medical Council came under suspicion from the public. As Dame Janet Smith reports:

The fact is that the public has come to regard the GMC with suspicion and distrust because it perceives that the GMC acts, not in the interests of patients, but in the interests of doctors.¹

Healy has also been highly critical of the medical profession’s efforts to embrace safer health care. Her view is that medical practitioners have not been prepared to acknowledge that human beings make mistakes and consequently, that they must design safer systems where adverse events cannot occur. As she observes:

High-risk industries assume both human fallibility and system fallibility, but the health sector has been reluctant until recently to acknowledge that professionals can make mistakes and that systems can fail. This is paradoxical since the health professions value learning from failures as well as successes …. [There are] regulatory efforts to inculcate a safety culture and to design safer systems. This is a challenge since the medical profession, in particular … has been reluctant to overcome its complacency, to put patients first, and to comply with interventions to improve safety and quality.²

The Healy regulatory pyramid is well adapted to the safety aspect of health care but is not as appropriate for encouraging better professional embrace of patient-centred care. For example, there is no specific mention of professional codes of conduct. Codes could be added to the list of co-regulatory interventions through the melding of hard law requirements with the need to draw on professional expertise in development of codes. The pyramid does advert to the place of clinical protocols and continuing professional education but, once again, these appear to be in the context of the promotion of a safety consciousness rather than promotion of quality patient-centred care.

When the medical regulator considers that there is a threat to patient safety caused by conduct of a medical practitioner, such as conduct specified in section 140 of the National Law providing for mandatory notifications,³ disciplinary proceedings can be instituted. Section D will outline the hierarchy of disciplinary sanctions available under the National Law. Healy suggests a pyramid of available sanctions that could be adapted to medical disciplinary matters, by the addition of conditions, fines, reprimands, cautions and suspension.⁴ As the cases summarised in Section D

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² Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 137.
³ See Section D below.
⁴ Judith Healy, Improving Health Care Safety and Quality (Ashgate, 2011) 221.
show, a pyramid of sanctions of this type is already being implemented by tribunals in the discipline of medical practitioners.\(^7\)

9 Conclusion

Soft law has become the preferred means by which governments achieve compliance by industries with overall regulatory goals.\(^8\) This section has shown that soft law regulation can be applied to control a far broader range of activities and conduct than can total reliance on statute supported by the common law. It can provide flexibility under changing circumstances. It can be implemented more rapidly than hard law and can fill in gaps that become apparent as contingencies emerge. Soft law development can also draw on a wider range of expertise than is possible in the legislative process, a factor that is important for developing soft law regulatory protocols for health practitioners.

As the Report of the Taskforce on Reducing Regulatory Burdens on Business has observed: ‘... there is much to be said for establishing the key principles and objectives in legislation and allowing regulators discretion in how they are applied including through subordinate or quasi-regulation’.\(^9\) Subordinate and quasi-regulation are more appropriate to an industry or profession when the expertise of the profession is harnessed in their preparation.

C HARD AND SOFT LAW GOVERNING MEDICAL PRACTITIONERS

1 Introduction

As the introduction to this chapter states, medical practitioners, along with all health practitioners, are subject to the provisions of the Health Practitioner Regulation National Law (the National Law) that specifies how they are to be regulated. This legislation establishes, in some detail, the machinery for supervising the processes of registration of health practitioners. Regulation of health practitioners is no longer achieved through a series of statutes that differ in content from jurisdiction to jurisdiction. Whilst registration of health practitioners is constitutionally a matter for states and territories, the states and territories have

\(^7\) Section 196(2) of the National Law sets out a similar hierarchy of sanctions.
\(^8\) Ian Ayres and John Braithwaite, Responsive Regulation (Oxford University Press, 1992) 38.
accepted that there are good overriding reasons why a ‘uniform’ system should be adopted. For example, in New South Wales, Ms Carmel Tebbutt, as Deputy Premier and Minister for Health stated:

Under the national law registered health practitioners will pay a single registration fee that will entitle them to work across the entire country without being required to meet additional criteria or pay additional fees. The national law will ensure that nationally uniform processes and criteria exist for registering practitioners and accrediting educational programs. The establishment of these uniform processes and standards will mean that uniformly high standards will be applied nationwide and that the public can have increased confidence that all registered health practitioners meet appropriately high standards.\(^\text{10}\)

Likewise, the Minister for Health in the Victorian Legislative Assembly, Mr Andrews stated:

The cornerstone of the national law is protection of the public. It provides a framework for the regulation of health practitioners in relation to registration, accreditation, complaints and conduct, health and performance, and privacy and information sharing. It builds on the best elements of existing regulatory models, such as the Victorian Health Professions Registration Act 2005 (‘the HPR act’) [sic] and other health practitioner legislation throughout Australia.\(^\text{11}\)

This section explores the relevant provisions of the National Law concerning registration, accreditation and discipline. However, as mentioned above, statutes are often too rigid to respond promptly to changing circumstances. Hence, the need for a broad range of soft law regulatory instruments to enhance the effectiveness of the legislation. This section also examines soft law, paying particular attention to the most important regulatory tools developed by ACSQHC and showing how these are necessary for the proper regulation of medical professionals.

In addition, many professional bodies prepare and supervise codes of conduct for medical professionals, together with technical guidelines about appropriate treatment protocols. This section will briefly review the relevant codes of conduct for the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS) and provide some examples of treatment protocols and position statements.

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\(^{10}\) New South Wales, Parliamentary Debates, Legislative Assembly, 28 October 2009 (Ms Carmel Tebbutt).

\(^{11}\) Parliament of Victoria, Parliamentary Debates, Legislative Assembly, 15 October 2009 (Mr Andrews) 3695.
2 Background

Following a report of the Productivity Commission in 2005, the Council of Australian Governments (COAG) determined that a national scheme be established to govern the registration, regulation and accreditation of all health practitioners. The report found that the system of state and territory registration and regulation at that time was inhibiting mobility of health professionals in a health system subject to perpetual personnel shortages. Because health regulation was not a power given to the Commonwealth of Australia under sections 51 or 52 of the Australian Constitution, or referred to it by a state under section 51(xxxvii) of the Constitution, responsibility for regulation and registration of health practitioners was devolved to individual states and territories. The resulting complexity led the Productivity Commission to argue for the establishment of a ‘... consolidated national accreditation regime ... ’ to ‘... encourage “cross-professional” workplace innovations ... ’ and to ‘... facilitate the development of uniform national registration standards for health professionals.’ A meeting of COAG on 14 July 2006 agreed to ‘establish a single national registration scheme for health professionals’, and a ‘single national accreditation scheme for health education and training’. The Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions made between the Commonwealth and each state and territory was entered into on 26 March 2008. COAG also agreed on 26 March 2008 that the scheme should commence on 1 July 2010 based on Queensland legislation designated as the model for state and territory parallel legislation.

3 Hard Law in the National Law

Uniform legislation to govern the accreditation, registration and regulation of all health practitioners is now in place. The legislation, first passed in Queensland as the ‘Schedule’ the terms of which are contained in section 4 of the Health Practitioner Regulation National Law Act 2009 (Qld), has been mirrored in all states and territories of Australia creating the Health Practitioner Regulation

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13 Ibid iii, 11.
14 See eg, Medical Practitioners Act 1930 (ACT); Medical Practice Act 1992 (NSW); Medical Practice Act 2004 (SA); Medical Practice Act 1994 (Vic); Medical Act 1894 (WA).
15 Productivity Commission, Australia's Health Workforce, Research Report, 2005 xxiv.
17 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions (26 March 2008).
National Law (the National Law). Each Australian jurisdiction has passed, in accordance with the National Law, complementary legislation that applies within its own area, known as the Health Practitioner Regulation National Law (participating jurisdiction). The primary justification for the National Law is to protect the public by ensuring that ‘... only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered, ...’.

Part 4 of the National Law establishes the Australian Health Practitioner Regulation Agency (AHPRA), called the National Agency, as the central body for registration of health practitioners and for investigating professional conduct, performance and health of health practitioners. AHPRA’s disciplinary processes operate across all jurisdictions except for New South Wales that has retained its Health Professional Councils Authority and Health Care Complaints Commission, and Queensland where the disciplinary function is performed by the Queensland Health Ombudsman.

Part 5 of the National Law sets up National Boards. Section 31 establishes National Health Practitioner Boards with powers over each of the 14 professions designated as health professions as named in the National Law. Members of each National Board are appointed by the Australian Health Workforce Ministerial Council comprising ‘... Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health.’

Under section 32, each National Board is given the powers that allow it to exercise its functions. Section 35 outlines the functions of each National Board that include

18 Health Practitioner Regulation National Law s 3(2)(a).
19 Health Practitioner Regulation National Law s 23(1).
20 The National Boards are:
   Aboriginal and Torres Strait Islander Health Practice Board of Australia;
   Chinese Medicine Board of Australia;
   Chiropractic Board of Australia;
   Dental Board of Australia;
   Medical Board of Australia;
   Medical Radiation Practice Board of Australia;
   Nursing and Midwifery Board of Australia;
   Occupational Therapy Board of Australia;
   Optometry Board of Australia;
   Osteopathy Board of Australia;
   Pharmacy Board of Australia;
   Physiotherapy Board of Australia;
   Podiatry Board of Australia;
   Psychology Board of Australia.
21 Health Practitioner Regulation National Law s5.
approving accreditation of programs of study submitted to it by an accreditation body, and developing registration standards to ensure appropriate qualifications for registration for members of the relevant health profession. Among other functions, a National Board must also oversee ‘receipt, assessment and investigation’ of notifications concerning registered health practitioners or students,\(^ {22}\) and establish panels to conduct hearings about ‘health and performance and professional standards for registered health professionals or students’.\(^ {23}\)

Section 38(1) of the *National Law* imposes on a National Board the *obligation*\(^ {24}\) to develop registration standards for health professionals, that must include provision for professional indemnity insurance, criminal history of applicants for registration and continuing professional development. Section 38(2) also specifies standards including physical and mental health of applicants, but registration standards must not include any matter that is included in accreditation standards.\(^ {25}\)

Section 39 of the *National Law* gives each National Board the *discretion*\(^ {26}\) to develop and approve codes and guidelines that are to direct the activities of relevant health practitioners and also other matters applicable to the exercise of its functions. In 2009 the Medical Board of Australia (MBA) issued a code of conduct under section 39 entitled *Good Medical Practice: A Code of Conduct for Doctors in Australia (the MBA Code)*.\(^ {27}\) It incorporates by reference the *Code of Ethics* of the AMA,\(^ {28}\) the *Declaration of Geneva*\(^ {29}\) and the *International Code of Medical Ethics*\(^ {30}\) issued by the World Medical Association (WMA), thus giving those instruments the same regulatory impact as the *MBA Code* itself.\(^ {31}\) Section 39 provides the legislative ‘hook’ for the soft law codes and guidelines that direct the conduct of health practitioners.

\(^{22}\) *National Law* s 35(g).

\(^{23}\) *National Law* s 35 (h).

\(^{24}\) The legislation uses the word ‘must’.

\(^{25}\) *National Law* s 38(3).

\(^{26}\) The legislation uses the word ‘may’.

\(^{27}\) Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at 2009).


\(^{31}\) Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at 2009) [1.1].
Section 40 requires each National Board to consult widely about the contents of the registration standards and each code or guideline. The MBA Code acknowledges the work of the Australian Medical Council and the input of many organisations including state and territory medical boards, plus the Commonwealth Department of Health and Ageing.32

Section 41 of the National Law then provides that both registration standards and codes and guidelines approved by a National Board are admissible in disciplinary proceedings against a health practitioner registered under the provisions of the National Law ‘as evidence of what constitutes appropriate professional conduct or practice for the health profession’. Because the MBA has exercised its discretion to prepare and promulgate the MBA Code, section 41 of the National Law invests that document with the enforceability of hard law, as if its specific provisions had been directly legislated. Definitions of professional misconduct, unprofessional conduct or unsatisfactory professional performance under the National Law relate back to standards reasonably to be expected of a registered practitioner of equivalent training or experience in the circumstances of the practitioner before the relevant disciplinary body. The disciplinary body has to call expert evidence from members of the profession as to what constitutes the specified level of training and experience before making a finding. It is the finding, once made, that attracts any sanction. Section D below analyses the disciplinary regime under the National Law and will illustrate this process by reference to a case before the Australian Capital Territory Civil and Administrative Tribunal (ACAT), Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44.

The MBA Code, is not only authorised under the National Law, but it is also a blueprint for professional conduct of medical practitioners in the sense of bringing together ‘standards that have long been at the core of medical practice’.33 Its provisions are to be used to provide a framework to guide professional judgement, to set standards against which professional conduct can be evaluated and to enhance the culture of medical professionalism.34 Consequently, registered medical practitioners must abide by the MBA Code as doing so is evidence of

32 The drafters also looked at similar documents from several countries, including Canada, the United Kingdom, the United States and New Zealand. The 2014 review of the 2009 version of the MBA Code was performed ‘in house’ by AHPRA (Personal correspondence with AHPRA, 13 November 2014).
33 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at 2009) [1.1].
34 Ibid [1.2].
appropriate professional conduct for them. The MBA has also developed guidelines as follows:

Sexual boundaries: guidelines for doctors;
Guidelines for mandatory notifications;
Guidelines for technology based patient consultations;
Guidelines for advertising regulated health services;
Guidelines – short-term training in a medical specialty for international medical graduates who are not qualified for general or specialist registration;
Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures.35

Therefore, section 41 of the National Law also confers on those guidelines enforceability like that of the MBA Code, that is, evidence that can support a disciplinary finding.

4 Soft law Instruments

The foregoing paragraphs outline the extent of the hard law regarding accreditation, registration and regulation of health practitioners. The details of how these are to be achieved emerges in soft law instruments.36

Health practice, particularly medical practice, is governed by a myriad of standards and guidelines not referred to in the National Law or drawn from it. This is where the reach of other forms of soft law becomes clear. Both the Commonwealth Interdepartmental Committee on Quasi-regulation and the Administrative Review Council have recognised that standards may be called upon by courts when determining whether an activity has been performed negligently.37 Similarly as Weeks observes, some soft law is useful to courts in determining the standard that can reasonably be expected within an industry, for the purposes of establishing negligence.38

5 Australian Commission on Safety and Quality in Health Care (ACSQHC)

ACSQHC acts with the Commonwealth Department of Health as a major regulatory actor in the Australian Health System and has prepared a wide range of

36 For example, those that govern the curricula of training institutions and the way evidence for registration is to be supplied by the applicant.
reports and guidelines. The reports and standards prepared by ACSQHC have been
developed ‘... to drive the implementation of safety and quality systems and
improve the quality of health care in Australia’. ACSQHC was established as a
‘corporate Commonwealth entity’ under the National Health Reform Act 2011
(Cth) and is jointly funded by all Australian Commonwealth, state and territory
governments. Its board is appointed by the Minister (the Commonwealth Minister
for Health) in consultation with state and territory Ministers for Health.

ACSQHC has developed a wide range of instruments in its quest to implement
safety and quality systems in medical practice. The most important of these are the
Australian Charter of Healthcare Rights and the National Safety and Quality
Health Service Standards. It has also developed the Australian Safety and Quality
Framework for Health Care which ‘describes a vision for safe and high-quality
care’ and sets out actions to achieve this vision. The framework was endorsed by
the Australian Health Ministers in 2010.

6 The Australian Charter of Healthcare Rights

As stated above and in keeping with its name, ACSQHC was established to ‘...
lead and coordinate national improvements in safety and quality’. Its view was
that ‘... a uniform articulation of patient entitlements — and appropriate
obligations — is a basic requirement for a safe and high quality healthcare
system’. In this context, quality implies a standard of excellence as formulated in
Chapter I. The Australian Charter of Healthcare Rights is the most fundamental of
the soft law instruments underpinning a quality Australian health care system. It
clearly enunciates its rationale: ‘These rights are essential to make sure that,
wherever and whenever care is provided, it is of high quality and safe’.

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39 Web site of Australian Commission on Safety and Quality in Health Care
40 Australian Commission on Safety and Quality in Healthcare, Australian Safety and Quality
Framework for Healthcare (at December 2010).  
41 Australian Commission on Safety and Quality in Health Care, Draft National Patient Charter of
42 Australian Commission on Safety and Quality in Health Care, Draft National Patient Charter of
43 Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare
Rights.
The Charter prescribes a set of seven principles to guide the provision of healthcare in Australia. The Charter is an acknowledgement that a patient-centred system of health care is associated with higher quality care and enhanced safety. It was developed during 2007 and 2008 and was endorsed in July 2008 by the Australian Health Ministers as applicable to all health environments in Australia, including public and private hospitals, general practice and community health services. ACSQHC also acknowledges that the Charter ‘... exists within a broader framework of human rights and the basic right to health care, as set out in the Universal Declaration of Human Rights, to which Australia is a signatory’. 

The Charter identifies seven principles:

Access – I have a right to health care. ([2.1.3], [4.3], [4.5].)

Safety – I have a right to receive safe and high quality care. ([1.4], [3.10], [4.2.1], [4.3.3], [4.4.3], [6], [8.4].)

Respect – I have a right to be shown respect, dignity and consideration. ([1.4], [2.4.1], [2.1.5], [3.1], [3.2.1].)

Communication – I have a right to be informed about services, treatment, options and costs in a clear and open way. ([1.4], [2.2.5], [3.1], [3.2.5], [3.3], [3.8.1], [3.9.2], [3.11], [3.12.7], [3.12.10], [4.5.1].)

Participation – I have a right to be included in decisions and choices about my care. ([2.2.11], [2.3], [3.2.4], [3.6.3], [3.8.3], [3.9.1].)

Privacy – I have a right to privacy and confidentiality of my personal information. ([3.2.1], [3.4.2], [3.4.5], [3.8.3]).

Comment - I have a right to comment on my care and to have my concerns addressed. ([3.10.8], [3.11], [8.10].)

All these principles parallel the principles in the concept of patient-centred care as outlined in Chapter I. The clauses in the MBA Code to which they relate are in square brackets after each of the rights.

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44 Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare Rights.
45 Australian Commission on Safety and Quality in Health Care, Windows into Safety and Quality in Health Care 2008, 5.
47 Australian Commission on Safety and Quality in Health Care, Draft National Patient Charter of Rights, (Consultation Paper, 22 January 2008) 5. Article 25 of the Universal Declaration of Human Rights recognises a right to a standard of living adequate for health and well-being and includes medical care and social services. The right to health care is also in Article 12(d) of the International Covenant on Economic, Social and Cultural Rights where a right to creation of conditions to assure medical service and medical attention to all is specified.
However, as has been made clear in the 2008 consultation report when the Charter was being formulated, the Charter is not just about rights of patients or consumers. There is also a balance to be struck between the rights and responsibilities of both patients and providers.48 For example, in respect of Communication, the right to be informed also entails the obligation to be open and honest in disclosing medical history and treatments.49 Likewise, the right to Respect does not only entail health care providers’ respect for each patient’s culture, beliefs and values. Patients must also respect staff and other health service personnel by treating them politely and considering their workload.50

Notwithstanding, McCaffery et al reported that patients and consumers must recognise that there may be limitations on matters such as Access when patients live in rural or remote areas51 or are Indigenous.52 This comment arose in the context of implementing shared decision making, a fundamental aspect of patient-centred care. They observe that shared decision-making is affected by such varied matters as health literacy,53 distance in rural and remote communities,54 cultural and linguistic diversity55 and Aboriginal and Torres Straight Islanders.56 Added to these drawbacks were internal organisational impediments such as lack of support for consumer input.57 Similar barriers could equally apply to the Charter Rights of Safety, Communication and Respect.

Yet whilst the Charter has an aspirational element, it is required to be implemented in all health service organisations and accreditation of these bodies includes their adoption of the principles underpinning the Charter’s rights. Therefore, patients can expect that their healthcare rights will be observed in all of their contacts with the health care system.

50 Australian Commission on Safety and Quality in Healthcare, Roles in Realising the Australian Charter of Healthcare Rights.
51 Australian Commission on Safety and Quality in Health Care, National Patient Charter of Rights (Consultation Report, June 2008) 17.
53 Ibid 236.
54 Ibid 235.
55 Ibid.
56 Ibid.
57 Ibid.
The National Safety and Quality Health Service Standards (the Standards) were promulgated by ACSQHC following an extensive consultation process and provide the benchmarks by which quality assurance must be implemented in hospitals and accreditation achieved. The Australian Health Ministers endorsed the Standards in September 2011.59

The ten standards require a total of 256 actions, each of which is a detailed protocol to ensure consistency and quality. Proving compliance with each protocol requires the creation of appropriate checklists that must be signed off.60 Since January 2013, all hospitals and day procedure services in Australia have had to commence the processes to obtain accreditation under these standards.61 Many private services have also applied for accreditation under these standards.62 There is already evidence that adoption of the Standards is transforming health care across Australia.63 By the end of 2017, it is expected that most of the organisations requiring accreditation, will have achieved it.64

The Standards were instituted to promote ways to protect the public from harm and to improve the quality of health care services.65 Medical practitioners are an integral part of health care delivery and favourable outcomes for implementing the Standards will depend, in good measure, on the adherence by medical practitioners to their requirements, whether in a health service organisation or in a private practice.

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58 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012).
60 I was the Quality Assurance Co-ordinator when Clayton Utz Canberra obtained its first quality certification.
61 Australian Commission on Safety and Quality in Health Care, Transforming the Safety and Quality of Health Care (October 2014) 2.
63 Ibid 2.
64 Ibid 4.
65 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) 3.
Standards 1 and 2 are the bases upon which the remaining standards are grounded. The relevant texts are: ‘Standard 1 - Governance for Safety and Quality in Health Service Organisations that describes the quality framework required for health service organisations to implement safe systems’. ‘Standard 2 - Partnering with Consumers that describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care’, that is, patient-centred medical practice emphasising partnership between patient and health care provider.

(a) **Standard 1 - Aspects of Governance in Health Care Institutions**

The process of governance specifies policies, procedures and structures that determine how an organisation functions. It sets the goals to be achieved, develops structures to promote quality outcomes (such as observance of patient-centred medical practice) and establishes systems to minimise the occurrence of harm to patients. For example, on its own, the estimated costs of the approximately 190,000 iatrogenic (medically caused) admissions to hospitals in Australia in 2011 was $660 million, the addition of about one dollar for every seven spent on hospital care.

One of the criticisms in the report of 31 July 2016 made by the Inquiry into the St Vincent’s Hospital Cancer scandal was that the hospital's response to the incident showed a lack of clinical governance. As the Final Report stated:

> Clinical governance had a proactive responsibility to coach and guide the hospital and clinical leadership on the best response to such situations and the best approach to look back and open disclosure. Such processes should be necessary only rarely, but have to be able to swing into place urgently when needed.

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66 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2013) 1. Standards 3–10 are as follows:

3 Preventing and controlling healthcare associated infections
4 Medication safety
5 Patient Identification and procedure matching
6 Clinical handover
7 Blood and Blood products
8 Preventing and managing pressure injuries
9 Recognising and responding to clinical deterioration in acute health care
10 Preventing falls and harm from falls.

67 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2013) 3.


It is clear from these findings that Standard 1 of the *National Safety and Quality Health Service Standards*, namely Governance for Safety and Quality in Health Service Organisations, had not been observed.

The Final Report dated 31 July 2016 refers to patients of the same medical practitioner in the Western New South Wales Local Health District. The terms of reference were expanded on 4 April 2016 to include these patients. A report into their treatment was released on 16 September 2016 (the Western NSW Local Health District Report).\(^7^0\) As in the Final Report, the Western NSW Local Health District Report was critical of the Local Health District finding that ‘... there were governance issues in how cancer services were managed’.\(^7^1\)

The costs of poor clinical governance are reflected in both increased financial burdens on the health care system and the compromising of patient safety, together with institutional responses to safety lapses.

\(b\) *Standard 2 - Developing Partnerships between Patients, Carers and Health Service Organisations*

This standard recognises the need to involve patients and their carers in all aspects of their treatment, including design of systems for the provision of services and being involved in monitoring and evaluation of their effectiveness. Patient involvement provides a basis for high quality health care. Not only are clinical outcomes enhanced but there are business benefits in the reduction of treatment costs per patient, happier and more stable personnel and better experiences regarding liability claims.\(^7^2\)

However, the difficulty of achieving this standard is exemplified by a survey concerning multi-disciplinary teams where it was remarked that no surgeons involved in breast cancer treatment reported including the patient in discussions about the patient’s treatment.\(^7^3\)

Similarly, the report into St Vincent’s Hospital stated:

\(^{7^0}\) Inquiry under Section 122 of the *Health Services Act 1997, Prescribing of Chemotherapy* (Report on Patients Treated at Western NSW Health District, 16 September 2016).

\(^{7^1}\) Inquiry under Section 122 of the *Health Services Act 1997, Prescribing of Chemotherapy* (Report on Patients Treated at Western NSW Health District, 16 September 2016) [61].

\(^{7^2}\) Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2013, 23).

Almost all of the patients and next-of-kin reported that they did not recall Dr Grygiel discussing chemotherapy drug options with them but rather that they were told by Dr Grygiel which chemotherapy drug was recommended.74

The value of this standard for the implementation of patient-centred care lies in its comprehensiveness. It can only be effective if patients are treated as equals at all stages. In this sense, equality does not mean having the technical expertise of the medical practitioner, but respect for the patient leading to greater equality of status in the discussions. However, as the St Vincent’s Hospital report of 31 July 2016 quoted above demonstrates, there still appeared to be a perception by the doctors that ‘doctor knows best’. 75

8  Soft Law in Codes and Guidelines of Professional Bodies

Drawing up soft law regulatory directions is not limited to government bodies. This part also shows how guidelines from professional bodies influence medical practice. Medical associations together with the learned specialty colleges supplement ‘official’ standards with a wide variety of codes of conduct, treatment guidelines and position statements.

Guidance is found in codes and guidelines issued by medical professional bodies such as the Australian Medical Association (AMA) and the specialist medical colleges. Failure to adhere to one of these codes or guidelines may constitute evidence that a practitioner has fallen short of professional norms. Tribunals take these instruments into account during their deliberations for the purpose of deciding whether a disciplinary sanction is required.76

The major specialist colleges like the RACP and the RACS are companies limited by guarantee and membership and termination of membership is in accordance with their constitutions. Their primary function is to provide specialist training and to award advanced qualifications. Each of these specialist colleges has a code of conduct for its members and issues guidelines. For example, RACP is actively involved in policy and advocacy and publishes a wide range of guidelines, position statements and submissions on its web site.77 These vary from guidelines such as

75 Ibid [101]-[102].
76 See eg. Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [24].
the Clinical Practice Guidelines for Dementia, to position statements such as the Immunisation Position Statement or The Health of Refugee Children Position Statement. It also makes submissions to Commonwealth and state and territory governments, and governmental bodies like ACSQHC\(^78\) and the Therapeutic Goods Administration (TGA).\(^79\)

RACS also publishes a wide range of position papers\(^80\) including guidelines like Bullying and Harassment, Recognition, Avoidance and Management and Implications of Obesity for Outcomes of Non-Bariatric Surgery. It also publishes a Surgical Safety Checklist.\(^81\)

Guidelines relate to specific medical conditions, for example the RACP National Guidelines for the Management of Haemophilia, and to situations related to particular groups of patients, such as AMA position statements on Care of Older People or Care of Aboriginal and Torres Straight Islander Communities. They also extend to guidelines for matters occurring in practice such as certifying illness for the purposes of school or employment.\(^82\)

9 Common Law Recognition of Soft Law

Soft law standards, while ‘unenforceable’ in theory, have been recognised by courts. Both the Grey Letter Law report\(^83\) and the Administrative Research Council report\(^84\) described the case of Anne Christina Benton v Tea Tree Plaza Nominees\(^85\) where the court referred to a voluntary Australian standard on kerb height as a factor in determining negligence. The question of the enforceability of soft law in the context of medical practice appears to be going through a transition stage.

Whilst there has been no clear legal principle in Australia that always recognises as


\(^79\) Royal Australasian College of Physicians, Budget Submission: Adverse Drug Event Reporting.

\(^80\) Royal Australasian College of Surgeons, Surgical Safety Checklist (Oct 09). The efficacy of checklists will be explored in Chapter VI.


\(^82\) Commonwealth Interdepartmental Committee on Quasi-regulation, Grey Letter Law, Report (December 1997) at xii, 34, 36, 47.

\(^83\) Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) at 10 (fn 46).

\(^84\) Anne Christina Benton v Tea Tree Plaza Nominees (1995) 64 SASR 494.
enforceable codes and standards other than those promulgated by the MBA, courts in the United Kingdom are endorsing some relevant codes of practice and this is also occurring in Australia as the following examples illustrate.

In Montgomery v Lanarkshire Health Board, the UK Supreme Court pointed out that the days of medical practitioners dealing with ‘ignorant’ patients was over and that patients had rights that must be observed, including the provision of sufficient information so that the patient could make a properly informed choice about how to proceed. This view was reinforced by guidelines issued by the GMC that specified the duty of the doctor to provide relevant information to the patient in a way that the patient can understand, thus permitting the patient to weigh benefits, risks and other options, including that of not acting at all. By acknowledging the GMC guidelines, the court was adopting its provisions as applicable to the circumstances, and against which the conduct of the medical practitioner could be evaluated.

In Australia, as a result of section 41 of the National Law, there are numerous examples in tribunal cases of the conduct of a medical practitioner not being professional as measured against standards specified in the MBA Code. Courts also have acknowledged the MBA Code. In Woollard v The Medical Board of Australia Sitting as a Performance and Professional Standards Panel, the Supreme Court of Western Australia specifically acknowledged that the MBA Code was relevant and appropriate to determine whether conduct of the medical practitioner had been professional. In Nitschke v Medical Board of Australia, the medical practitioner had appealed against a decision of the Northern Territory Health Professional Review Tribunal to take immediate action to suspend him under section 156 of the National Law. The reason was that he ‘... did not exercise the care and skill required of a registered health practitioner, in particular having regard to clause 1.4 ... of the MBA Code’ that provided that Dr Nitschke had ‘... a

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87 General Medical Council, Good Medical Practice (at 22 April 2013) [32].
88 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [77] (Lord Kerr and Lord Reid).
89 See eg, Dr A v Health District (No 2) [2014] NSWIRComm 50; Medical Board of Australia v Kanapathipillai [2016] ACAT 16; Medical Board of Australia and Veettil [2015] WASAT 124; Aroo v Medical Board of Australia [2015] QCAT 482; Crickitt v Medical Council of NSW (No 2) [2015] NSWCATOD 115; Medical Board of Australia v Mbo [2015] ACAT 69.
90 Woollard v The Medical Board of Australia Sitting as a Performance and Professional Standards Panel [2015] WASC 332.
91 Nitschke v Medical Board of Australia [2015] NTSC 39.
responsibility to protect and promote health of individuals and the community’. On appeal, the Northern Territory Supreme Court found that there was no evidence of any conduct by the medical practitioner that was proscribed by the MBA Code, implying that the MBA Code embodied appropriate principles of conduct for medical practitioners. There is also acknowledgement in tribunals that codes and guidelines other than those specified in the MBA Code can be relevant to determine whether or not a medical practitioner’s conduct has complied with professional norms. 

10 Soft Law Enforceability other than Legislation or Common Law

In addition to the ‘enforceability’ of soft law through supporting statements by courts, compliance with soft law may be compelled by other means. In the absence of any case law, the best example of this process is the enforceability of the National Safety and Quality Health Service Standards, against which every health service provider must be accredited. As discussed above, the Standards have been endorsed by the Australian Health Ministers and are applicable to every health service provider, whether hospital or clinic, public or private.

The enforceability of the Standards lies in the fact that, unless adopted, the health service provider will not be accredited and so will be prevented from operating. The Standards have been prepared based on empirical evidence of where the greatest number of adverse events occurs in medical practice.

As the Administrative Review Council observed: ‘Government soft law is generally not subject to the range of administrative law mechanisms applicable to the “black letter” law that is ... administered by government agencies’. For an aggrieved health service provider to seek tribunal or court review may be difficult. The Standards do not meet the definition of a legislative instrument for the purposes of the Legislation Act 2003 (Cth). They have not been made ‘under an enactment’ so any regulatory decision will not be relevant for the the purposes of

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92 Nitschke v Medical Board of Australia [2015] NTSC 39 [62] that is quoting from the findings of the South Australian Immediate Action Committee.
93 See eg, Medical Board of Australia v Koniuszko [2016] VCAT 492 [56] (Guidelines issued by the Medical Practitioners’ Board of Victoria); Medical Board of Australia v Curran [2015] SAHPT 4 [28] (Royal Australian and New Zealand College of Psychiatrists Code of Ethics); Bahramy v Medical Council of New South Wales [2014] NSWCATOD 116 [113] (Expert Code of Conduct - tertiary institutions).
94 Administrative Review Council, Administrative Accountability in Business Areas Subject to Complex and Specific Regulation (November 2008) xi.
95 Legislation Act 2003 (Cth) s 8.
the *Administrative Decisions (Judicial Review) Act 1977 (Cth)*. A breach by a health service provider would only be subject to review under section 39B of the *Judiciary Act 1903 (Cth)* if the accrediting body were an ‘officer of the Commonwealth’. This could mean that the only way to redress for a perceived adverse assessment by the accrediting instrumentality might be through the Commonwealth Ombudsman.

There have been no cases to date brought by a health service provider seeking review where an application for accreditation has not been granted. If however the matter did come before a court, it is submitted that a court would find that the *Standards* and their matching actions to achieve implementation were relevant and applicable to all health service providers seeking accreditation. Thus, health service providers will make sure that they comply with both the letter and the spirit of the *Standards*. In this way, an apparently soft law instrument is both designed to achieve and will achieve compliance from all the bodies to which it is addressed.

### 11 Conclusion

Medical practitioners are regulated by some specific legislation. However, most regulation of day-to-day conduct of medical practitioners or health service providers occurs by virtue of soft law instruments, both made under the authority of the *National Law* and by other regulatory bodies, the most important of which is the government-funded ACSQHC. There are also state-funded bodies that issue important guidance. Added to soft law instruments issued by these bodies are those issued by professional bodies including the specialist medical colleges.

There is clearly a high degree of observance of these instruments. However, where there is not, failure to observe various codes and guidance documents has been regarded by disciplinary tribunals as evidence of conduct of a practitioner that falls below the standards of professionalism evidenced in these instruments. What constitutes evidence of professional conduct as found in these guides is supplemented by evidence from relevant health professionals. The justification for disciplinary proceedings lies in this failure to observe professional norms, and it is these processes that now demand analysis.

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*Administrative Decisions (Judicial Review) Act 1977 (Cth) s 3.*

*See eg, Clinical Excellence Commission in New South Wales, the Victorian Centre of Excellence in Eating Disorders, and the Centre for Clinical Interventions in Western Australia.*
D MAINTAINING PROFESSIONAL DISCIPLINE

1 Introduction

In pursuit of its remit to legislate for the safety of members of the public in their interactions with health practitioners, the National Law makes express provision for the discipline of health practitioners. It specifies a series of behaviours\(^9\) that health practitioner colleagues must report to the National Agency namely AHPRA,\(^9\) and details a number of grounds upon which a voluntary notification may be made by ‘any entity’.\(^10\) This section explores the outcomes of a sample of disciplinary decisions and notes the recurrence of themes identifiable as notifiable conduct. Despite the publicity given to disciplinary proceedings, the recurrence of these themes suggests that some medical practitioners have not internalised the obligation to practise medicine in a patient-centred, that is, professional manner.

Once AHPRA has made a preliminary assessment of the notification, it will determine whether the matter should be referred to a National Board to be subject to that board’s processes. The relevant National Board may investigate a health practitioner if it has received a notification through AHPRA, or has some other reason to suspect impairment or unsatisfactory conduct or practice. The National Board may require the practitioner to undergo a health\(^10\) or performance assessment\(^10\) through relevant special panels.\(^10\) A National Board can also determine whether the outcome of a panel determination should be referred to a tribunal.

This section commences by describing the rationale for the disciplining of health practitioners. The primary reasons for disciplining medical practitioners are advising members of the public about, and to protect them from, deficient practices and to apprise other health practitioners and the public as to what constitutes good medical practice. The grounds for discipline are directly related to what is considered to be acceptable professional behaviour.

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\(^9\) National Law s 140.
\(^9\) National Law s 141.
\(^10\) National Law s 145. In accordance with s 5 of the National Law, ‘entity includes a person and an unincorporated body’.
\(^10\) National Law s 169.
\(^10\) National Law s 170.
\(^10\) A health panel is authorised by National Law s 181 and a performance and professional standards panel is authorised by National Law s 182.
This section proceeds to scrutinise the behaviours identified by the legislation as notifiable conduct and notes the criticisms of the mandatory reporting regime that suggest over-reporting whilst other evidence implies under-reporting. It examines arguments for and against legislation that exempts practitioners who are treating other practitioners with impairments from reporting their colleagues.

This section then discusses the link between professional conduct and disciplinary proceedings and explores the four-stage process between referral to a tribunal and any sanction imposed. As signalled earlier in this chapter, this exploration is exemplified by the Australian Capital Territory case of Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44.

Even considering that a substantial share of these notifications will be dismissed, the number of notifications made is of concern. This chapter surveys the outcomes of a sample of disciplinary decisions considered by tribunals and courts from the period 1 July 2013 to 30 June 2016. Overwhelmingly, these cases reflect the behaviours identified as warranting a mandatory notification to AHPRA.

2 The Rationale for Disciplining Medical Practitioners

The rationale for disciplinary proceedings is the protection of the public. In disciplinary proceedings, where a determination on the balance of probabilities is to be made, the relevant standard is higher than the normal civil standard but below the ‘beyond a reasonable doubt’ standard required for criminal cases. As stated by Dixon J in Briginshaw v Briginshaw:

[reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequences of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters, ‘reasonable satisfaction’ should not be produced by inexact proofs, indefinite testimony, or indirect inferences.]

The reason that the Briginshaw test is more demanding than the usual civil standard of proof is because the balance of probabilities test might be satisfied without adequate consideration of the ‘nature and consequences of the fact or facts to be proved’ such as the seriousness of allegations or the gravity of any consequences flowing from a particular finding. Disciplinary proceedings are not

104 Briginshaw v Briginshaw (1938) 60 CLR 336.
105 Briginshaw v Briginshaw (1938) 60 CLR 336, 362 (Dixon J).
supposed to be a punishment\textsuperscript{106} but are a way of holding the professional to account, both for public safety and for the reputation of the profession.\textsuperscript{107} Any decision to suspend or deregister a medical practitioner is a function of the requirement for patient safety, and sends a message to members of the profession. It also signals to the public that the regulator is not prepared to tolerate sub-standard performance. As the New South Wales Court of Appeal stated:

The objective of protecting the health and safety of the public is not confined to protecting the patients or potential patients of a particular practitioner from the continuing risk of his or her malpractice or incompetence. It includes protecting the public from the similar misconduct or incompetence of other practitioners and upholding public confidence in the standards of the profession. That objective is achieved by setting and maintaining the standards and, where appropriate, by cancelling the registration of practitioners who are not competent or otherwise not fit to practise, including those who have been guilty of serious misconduct. Denouncing such misconduct operates both as a deterrent to the individual concerned, as well as to the general body of practitioners. It also maintains public confidence by signalling that those whose conduct does not meet the required standards will not be permitted to practise.\textsuperscript{108}

When determining the appropriate orders, tribunals take into account a series of factors:

1. protection of the public;
2. the maintenance of professional standards in the eyes of the public; a weighing of the public interest in the practitioner continuing to practise against the public interest in protecting clients from any repetition of the conduct exhibited;
3. evidence of insight and/or remorse, where relevant; and
4. the role of general and specific deterrence.\textsuperscript{109}

A finding that conduct has deviated from professional norms triggers relevant sanctions. Section 5 of the National Law provides the definitions of professional misconduct, unprofessional conduct and unsatisfactory professional performance.\textsuperscript{110}

\begin{footnotesize}
\textsuperscript{106} NSW Bar Association v Evatt (1968) 117 CLR 177, 183–184 (Barwick CJ, Kitto, Taylor, Menzies and Owen JJ).
\textsuperscript{107} Health Care Complaints Commission v Litchfield [1997] NSWSC 297 (Gleeson CJ, Meagher JA and Handley JA) “Disciplinary proceedings against members of a profession are intended to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession.”
\textsuperscript{108} Health Care Complaints Commission v Do [2014] NSWCA 307 [35].
\textsuperscript{109} Medical Board of Australia v Fox [2016] VCAT 408 [58].
\textsuperscript{110} For example, the definition of professional misconduct is as follows: professional misconduct, of a registered health practitioner, includes—

(a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
\end{footnotesize}
All these definitions in the National Law refer back to conduct being below a standard that might be reasonably expected, by the public or the practitioner’s peers, of a health practitioner of similar education and experience. As in New South Wales, sanctions imposed by tribunals range, in a ‘pyramid’ depending on the practitioner’s conduct, from counselling and imposition of conditions, through fines, reprimands and cautions to suspension or cancellation of registration. New South Wales and Queensland have their own disciplinary procedures.

(a) New South Wales

New South Wales has not adopted the definitions in section 5 of the National Law and introduces its own definitions and disciplinary procedures in the Health Practitioner Regulation National Law (NSW). Part 8 of the National Law (NSW) provides a detailed scheme for disciplinary action against health practitioners. It has designated the Health Care Complaints Commission and the Medical Council of New South Wales to handle complaints and notifications about medical practitioners. Determinations of these bodies may, depending on the perceived severity of the aberrant behaviour, refer matters to the Professional Standards Committee or to a tribunal. Until 1 January 2014, cases were dealt with by the Medical Tribunal. However, following the enactment of the Civil and Administrative Tribunal Act 2013 No 2 (NSW), the Medical Tribunal has been abolished and cases are dealt with by the Civil and Administrative Tribunal in its Occupational Division. The National Law (NSW) defines professional misconduct and unsatisfactory professional conduct. Its definition of professional misconduct does not refer to standards reasonably expected of a health practitioner, for example, as in the National Law (ACT), but specifies that conduct, whether a single instance or a series of instances, must be ‘sufficiently serious’ to justify suspension or cancellation of registration. Unsatisfactory professional conduct includes a specification of conduct ‘significantly below’ the standard reasonably expected of a health practitioner of equivalent training or experience, but also

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(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner’s profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

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111 Health Practitioner Regulation National Law (NSW) No 86a ss 149A, 149B and 149C.
112 National Law s 196(2).
113 Health Practitioner Regulation National Law (NSW) No 86a.
114 Health Care Complaints Act 1993 (NSW) s 75.
115 Health Practitioner Regulation National Law (NSW) No 86a s 41B(1).
116 Civil and Administrative Tribunal Act 2013 (NSW) s7, and cl 3 Schedule 1.
117 Health Practitioner Regulation National Law (NSW) No 86a Section 139E.
includes details of other behaviour that amounts to ‘unsatisfactory professional conduct’. It also introduces another level of disciplinary proceedings through the Professional Standards Committee, the findings of which are made public.

(b) Queensland

In Queensland, since 1 July 2014, disciplinary cases have been handled through the Office of the Health Ombudsman. This office replaced the Health Quality and Complaints Commission and has taken over some of the functions previously carried out by AHPRA. The Office of the Health Ombudsman is an independent statutory body established under the Health Ombudsman Act 2013 (Qld). The Health Ombudsman Act 2013 (Qld) repealed the Health Quality and Complaints Commission Act 2006 (Qld) and two other acts relating to health practitioners.118 The Director of Proceedings in the Office of the Health Ombudsman is responsible for taking proceedings against health practitioners before the Queensland Civil and Administrative Tribunal.119

3 The National Agency – Australian Health Practitioner Regulation Agency (“AHPRA”)

AHPRA has been established under the National Law.120 It operates under a series of state-based Medical Boards, part of the Medical Board of Australia and has state-based AHPRA staff. AHPRA has a co-ordinating function, receiving mandatory and voluntary notifications about health practitioners and referring them to health, and performance and professional standards panels established under the National Board of each health profession. Separate panels operate in each State and Territory. AHPRA does not publish the names of health practitioners about whom panel decisions have been made. Names of errant health practitioners only become public if they are referred to relevant tribunals in each jurisdiction.

AHPRA has published on its web site, a list of decisions about health practitioners since the National Law came into effect, but does not include decisions under previous legislation even if the decision has been made after the date of

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118 Health Ombudsman Act 2013 (Qld) s 321.
119 Health Ombudsman Act 2013 (Qld) s 12.
120 National Law s 23.
commencement of the *National Law*, 10 July 2010. AHPRA has also found itself, on occasion, the subject of suit.

4 Notifiable Conduct

The *National Law* has provision for both voluntary and mandatory notifications of activities of health professionals who may overstep legal and professional boundaries. Any entity may make a voluntary notification to AHPRA upon grounds specified in section 144. AHPRA must provide reasonable assistance to the notifier to make the notification and must then refer the notification to the National Board that has registered the health practitioner. Some cases are set in motion by complaints from patients through the voluntary notifications process.

5 Mandatory Notifications of Medical Practitioners by Other Medical Practitioners

Under section 141 of the *National Law*, every health practitioner is obliged to notify AHPRA where, in the practice of the profession, the practitioner has formed a *reasonable* belief that another health practitioner has behaved in a way that is notifiable conduct.

Section 140 defines mandatory notifiable conduct, meaning that the practitioner has:

(a) practised the practitioner’s profession while intoxicated by alcohol or drugs; or
(b) engaged in sexual misconduct in connection with the practice of the practitioner’s profession; or
(c) placed members of the public at risk of *substantial* harm in the practitioner’s practice of the profession because the practitioner has an impairment; or
(d) placed members of the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards. (emphasis added).

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122 See eg, Stanley-Clarke v Australian Health Practitioner Regulation Agency [2012] QSC 250 where a complaint against a medical practitioner was determined by AHPRA as disclosing no reasonable cause of action.
123 Health Practitioner Regulation National Law s 23.
124 Health Practitioner Regulation National Law s 147.
125 Health Practitioner Regulation National Law s 148.
127 Health Practitioner Regulation National Law s 140 (italics added).
One case of failure to make a mandatory notification about an employed medical practitioner who was in a sexual relationship with a patient, earned the employing practitioner a finding of professional misconduct leading to a reprimand and conditions upon registration.128

White, McDonald and Willmott maintain that mandatory reporting has been legislated in Australia because of the perception following several medical scandals that health professionals had become aware of deficient conduct or performance of colleagues but had failed to report it to relevant authorities.129 For example, evidence of a medical culture with a reluctance to criticise or comment upon the conduct of colleagues hampered The Canberra Hospital Inquiry into the activities of a neurosurgeon.130 Furthermore, the Inquiry into Off-protocol Prescribing in New South Wales131 found that ‘... the issue132 was inaccurately characterised ... and the response133 to it was internalised’134 leading to their assessment that ‘The overriding reason for this is cultural; remembering that, in its purest sense, culture is about how things are done’.135

AHPRA makes it clear that ‘... all registered health practitioners have a professional and ethical obligation to protect and promote public health and safe healthcare,’136 AHPRA has prepared guidelines under section 39 of the National Law to provide directions ‘... to registered health practitioners, employers of practitioners and education providers about the requirements for mandatory notifications under the National Law’.137 The threshold for reporting under section 141 of the National Law is high, requiring a reasonable belief in the reporting

128 Medical Board of Australia v Al-Naser [2015] ACAT 15.
129 Ben White, Fiona McDonald and Lindy Willmott, Health Law in Australia (Lawbook Co., 2nd ed, 2014) 625.
132 The issue was the prescribing of identical doses of a chemotherapy drug irrespective of individual characteristics of the patients concerned.
133 The response was the failure to identify or notify the affected patients or notify the public. ‘No medical oncologist was providing input to the hospital’s executive team to inform and prepare the public statements, nor check their accuracy’. Inquiry under section 122 of the Health Services Act 1997, Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers, Final Report (31 July 2016) [159].
135 Ibid [161].
137 Australian Health Practitioner Regulation Agency, Guidelines for Mandatory Notifications (March 2014) 2.
practitioner that the conduct constitutes notifiable conduct. The risk of harm from an impaired health practitioner must be substantial and potential harm from the departure from accepted professional standards must be significant. Each of the four notifiable activities refers back to practice of the profession whilst subsection (d) also measures the activity against accepted professional standards.

Where one practitioner is treating another practitioner with an impairment, the overriding principle is risk of harm to the public. So long as a practitioner's 'impairment' is controlled during treatment and there is no risk to patient safety, there is no obligation on the treating medical practitioner to make a mandatory notification.

Bismark et al observe that whilst mandatory reporting has also been legislated in New Zealand and some states in the United States, Australia’s legislation is unusually far-reaching in that it requires health practitioners to report both health impairments and performance deficiencies. The legislation also does not specifically exempt a treating health practitioner from a requirement to report an impaired patient who is another health practitioner.

The mandatory obligation to report under section 141 of the National Law has been criticised on the basis that it may deter some health practitioners from seeking professional help to overcome some of the specified problems. Parker argues that any practitioner who is aware of having an impairment that might pose a substantial risk should feel ethically obliged to self-report. Similarly, medical practitioners who consider that the health professional they are treating poses a substantial risk to the public, should also feel ethically obliged to report. He also observes that if impaired doctors and their treating physicians feel deterred by the

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138 Ibid 3.
139 National Law s 140(c).
140 National Law s 140(d).
141 Impairment is defined in s 5 of the National Law and includes ‘... a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect ...’ for a registered health practitioner, ‘... the person’s capacity to practise the profession ...’.
142 Australian Health Practitioner Regulation Agency, Guidelines for Mandatory Notifications (March 2014).
mandatory reporting requirements, we should be able to conclude that there has been and continues to be considerable under-reporting.145

Parker’s observation seems to have been confirmed by recent research carried out by Bismark et al who examined 846 mandatory reports to AHPRA, finding that only 8% of reports had been made of medical practitioners by medical practitioners, that is 64 medical practitioners. Of these, only 14 of the 64 were made by the medical practitioner’s treating physician. The authors concluded that mandatory reports by treating practitioners were rare and they speculate that, far from ‘opening the floodgates’ to over-reporting, the infrequency of the reports led to a conclusion that under-reporting was more likely.146 Earlier research from the same lead author and others had concluded that some of the harms predicted for mandatory reporting as well as anticipated benefits were, so far, not occurring.147

In Hocking v Medical Board of Australia, Murrell CJ referred to section 141 of the National Law as

> designed to require practitioners to make complaints that may, upon further investigation, be shown to be warranted and to ensure that practitioners do not adhere to a code of silence in relation to significant misconduct by other practitioners. The provision gives effect to the s 3(2)(a) objective of protection of the public.148

In the case of Health Care Complaints Commission v Orr, the New South Wales Civil and Administrative Tribunal suggested that a ‘code of silence’ was operating in this case that was detrimental to the health of the practitioner concerned and the practitioner’s professional standing. It criticised all the health practitioners who had come into contact with this impaired pharmacist as

> [p]roof ... that a failure to notify actually inhibited this impaired practitioner from being provided the supervision, monitoring and treatment that could have helped him, and may even have prevented the events that ultimately led to these disciplinary proceedings.149

The mandatory reporting system has also been criticised on the basis that medical practitioners are sometimes subjected to vexatious reports by other medical

148 Hocking v Medical Board of Australia [2014] ACTSC 48 [148].
practitioners as a method of bullying and harassment. This allegation was investigated as part of a Senate inquiry into bullying and harassment in the medical profession.

In order to avoid the criticism that some practitioners may be deterred by the mandatory reporting regime from seeking treatment, Western Australia took another approach. When legislating the National Law (WA), Western Australia added an exemption for a health practitioner from making a mandatory notification where another practitioner is being treated by the first health practitioner for an impairment that may otherwise be reportable. Section 4(7) of the Health Practitioner Regulation National Law (WA) inserts an additional exemption in section 141(4) as paragraph (da) as follows:

(da) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student;

Goiran et al contend that the National Law has created a perception of a barrier to health access, and that the Western Australian amendment removes this perception while still fulfilling the professional requirement to make sure that patient safety is being enhanced. However, the Australian Health Workforce Ministerial Council does not favour the adoption of the Western Australian legislation in the absence of relevant evidence.

The ‘ethical’ obligations concerning the promotion of public health and safe health care are fundamental to the principles of patient-centred care and a hallmark of the good medical professional. Practising while intoxicated, or engaging in sexual

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151 Tessa Hoffman, 'Inquiry to Investigate Doctors' Vexatious Claims' Australian Doctor (Online) (18 March 2016) <http://www.australiandoctor.com.au/news/latest-news/inquiry-to-investigate-doctors-vexatious-claims>. However, in response to the Senate findings, AHPRA announced that it would crack down on vexatious complaints by other doctors, though its belief was that vexatious complaints were on a relatively small scale. (Antony Scholefield, AHPRA to Crack Down on Vexatious Complaints', Australian Doctor (Online) (2 December 2016) <https://www.australiandoctor.com.au/news/latest-news/ahpra-to-crackdown-on-vexatious-complaints>). Researchers at University of Melbourne had identified only 6 complaints (including those from patients) that appeared to be vexatious out of a total of 850.
misconduct cannot, almost by definition, be patient-centred. The remaining two categories specify harm as the trigger for the mandatory notification, thus falling into the category of promotion of public health and safe health care, that is, the duty to practise medicine safely. The stipulation respecting patient safety is also reflected in the MBA Code that states it is the duty of all medical practitioners ‘...to make the care of patients their first concern and to practise medicine safely ...’.

6 Professionalism as the Yardstick in Disciplinary Proceedings against Medical Practitioners

As the definitions of deficient professional conduct, spelled out in the National Law make clear, discipline of medical practitioners refers back to aspects of what constitutes professional conduct. As foreshadowed, a four-step process of disciplining medical practitioners can be demonstrated by an analysis of the ACAT decision in Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44. ACAT also made reference to provisions of the MBA Code and the RACS Code of Conduct. This case also illuminates the definitions of professional misconduct, unprofessional conduct and unsatisfactory professional performance.

The four steps are firstly, that allegations are referred to the relevant tribunal by AHPRA. The tribunal then listens to expert evidence about what constitutes professional conduct in the circumstances, and then makes a finding of no case to answer or that the medical practitioner has been guilty of professional misconduct, unprofessional conduct or unsatisfactory professional performance. A finding having been made leads to the fourth step, a decision whether to impose any sanction.

Three matters were considered by the two-member Tribunal - one each concerning Patients A and B, and an appeal against the continuation of conditions imposed by the Medical Board of Australia in respect of an earlier matter. Under section 193 (1) of the National Law (ACT), the Medical Board of Australia had referred the matter to ACAT. The most comprehensive and complex matter related to Patient B, for whom there were three allegations against the medical practitioner, treatment

154 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
of the patient that was not indicated by her medical condition, failure to advise the
mother of Patient B that there were restrictions on the medical practitioner’s
registration from a complaint regarding an earlier matter and producing a second
report — several months after the event — of the original operation on Patient B ‘...
which on its face purported to be a contemporaneous account of the operation ...’

The Tribunal considered detailed evidence from a number of witnesses, all medical
experts in some aspect of orthopaedic practice. On each allegation, the Tribunal
reached a conclusion. The Tribunal commented on the definitions in section 5 of
the National Law that relate to findings that can be made, professional misconduct,
unprofessional conduct and unsatisfactory professional performance. The Tribunal
noted that the definition of professional misconduct is inclusionary — for example,
it includes unprofessional conduct — and is not an exhaustive statement of the
term. The Tribunal also commented on the declaration by McLure P in Bernadt
v Medical Board of Australia that:

> Professional misconduct has both a performance aspect (conduct that is substantially
below the standard reasonably expected of a registered health practitioner of an
equivalent level of training and experience) and a conduct component (conduct
whether occurring in connection with the practice of the practitioner’s profession or
not, that is inconsistent with the practitioner being a fit and proper person to hold
registration in the profession).

The Tribunal went on to observe that the definition of unprofessional conduct was
an exhaustive statement of the term that had both a performance element and a
conduct element. However, when the definition of unsatisfactory professional
performance was considered, the Tribunal noted that it is also exhaustive but only
has a performance component.

The Tribunal then reviewed the evidence and found that the medical practitioner’s
‘... conduct in relation to allegation 1 was unsatisfactory professional performance,

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155 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [41].
156 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [116], [142–143], [178–185].
157 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [193].
158 Bernadt v Medical Board of Australia [2013] WASCA 259 [23].
159 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [199].
160 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [200].
161 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [201].
that allegation 2 was also unsatisfactory professional performance, and that his conduct in relation to allegation 3 was unprofessional conduct.  

The Tribunal also considered evidence in relation to Patient A and, following a similar procedure as that which related to Patient B, found that Dr Hocking had no case to answer from his use of PRP [Platelet Rich Plasma], that his failure to refer was unsatisfactory professional performance, but that he did not knowingly misrepresent the safety of the treatment to patient A’s mother, and there is insufficient evidence for the Tribunal to be satisfied that her consent was not informed.  

The fourth stage in the process was the determination of sanctions. The Tribunal had to decide whether the conditions imposed on Dr Hocking in respect of an earlier matter should be maintained or removed. Section 126(3)(a) of the National Law provides that a condition may not be changed until any review period has passed and then only if the tribunal believes that ‘... there has been a material change in the health practitioner’s ... circumstances ...’. The Tribunal considered the evidence including reports from ‘... supervisors, mentors and experts ...’ but noted that Dr Hocking had been the subject of 44 complaints though only a small number had led to an ‘adverse finding’. However, the Tribunal had received evidence that Dr Hocking had learned from his mistakes. He had undergone extensive retraining and close supervision and that there was ‘evidence of a significant improvement in Dr Hocking’s performance’. The Tribunal then ordered that previous conditions be lifted but substituted an order providing for a new set of conditions as recommended by expert witnesses. It also accepted an undertaking from Dr Hocking ‘... that he no longer practises or intends to practise in paediatric surgery, other than trauma surgery, where he is supported by a team’. The Tribunal, although urged to do so, did not deregister the practitioner.

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162 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [229].
163 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [311].
164 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [344].
165 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [347].
166 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [349].
167 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [363].
168 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [365].
169 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [369].
170 Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44 [370].

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The same procedure is undertaken by tribunals throughout Australia when matters have been referred to them by the relevant Medical Board. The following section now looks at outcomes rather than processes.

7 Survey of Disciplinary Proceedings

Having described the process by which one administrative tribunal came to a decision, this section makes a broader survey of cases that have come to the attention of AHPRA and the New South Wales Health Professional Councils Authority. The purpose of this scrutiny is to determine patterns of medical practitioner conduct that have found their way through preliminary processes into the tribunal system. Once recurring unprofessional behaviours have been identified through this section, this thesis will propose possible methods by which each of those identified might be addressed. Eliminating recurring misbehaviours may never be possible, but the proposals aspire to reduce their incidence, or perhaps merely modify their worst impacts on patients. Behaviours of individual practitioners will have been dealt with by orders of the relevant tribunal in accordance with the range of options available under section 172(2) of the National Law. 171

The Australian Institute of Health and Welfare reports that in 2015 there were 102 805 medical practitioners registered in Australia of whom, 88 040 were employed. This web site does not provide a specific date. Of this total 95.1% worked in a clinical role.172 However, the MBA reports that, as at 31 December 2015, 103 044 medical practitioners were registered in Australia.173 Of these, 32 037 were in New South Wales, 25 037 in Victoria and 20 018 in Queensland. As stated below, AHPRA reported that in 2014/2015, there were 4541 notifications whilst in 2013/2014 there were 5585, a high proportion of the total number of registered medical practitioners in clinical practice. The Annual Report for AHPRA for

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171 Katie I Elkin et al, ‘Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000–2009’ (2011) 194(9) MJA 452 at 455 reported for the first time the frequency of specific types of misconduct of medical practitioners in Australia and New Zealand. The figures related to the years 2000 to 2009 and the number of cases surveyed over the ten year period was 485. The article categorised the conduct subject to disciplinary proceedings slightly differently from the categories in Appendices IIIA, IIIB and IIIC. However, sexual misconduct, inappropriate prescribing and inappropriate medical care were identified. There were no separate figures for impairment or inadequate record keeping.


173 Medical Board of Australia, Registrant Data, (Reporting Period: October 2015 - December 2015) 4.
2015/2016 stated that there were 5371 notifications.\textsuperscript{174} Whilst there were many occasions that there was more than one complaint or notification against a single medical practitioner, the total numbers of notifications still provide a substantial proportion of the total cohort of registered medical practitioners.

A survey of substantive proceedings\textsuperscript{175} in Tribunal and Supreme Court decisions from 1 July 2015 to 30 June 2016 relating to medical practitioners revealed a total of 49 medical practitioners who were subject to disciplinary proceedings, the largest number of proceedings occurring in New South Wales, followed by Queensland. From 1 July 2014 to 30 June 2015 there was a total of 59 medical practitioners registered or previously registered in Australia who were the subject of disciplinary proceedings. Once again the largest number of proceedings occurred in New South Wales, followed by Queensland. In the period from 1 July 2013 to 30 June 2014, there were 57 disciplinary proceedings, nearly half of which came from Queensland, with New South Wales having almost half of the Queensland number. As Appendices IIIA, IIIB and IIC show, in the same periods there were significantly fewer proceedings in Victoria, the second most populous state. The survey for 2013–2014 appears as Appendix IIIA, the survey for 2014–2015 appears as Appendix IIIB, whilst the survey for 2015–2016 is in Appendix IIIC. It is interesting to speculate as to whether the way disciplinary proceedings are handled by the different disciplinary arrangements in New South Wales and Queensland has led to a more thorough process and more proceedings, rather than more medical practitioners who do not abide by ethical codes. It is not clear from most of the substantive cases whether the particular action was initiated following a mandatory notification, though AHPRA keeps raw figures of mandatory and voluntary notifications.

As the tables below show, in addition to deficient clinical practice, there is a substantial number of boundary violations, particularly inappropriate sexual conduct. A boundary violation includes not only inappropriate sexual activities but other overstepping of boundaries such as borrowing money from patients. There are cases concerned with inappropriate prescribing of drugs to drug dependent persons and occasionally, self-administration of addictive or restricted drugs, or

\textsuperscript{174} Australian Health Practitioner Regulation Agency, Annual Report 2015/16 (November 2016) 48. At page 3, the report also stated that 53.3% of notifications were about medical practitioners who only make up 16.3% of total practitioners. There was an increase of 17.7% in mandatory notifications against health practitioners and an increase of 18.3% in notifications about medical practitioners.

\textsuperscript{175} Procedural questions, duplications, vexatious matters were not included.
alcohol. Many of the latter have led to findings of impairment against the medical practitioner concerned. In many cases, there has been more than one finding so the numbers do not tally. Some cases show that the medical practitioner has been found guilty of both professional misconduct and unprofessional conduct (or the equivalent finding in New South Wales).

Annual Reports of AHPRA tabulate all notifications made against health professionals. The highest numbers were made against medical practitioners followed by notifications concerning nurses. Relevant figures from AHPRA Annual Reports for 2015/16, 2014/2015 and 2013/2014 are reproduced below.

The numbers of notifications involving medical practitioners for 2015/2016 are as follows:

<table>
<thead>
<tr>
<th>Table N2: Notifications Received 2015/16 by State or Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>105</td>
</tr>
</tbody>
</table>

Notifications involving medical practitioners for 2014/2015 are as follows:

<table>
<thead>
<tr>
<th>Table N1: Notifications Received 2014/15 by State or Territory</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>92</td>
</tr>
</tbody>
</table>

176 Australian Health Practitioner Regulation Agency, Annual Report 2015/2016 (November 2016) (Table N2) 49. The figure for New South Wales is the sum of the figures for matters managed by AHPRA where the conduct occurred outside New South Wales, together with the figure for matters handled by the Health Professional Councils Authority (HPCA) in New South Wales.

Comparable figures for 2013/2014 are:¹⁷⁸

<table>
<thead>
<tr>
<th>ACT</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>NSW</th>
<th>TOTAL 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>166</td>
<td>109</td>
<td>1361</td>
<td>421</td>
<td>173</td>
<td>1125</td>
<td>457</td>
<td>1773</td>
<td>5585</td>
</tr>
</tbody>
</table>

Mandatory notifications for 2015/2016 were as follows:¹⁷⁹

<table>
<thead>
<tr>
<th>ACT</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>NSW</th>
<th>TOTAL 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>0</td>
<td>6</td>
<td>43</td>
<td>11</td>
<td>72</td>
<td>37</td>
<td>88</td>
<td>269</td>
</tr>
</tbody>
</table>

Mandatory notifications for 2014/2015 were as follows:¹⁸⁰

<table>
<thead>
<tr>
<th>ACT</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>NSW</th>
<th>TOTAL 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>7</td>
<td>42</td>
<td>7</td>
<td>57</td>
<td>37</td>
<td>53</td>
<td>212</td>
</tr>
</tbody>
</table>

Mandatory notifications for 2013/2014 were as follows:¹⁸¹

<table>
<thead>
<tr>
<th>ACT</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>NSW</th>
<th>TOTAL 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>2</td>
<td>134</td>
<td>51</td>
<td>17</td>
<td>39</td>
<td>27</td>
<td>76</td>
<td>351</td>
</tr>
</tbody>
</table>

¹⁷⁸ Australian Health Practitioner Regulation Agency, Annual Report 2013/2014 (November 2014) (Table N2) 130.
¹⁷⁹ Australian Health Practitioner Regulation Agency, Annual Report 2015/2016 (November 2016) (Table N9) 55. Once again the NSW figure is a total of AHPRA and HPCA figures. In addition there were 4 matters where there was no principal place of practice, including an overseas address.
As can be seen from the numbers of cases for Victoria in Appendices IIIA, IIIB and IIIC, it is noteworthy that the raw numbers of notifications for Victoria has not translated to tribunal or court attention. However, it is impossible to relate the raw numbers of notifications to specific outcomes. Grounds for mandatory notifications (Tables N10, N9 and combined Tables N21 & N22 below) show that the highest numbers relate to standards, that is section 140(d) of the National Law. Thus, notifications reflect the reasonable belief of the person making the notification that the medical professional ‘... has practised the profession in a way that constitutes a significant departure from accepted professional standards’.  

Grounds for mandatory notifications for 2015/2016 are reproduced below:

<p>| Table N10: Grounds for Mandatory Notification - (2015/2016) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Standards</th>
<th>Impairment</th>
<th>Alcohol or Drugs</th>
<th>Sexual Misconduct</th>
<th>Not Classified</th>
<th>Total 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>183</td>
<td>58</td>
<td>12</td>
<td>15</td>
<td>4</td>
<td>272</td>
</tr>
</tbody>
</table>

Figures for 2014/2015 are as follows:

<p>| Table N9: Grounds for Mandatory Notification - (2014/2015) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Standards</th>
<th>Impairment</th>
<th>Alcohol or Drugs</th>
<th>Sexual Misconduct</th>
<th>Not Classified</th>
<th>Total 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>116</td>
<td>61</td>
<td>13</td>
<td>20</td>
<td>2</td>
<td>212</td>
</tr>
</tbody>
</table>

Figures for 2013/2014 follow:

<p>| Table N21 &amp; N 22: Grounds for Mandatory Notification - (2013/2014) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Standards</th>
<th>Impairment</th>
<th>Alcohol or Drugs</th>
<th>Sexual Misconduct</th>
<th>Not Classified</th>
<th>Total 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>221</td>
<td>86</td>
<td>10</td>
<td>28</td>
<td>6</td>
<td>351</td>
</tr>
</tbody>
</table>

182 National Law s 140(d) - ‘... placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards’.

183 Australian Health Practitioner Regulation Agency, Annual Report 2015/2016 (November 2016) (Table N10) 56. Instead of a separate figure for New South Wales, the AHPRA and HPCA figures have been combined.

184 Australian Health Practitioner Regulation Agency, Annual Report 2014/15 (November 2015) 44. Separate figures for AHPRA and NSW have been totalled.

185 Australian Health Practitioner Regulation Agency, Annual Report 2013/2014 (November 2014) 147–148. Figures for AHPRA from Table N21and NSW from Table N 22 have been totalled.
Appendices IIIA, IIB and IIC have selected some recurring grounds in the cases surveyed. As noted above, they may or may not have arisen from a mandatory notification. For example, Queensland no longer keeps figures separately for mandatory and voluntary notifications. Also, figures have been extracted where, in addition to the other ground for discipline, the court or tribunal has commented upon inadequate record keeping that, especially in 2014/2015 and 2015/2016, has attracted the relevant tribunal’s attention.

Figures gleaned from Appendix IIIA are summarised as follows:

<table>
<thead>
<tr>
<th>Appendix IIIA - Total Figures and Percentages of Total Disciplinary Cases - (2013/2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficient Clinical Standards</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>35.1%</td>
</tr>
</tbody>
</table>

Similarly, figures and percentages from Appendix IIB are tabulated below:

<table>
<thead>
<tr>
<th>Appendix IIB - Total Figures and Percentages of Total Disciplinary Cases - (2014/2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficient Clinical Standards</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>27</td>
</tr>
<tr>
<td>45.8%</td>
</tr>
</tbody>
</table>
Figures and percentages from Appendix IIIC are provided below:

<table>
<thead>
<tr>
<th>Appendix IIIC - Total Figures and Percentages of Total Disciplinary Cases - (2015/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficient Clinical Standards</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>26.5%</td>
</tr>
</tbody>
</table>

It is unlikely that any of the notifications in the tables above relates to the disciplinary cases referred to in each Appendix as there is usually a lapse of time between the original notification and a disciplinary hearing. Consequently, it is not possible to relate a particular notification to a specific outcome. However, whilst the total figures in Appendices IIIA and IIIB are almost identical, the breakdowns differ. New South Wales seems to have a particular concern with adequacy of records, especially in 2013/2014 compared with the other jurisdictions though in 2014/2015 and 2015/2016, nearly all jurisdictions commented about records. The numbers of cases finding deficient clinical standards was 50% higher in 2014/2015, a matter for serious concern. This figure had dropped back in 2015/2016. The 2015/2016 year also showed a total of fewer cases before tribunals.

The Annual Report of AHPRA for 2014/2015 reported raw figures for mandatory notifications during the 12 month period from 1 July 2014. Because New South Wales and Queensland are co-regulatory jurisdictions, complete figures for Australia are not readily available. AHPRA is dependent on those jurisdictions to provide relevant figures and notes that there were 61% fewer notifications reported by Queensland. This fact was unusual considering that Queensland normally has the second highest number of notifications after New South Wales.\(^{186}\) The case summaries in Appendices IIIA and IIIB also show a substantial drop in tribunal or court cases for Queensland between the two periods, 2013/2014 and 2014/2015. The number of Queensland cases in Appendix IIIC is almost the same as in 2014/2015.

Disciplining of medical practitioners following notification is one of the matters that is specifically legislated in the National Law. The grounds for both mandatory and voluntary notifications are prescribed. However, these grounds can only be set out in general terms. How those grounds are interpreted by AHPRA influences whether the notification is proceeded with or not. Those that are to be investigated are passed on to the MBA for referral to appropriate health or performance panels or directed by the board to a tribunal. New South Wales and Queensland have their own provisions for discipline and figures are not necessarily provided to AHPRA to give a national picture of what is reported, nor their outcomes.

However, it is clear that the bulk of court and tribunal cases shows recurring patterns of behaviour from year to year though it is not possible to eliminate the behaviours that lead to disciplinary cases. Nevertheless, a profession that proclaims its trustworthiness and professionalism should be held to a high standard and efforts should be made to minimise deviation from professional ideals.\(^\text{187}\)

The continuing numbers of cases concerning the keeping of inadequate records is a major concern. This is particularly worrying as Australia moves to a centralised national system of electronic medical records.\(^\text{188}\) The rationale for centralised, electronic medical records is to assist safe and effective care by giving access by treating health practitioners to all relevant data concerning each patient. This chapter now examines, in Section E, the question of the adequacy of medical records and makes some suggestions to improve this critical aspect of medical practice. Problems that may arise when a medical practitioner has to try to treat a patient without any knowledge of the patient’s background has been exemplified in a report of a coroner’s findings concerning a woman travelling around Australia who became ill in an outback town. Despite evaluating various symptoms, the general practitioner did not consider serious cardiac failure, of which she died.\(^\text{189}\)


\(^{188}\) 'The My Health Record (previously known as the Personally Controlled Electronic Health Record) was launched on 1 July 2012. A My Health Record is a secure online summary of an individual’s health information.’ <http://www.health.gov.au/internet/main/publishing.nsf/content/ehealth-record>.

Boundary violations that are mostly sexual indiscretions, self-medication with addictive drugs and prescribing drugs to known addicts are recurring problems. These problems might be addressed by enhanced training in medical ethics as Chapter II has suggested. However, a large number of cases involves deficient clinical treatment practices. The answer to this problem may be the introduction of a process of revalidation in Australia. Revalidation is designed to make sure that medical practitioners remain up-to-date and fit to practise. The question of whether a revalidation requirement should be introduced into Australian regulatory processes will be explored in Section F.

E IMPROVING THE PREPARATION AND MAINTENANCE OF MEDICAL RECORDS — ADOPTION OF COMPUTERISED MEDICAL RECORDS

1 Introduction

The importance of good medical records is hard to overestimate. Good records can provide greater safety for the patient. They can also protect the doctor in the event of any suggestion that an adverse event has occurred, or when medical negligence is alleged. In addition, presenting good records is an obligation to professional colleagues, to provide all necessary information for a change in treating personnel. Forty-two of the 651 cases summarised in Appendices IIIA, IIIB and IIIC explicitly referred to inadequate record keeping. One of the requirements of good medical practice is that full and complete records of contacts between any medical professional and the patient be maintained.190

Good medical records show that the patient is truly the medical practitioner’s first priority. The professionalism that leads to patient-centred care demands that the patient be shown due respect and inadequate records suggest a lack of concern for the patient. The National Law does not prescribe the specifics of what medical records must contain. Rather, it has left details of how medical records are to be kept to be dealt with by the MBA. Consequently, the MBA Code specifies the importance of medical records and how they are to be maintained

Paragraph 8.4 of the MBA Code provides:

190 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [8.4].
8.4 Medical Records

Maintaining clear and accurate medical records is essential for the continuing good care of patients. Good medical practice involves:

8.4.1 Keeping accurate, up-to-date and legible records that report relevant details or clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners.

8.4.2 Ensuring that your medical records are held securely and are not subject to unauthorised access.

8.4.2 Ensuring that your medical records show respect for your patients and do not include demeaning or derogatory remarks.

8.4.4 Ensuring that the records are sufficient to facilitate continuity of patient care.

8.4.5 Making records at the time of the events, or as soon as possible afterwards.

8.4.6 Recognising patients’ right to access information contained in their medical records and facilitating that access.

8.4.7 Promptly facilitating the transfer of health information when requested by the patient.

Similar requirements are specified by the GMC Code in the United Kingdom in paragraphs 19–21.¹⁹¹ Both the MBA Code and the GMC Code stipulate that clinical records should include relevant clinical findings, information given to patients and medication prescribed and treatment to be undertaken, and that records must be kept securely. In addition, records must be made at the time of the events being recorded and in a form that can be understood by other health practitioners.

New South Wales has been most concerned to specify the detail that must be entered into a patient’s medical records. From the Medical Practice Regulation 1998 (NSW) to the Medical Practice Regulation 2003 (NSW), each made under the Medical Practice Act 1992 (NSW), regulations designated what records should be kept and when they must be made. Now, the Health Practitioner Regulation (New South Wales) Regulation 2016 (NSW) made under the Health Practitioner Regulation National Law (New South Wales) has, in similar terms to the 1998 and 2003 regulations, minutely specified requirements for record keeping by health practitioners. Clauses 6(1) and 7(4) of the 2016 regulations draw attention to Schedule 4 that specifies the NSW requirements.

¹⁹¹ General Medical Council, Good Medical Practice (at 22 April 2013).

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.

21 Clinical records should include:
   a relevant clinical findings
   b the decisions made and actions agreed, and who is making the decision and agreeing the actions
   c the information given to patient
   d any drugs prescribed or other investigation or treatment
   e who is making the record and when.
2  Code Deficiencies

(a)  Treatment Outcomes
Whilst the MBACode provides an outline of what basic record keeping should contain, there is some misalignment between the code and the regulations in New South Wales. Not only are the code requirements sketchy, they are deficient in one important respect. Arguably, one of the most important aspects of a medical record is precision regarding the outcome of each intervention — required by clause 1(4)(f) of the Health Practitioner Regulation (New South Wales) Regulation 2016 (NSW). Clause 1(4)(f) is in the following terms:

1(4) A record must include the following particulars of any medical treatment or other medical service that is given to or performed on the patient by the medical practitioner who is treating the patient: …
  (f) the results or findings made in relation to the treatment.

A crucial oversight in the MBA Code is that this obligation does not appear in paragraph 8.4. Outcomes of treatments are very important in patient-centred medical practice. Unless outcomes are documented, any record will be incomplete. Failure to detail results or findings will risk repetition of a treatment that is either ineffective, or minimally effective. In the worst case, failure to document a treatment outcome may be positively dangerous. Subsequent treatment may lead to harmful drug interactions or an adverse event if crucial information is not in the record.

(b)  Lack of Detail
The requirements in paragraph 8.4 of the MBA Code should be more specific. Considering how many cases find that medical records are inadequate, the MBA could follow New South Wales192 and mandate the detail of the form of medical record to be used, to be set up as part of the computerised medical records of the practitioner. Yet, as Appendices IIIA, IIIB and IIIC show, even under the highly detailed requirements of the New South Wales regulation, up to one-third of the cases from New South Wales still reveal inadequate record-keeping.

192 Online research into hansard, explanatory memoranda and second-reading speeches did not provide information about a reason for the stringency required in New South Wales record keeping obligations.
(c) Computerised Records

Not only should the MBA mandate stringent record-keeping and monitor compliance for ongoing registration, it could reasonably require evidence that computerised record-keeping, in a form approved by the MBA, is being practised. Not only would an appropriate and approved computer program act as an aide memoire for the practitioner, it would protect the patient and, by showing exactly why some particular medication, test or procedure was adopted, it would protect the medical practitioner. It would also provide crucial information for any practitioner taking over treatment of that patient.

Some medical practitioners are already using computerised records. However, a standardised format is necessary for medical records to be most efficiently computerised and centralised. The medical press reports that the implementation of the My Health Record centralised computerised record-keeping system is being limited by poor quality of electronic medical records.193 The article recommends that the government should introduce minimum standards for electronic records in medical practices and suggests that TGA could license computer programs as a therapeutic device.194 Whether licensed by TGA or not, the MBA has the power to mandate acceptable computerised record-keeping systems for medical practitioners. Any suggestion that some practitioners are not adequately computer literate must be met with the response that it is now the 21st Century and an 'up-to-date and fit to practise' medical practitioner must demonstrate familiarity with computers.

To the extent that some older practitioners cannot change, it could be assumed that they will soon no longer seek to maintain registration. As pointed out by Choudry, Fletcher and Soumerai, there is evidence from several jurisdictions that the longer a

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193 As mentioned in Chapter III, ‘The My Health Record (previously known as the Personally Controlled Electronic Health Record) was launched on 1 July 2012. A My Health Record is a secure online summary of an individual’s health information.’

194 Antony Scholefield, ‘Quality of GP e-Records Limiting MyHealth Record’ Australian Doctor (Online) (2 August 2016) <http://www.australiandoctor.com.au/news/latest-news/myhealth-record-limited-by-quality-of-gps-e-record>. The article also observed that the United Kingdom introduction of accreditation of computer programs had led to culling the market from twenty programs to about three and the United States was working on gradually working towards a high level of standardisation.
practitioner has been in practice, the less likely is that practitioner ‘to deliver high quality care’.\textsuperscript{195} They go on to observe that

[although it is generally assumed that the tacit knowledge and skills accumulated by physicians during years of practice lead to superior clinical abilities, it is also plausible that physicians with more experience may paradoxically be less likely to provide technically appropriate care.\textsuperscript{196}

(d) Currency of Records

Both the \textit{MBA Code}\textsuperscript{197} and the \textit{GMC Code}\textsuperscript{198} mandate that records must be made concurrently or as soon as possible after the events being recorded. The practitioner has an ethical duty both to the patient and to professional colleagues to find time to make complete records. Where there is an emergency, records should be completed at the first opportunity after the urgency has passed and while the decisions made are still fresh in the practitioner’s memory. However, whilst paragraph 4(2) of Schedule 4 of the Health Practitioner Regulation (New South Wales) Regulation 2016 (NSW) specifies that each entry in a record must be dated and clearly identify the person making the record, what is missing is a requirement that the record be made contemporaneously, or as nearly as possible after the events being recorded. Contemporaneity means the record being made is more likely to be correct. Leaving the making of a record too long risks inaccuracies as matters can be forgotten or the record may be ambiguous.

(e) Conclusion

Better computerised records would also provide a defence if sub-standard professional practice were alleged. A good quality computer program would act as a checklist. It would provide evidence of the reasons for a specific diagnosis and any proposed treatment. Greater use of checklists in all aspects of medical practice are not an affront to the technical expertise of the medical practitioner. Rather,\textsuperscript{196}


\textsuperscript{196} Niteesh K Choudhry, Robert H Fletcher and Stephen B Soumerai, ‘Systematic Review: The Relationship between Clinical Experience and Quality of Health Care’ (2005) 142 \textit{Annals of Internal Medicine} 260, 260.

\textsuperscript{197} Paragraph [8.4.5].

\textsuperscript{198} Clause 19.
they provide timely prompts. Many adverse events occur when the very simple things are either not done, or not done at the right time. The use of checklists is explored in more detail in Chapter VI.

Related, but equally amenable to the use of computer templates, are referral letters by general practitioners to emergency departments. Researchers have shown that much vital information is omitted from handwritten referrals. They recommend use of a comprehensive computerised template. They also suggest that any proposed template should be disseminated to GPs for feedback to make sure that it complies with the realities of medical practice.\(^{199}\) Where a computerised referral is used, based on a template, the information is likely to be more comprehensive.\(^{200}\)

As comprehensive centralised computerised records become the standard, patient safety should be enhanced, especially if the records are to be accessed by different health professionals. One of the slated benefits of centralised computerised medical records is ease of identification of patient morbidities, drug allergies and treatments. The existence of important documents could also be part of the computerised record:

- a Do Not Resuscitate Order and its terms;
- an enduring power of attorney and by whom it is held;
- an advance directive detailing patient wishes for treatment to be provided or withheld.

F  REVALIDATION: QUESTIONING HOW REGULATORS DETERMINE WHETHER MEDICAL PRACTITIONERS ARE ‘UP-TO-DATE AND FIT TO PRACTISE’

There are many problems and difficulties in the education of a medical student, but they are not more difficult than the question of the continuous education of the general practitioner. Over the one we have some control, over the other none. The university and the state board make it certain that the one has a minimum, at least, of professional knowledge, but who can be certain of the state of that knowledge of the other in five or ten years from the date of his graduation?\(^{201}\)

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201 William Osler, *Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine* (Blakiston, 1904) 347.
The question of the ongoing competence of medical practitioners is not new. The above quote comes from a speech made by Sir William Osler on the occasion of the Centennial Celebration of the New Haven Medical Association, at New Haven in the United States on 6 January 1903. This section explores the rationale for introduction of a revalidation process in Australia, and progress being made towards its implementation.

Whilst there had been references in the GMC from about the 1970s to the need for the introduction of periodic reassessment of practitioners’ fitness to practise, it was not until 1998 that the proposal was considered seriously. Action in the United Kingdom was triggered by the findings of the Inquiry into the Bristol Royal Infirmary and the erasure from the register, of medical practitioners such as Rodney Ledward, a gynaecologist who had injured many of his patients. About the same time, Harold Shipman was arrested on suspicion of the murder of Mrs Kathleen Grundy.

Reaccreditation was originally envisaged by the GMC President at the time, Sir Donald Irvine, as only required for unsupervised medical practitioners. However, by early 1999, the GMC had decided that all medical practitioners should be subject to a revalidation process.

As Sir Donald Irvine noted, the fact of registration should indicate to members of the public that the medical practitioners whose names are on the register are up-to-date and fit to practise. As is the current situation in Australia, prior to revalidation, the name on the register in the United Kingdom was merely a historical record that the medical practitioner had passed certain examinations and paid an annual fee. There had been no way of judging whether the practitioner had maintained his or her education and was otherwise fit to practise.

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202 Ibid 345.
204 In the United Kingdom, the term ‘erasure’ appears to be used rather than ‘striking off’ or ‘cancellation’.
206 Ibid [26.10].
Discussing a Prospectus issued by the GMC in April 2003, Dame Janet Smith reported that revalidation would be analogous to the formal periodic reassessment undertaken by airline pilots. The Prospectus promoted the idea firstly, of regular confirmation of fitness to practise. Secondly, the purpose of reassessing pilots was not to find that they were bad pilots, but to ensure they remained good pilots and this motivation should apply to medical practitioners too. Finally it was suggested that no airline would rely solely on these periodic assessments because, in addition, each airline had its own local management procedures to assess their pilots’ suitability for specific work. Dame Janet remarked:

In one respect, this comparison between doctors and pilots is particularly apposite; both doctors and airline pilots take our lives in their hands when working. I can see also that there may be other similarities between the revalidation of doctors and the formal assessments undergone by pilots. However, the answer in the Prospectus did not mention an important distinction between the two processes, namely that pilots have to undergo a series of competence tests in the course of their periodic assessment, whereas revalidation, as proposed in the prospectus, would not involve any such testing. 

Gaba has advocated a systems approach to reducing errors in anaesthetics. He observes that anaesthetists have used engineers, and examined safety models used in other hazardous industries like aviation. He has advocated the use of simulators as a way of training anaesthetists in many settings, including uncommon but critical situations where a rapid response is required. As Gawande reports, Gaba ‘... points out, pilot experience is recognised to be invaluable but insufficient: pilots seldom have direct experience with serious plane malfunctions anymore. They are therefore required to undergo yearly training in crisis simulators. Why not doctors too?’

Re-accreditation or revalidation of medical practitioner registration is generating a great deal of discussion in Australia. Breen reports that medical practitioners in the United Kingdom have reluctantly accepted that revalidation is necessary. Following the United Kingdom’s introduction of mandatory five-yearly revalidation from 3 December 2012, the subject is clearly on the agenda in Australia. Following its introduction in the United Kingdom, the MBA’s Chair, Dr

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209 Ibid [26.66].
211 Atul Gawande, Complications (Metropolitan Books, 2002)68.
212 Kerry J Breen, 'Revalidation — What is the Problem and What are the Possible Solutions?' (2014) 200 MJA 153.
Joanna Flynn, flagged the introduction of revalidation for medical practitioners within a few years.\textsuperscript{213}

The United Kingdom revalidation process commenced in December 2012 and was gradually rolled out with the intention of completing, by March 2016, the revalidation of all medical practitioners who were on the General Medical Council’s register in 2012/2013.\textsuperscript{214}

The King’s Fund was commissioned to write a report on the impact, to October 2013, of the revalidation system on practitioner behaviour. It surveyed seven case study sites where medical revalidation had been completed. The report detailed both positive and negative consequences. Some of the positive outcomes identified in the report were:

- a structure for learning\textsuperscript{215} – simply going through the actions brought a more formalised process to their existing behaviours, such as reflection on their learning, developing new knowledge, and continuing professional development (CPD);
- increased accountability,\textsuperscript{216} such as greater self-regulation and self-scrutiny;
- increased communication around errors and earlier identification of problems\textsuperscript{217} – some doctors felt more able to raise concerns about colleagues on the ground that they were confident that action would be taken;\textsuperscript{218}
- more cognisant of patient views\textsuperscript{219} – awareness of patient feedback and need to see complaints as part of the appraisal process.

Negative responses included

- the time and emotional cost of revalidation\textsuperscript{220} – some saw the collection of the necessary data as ‘obsessional’, others saw the process as a distraction from clinical practice;
- tick-box behaviour\textsuperscript{221} – unthinkingly following a regimented process was leading to complacency and abrogation of responsibility;
- reduced willingness to share more serious errors\textsuperscript{222} – less likelihood of discussing errors during appraisal for ‘fear of being reported to the General Medical Council’.


\textsuperscript{214} Vijaya Nath, Becky Seale and Mandip Kaur, Medical Revalidation (The King’s Fund, March 2014) 4.

\textsuperscript{215} Ibid 12.

\textsuperscript{216} Ibid 13.

\textsuperscript{217} Ibid.

\textsuperscript{218} Ibid 14.

\textsuperscript{219} Ibid.

\textsuperscript{220} Ibid.

\textsuperscript{221} Ibid.

\textsuperscript{222} Ibid 16.
One positive outcome was that

[M]any doctors expressed the potential for revalidation to lead to more reflective practice. While this wasn’t yet widespread, there were signs of some doctors becoming more reflective as a result of revalidation. Few doctors (appraisers or appraissees) felt that revalidation had yet prompted true reflection among those who weren’t already inclined. However, for those who were, the appraisal form had the effect of prompting reflection: ... 223

The need for more reflection in medical practice as canvassed in Chapter II, has been emphasised in the United Kingdom’s revalidation requirements. 224 The King’s Fund report comments that ‘... those who resist the most are the ones who will benefit the most’ and that ‘[m]ore vexing perhaps were those in a senior position whose attitude and behaviour was felt to be regularly inappropriate but rarely challenged’. 225 These comments echo the sentiments reported in Chapter II about bad behaviour among some senior practitioners in their interactions with both patients and medical trainees. 226 Another benefit of revalidation seen by some medical administrators was the encouraging of a more patient-centred service, 227 a follow up from patient feedback’s being part of the revalidation process.

One of the outcomes of the King’s Fund report on revalidation was identified by it as an unintended consequence that could be either positive or negative. The report noted that some older medical practitioners had left medical practice because of either a failure or an unwillingness to complete the revalidation process. That was seen by some as a positive outcome because it removed practitioners who were ‘... not inclined to participate in continual medical education and statutory processes’. 228 However, there was a risk that the experience of good doctors would be lost. 229

Audet, Davis and Schoenbaum report that in the United States, the Accreditation Council for Graduate Medical Education has endorsed a set of six competencies, four of which are patient-centred care practices. Professional recognition,

223 Ibid 20.
224 General Medical Council, The Good Medical Practice Framework for Appraisal and Revalidation (March 2013) 1.
225 Vijaya Nath, Becky Seale and Mandip Kaur, Medical Revalidation (The King’s Fund, March 2014) 21.
227 Vijaya Nath, Becky Seale and Mandip Kaur, Medical Revalidation (The King’s Fund, March 2014) 24.
228 Ibid 16.
229 Ibid 17.
licensing and accreditation now also include patient-centred criteria. In addition, the American Board of Internal Medicine and the American Board of Medical Specialties require evidence of patient-centred practices.\textsuperscript{230}

There is also much discussion within Australian health departments and medical practitioner organisations as to whether revalidation is necessary. The MBA sought information from overseas to determine whether revalidation is working to provide greater safety in medical practice.\textsuperscript{231} The Final Report on evidence and options prepared by a team from the Collaboration for the Advancement of Medical Education Research and Assessment (‘CAMERA’) at Plymouth University Peninsula Schools of Medicine and Dentistry\textsuperscript{232} outlined revalidation processes in several other countries, and having examined them and relevant current research, suggested three models that could be adopted in Australia, together with their advantages and disadvantages. However, it appears that the three models suggested by CAMERA were rejected. Following receipt of the CAMERA report, and with the aim of developing how revalidation in Australia could be implemented, the MBA then decided to appoint an expert advisory group and a consultative committee, and to commission ‘... social research into what the profession and the community expect that medical practitioners should do to demonstrate ongoing competence and fitness to practise’.\textsuperscript{233}


1. maintaining and enhancing the performance of all doctors practising in Australia through efficient, effective, contemporary, evidence-based continuing professional development (CPD) relevant to their scope of practice (‘strengthened CPD’), and
2. proactively identifying doctors-at-risk of poor performance and those who are already preforming poorly, assessing their performance and when appropriate supporting the remediation of their practice.\textsuperscript{234}

\textsuperscript{230} Anne-Marie Audet, Karen Davis and Stephen C Schoenbaum, ‘Adoption of Patient-Centred Care Practices by Physicians’ (2006) 166 (April 10) \textit{Archives of Internal Medicine} 754, 758.
\textsuperscript{231} Medical Board of Australia, ‘Board Commissions Research on Revalidation’ (Media Statement, 24 March 2015).
\textsuperscript{232} Collaboration for the Advancement of Medical Education and Assessment, \textit{The Evidence and Options for Medical Revalidation in the Australian Context} (Final Report, 10 July 2015).
\textsuperscript{233} Medical Board of Australia, \textit{Expert Advisory Group on Revalidation} (Interim Report, August 2016) 14.
\textsuperscript{234} Medical Board of Australia, \textit{Options for Revalidation in Australia} (Discussion Paper, August 2016) 5.
The Expert Advisory Group also proposed that the following guiding principles be applied to all recommended approaches to revalidation under the first limb:

- **smarter not harder**: strengthened CPD should increase effectiveness but not require more time and resources for participants.
- **integration**: all recommended approaches should be integrated with — and draw on — existing systems where possible and avoid duplication of effort, and
- **relevant, practical and proportionate**: all recommended changes should be relevant to the Australian healthcare environment, feasible and practical and proportionate to public risk.235

All recognised CPD activities would be evidence-based and involve:

- performance review
- outcome measurement, and
- validated educational activities.236

The second limb of the revalidation process would involve identifying ‘at-risk’ medical practitioners. National and international research suggests that the main factors are

- age (from 35 years, increasing into middle and older age)
- male gender
- number of prior complaints, and
- time since last prior complaint.237

Some studies have also suggested other factors like lack of response to feedback and unrecognised cognitive impairment. In the United States, Papadakis et al found that there was a high correlation between disciplinary proceedings and unprofessional behaviour in medical school. Medical students who showed unprofessional behaviour were three times as likely as the control group to become the subject of disciplinary proceedings.238 However, as the Expert Advisory Group observes:

> Not all individuals in at-risk groups will be underperforming. Some practitioners who are identified as underperforming will return to safe practice simply through the process of being assessed and receiving feedback.239

Whilst international research suggests that ‘... about six percent of medical practitioners are poorly performing at any one time’, identifying under-performing

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235 Ibid.
236 Ibid 8.
medical practitioners in Australia will require future research specific to the
Australian context.\textsuperscript{240} Processes for remediation will also have to be developed.\textsuperscript{241}

An opinion piece by Michael Woodhead in \textit{Australian Doctor} referred to reports
that some general practitioners in the United Kingdom complained that the process
is time-consuming with a ‘limited scope for professionalism’ and ‘overemphasis on
legalism and managerialism’. The opinion piece concluded that ‘a badly designed
revalidation system leads to poor morale and an exodus of doctors from
practice’.\textsuperscript{242} Woodhead hoped that the MBA was taking notice.

Many Australian medical practitioners are sceptical about revalidation.\textsuperscript{243} They
consider that their CPD obligations are adequate to ensure that doctors are keeping
up-to-date with current medical trends and procedures. However, as previously
noted, there is evidence that it can take up to 17 years for doctors to adopt new
techniques and processes for at least half of American patients.\textsuperscript{244}

As reported in Section E above, there is also evidence that older medical
practitioners deliver a lower quality of clinical care.\textsuperscript{245} CAMERA describes how in
Canada, the revalidation system randomly chooses physicians under 70 years of
age to undergo peer assessment. Once they reach the age of 70 every physician
must undergo peer assessment every five years.\textsuperscript{246}

As has been suggested earlier in this thesis, incorporating matters that should be
second nature to medical practitioners into the revalidation process, is a practical
method of enforcing their adoption by individual medical practitioners who wish to

\begin{thebibliography}{9}
\bibitem{240} Ibid 11.
\bibitem{241} Ibid 12.
\bibitem{244} Atul Gawande, \textit{The Checklist Manifesto} (Profile Books, 2011) 133.
\bibitem{246} Collaboration for the Advancement of Medical Education and Assessment, \textit{The Evidence and Options for Medical Revalidation in the Australian Context} (Final Report, 10 July 2015) 26.
\end{thebibliography}
retain registration to practise. The proposed emphasis on CPD processes for revalidation is designed to answer this criticism.

As the Kings Fund report remarks:

What leads to culture change is when behaviour is internalised so that doctors are motivated to improve the quality of patient care – when no one is watching.  

G CONCLUSION

This chapter has surveyed the legal underpinnings for regulation of medical practitioners in Australia. It has discussed the modern regulatory reliance on soft law instruments to supplement specific legislation. Because of the intricacies of the regulatory environment, specific legislation cannot provide for every circumstance or nuance of activity and it is this that has led to the proliferation of soft law instruments. Research has also shown that regulation is best achieved by a system that includes the relevant industry in determining what regulation is required and how it can be achieved and, where possible, permitting the industry to self-regulate.  

What is apparent from the information in this chapter is that Australia has made a considerable effort to set in place a system of laws and regulations aimed at providing high quality medical care for its citizens. Traditionally, the preference of the medical profession has been to regulate itself. However, total self-regulation by the medical profession in Australia has been shown to be deficient. This conclusion has been reached following a series of high-profile medical scandals, thus leading to more stringent regulation. 

In Australia, the provisions of the National Law are backed up by an array of soft law instruments (codes, guidelines, charters, standards, frameworks and directions) that are intended to influence behaviour in the directions required by government regulators. Ultimately however, it is for governments to determine whether the

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247 Vijaya Nath, Becky Seale and Mandip Kaur, Medical Revalidation (The King’s Fund, March 2014) 25.
248 Ian Ayres and John Braithwaite, Responsive Regulation (Oxford University Press, 1992) 38.
existing regimes are adequate. As further medical scandals have become public, the question is how many medical scandals is too many.

The catalogue of grounds upon which disciplining of health practitioners can be initiated is also directed towards ensuring patient safety in a system of great complexity. The National Law has specified the grounds for notifications to regulatory bodies of deficient behaviours of health practitioners.

Ultimately however, regulation refers to what is perceived to be professional behaviour. The adoption by courts and tribunals of codes and guidelines as evidence of what constitutes professional behaviour is both authorised by section 41 of the National Law and by court and tribunal endorsement and application of their provisions. The story has been similar in the United Kingdom,\(^\text{251}\) showing that courts and tribunals in both countries are prepared to accept these instruments when determining whether or not there has been negligent behaviour.

Despite the move away from government acknowledgment of self-regulation as the only way to regulate medical practitioners, to requiring more stringent supervision, there are aspects of the structure of the law that have subjugated the interests of patients to those of the medical practitioner. For many years courts endorsed the perspective of a medical profession that did not recognise that it could be prone to error. Medical and insurance lobbies co-opted legislators, and sometimes stoked media and public concern to secure legislative change in favour of the medical profession. To a certain extent, the courts have moved towards a patient-centred perspective but there are still features of the law relating to medical practice that favour medical practitioners and these will be considered in Chapter IV.

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\(^{251}\) See eg, *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
CHAPTER IV: THE LAW AND ITS DEFERENCE TO THE CONCERNS OF THE MEDICAL PROFESSION

A INTRODUCTION

As the MBA Code asserts, good medical practice is patient-centred, involving partnerships between doctors and their patients, and is at the heart of medical professionalism. Professional medical bodies emphasise ‘... the assumption that at the heart of good medical care is a set of values, attitudes and behaviours called medical professionalism’,¹ and that ‘... it is medical professionalism that underpins the trust the public has in doctors’.²

However, despite the recognition of good medical practice as patient-centred, this chapter highlights the tensions between practitioner interests and the duty of doctors ‘... to make the care of patients their first concern’.³ It argues that, whilst the patient is, according to the rhetoric, the doctor’s first concern, there are structural biases in the law in favour of the medical practitioner that have led to some doctors being protected from the full force of the law despite a finding of negligence. The purpose of this chapter is to show, through three examples, how the competing interests of practitioner and patient, the paradox of the conflict⁴ between self-interest and altruism, have been treated by the courts and by statute. It focuses on how adherence by some medical practitioners to the ideals of patient-centred care can be disregarded, on occasion, in favour of professional concerns such as peer reputation⁵ and the defence of clinical autonomy.⁶

² Ibid xi.
³ Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
The three examples chosen for analysis are interlinked — firstly, the interpretation of a doctor’s duty of care by reference to the professional or *Bolam* standard; secondly, the requirement for patient consent before any medical treatment is initiated; and the way that legislation has constrained patient rights to compensation when negligence has been established. Any negative impacts on patients where professional interests have overwhelmed patient interests have implications for social justice, particularly where injured patients are denied adequate redress for substantiated negligent behaviour. Examination of these questions is best understood through the prism of tort law, particularly the action for negligence. Therefore, before commencing it is constructive to provide an outline of the matters that are considered by courts when determining whether or not an action by a medical practitioner has been shown to have been negligently performed.

Finally, the chapter investigates whether a ‘no fault’ injury compensation scheme should be adopted into Australia. Whilst there would be powerful lobbies against such a scheme, there are valid arguments that expense and waste in the current tort system could be diverted to providing life-long care for those injured, whether through the health system or otherwise.

**B KEY FACTORS IN THE ACTION FOR NEGLIGENCE**

The key elements to be shown in the modern action for negligence are that:

- there is a duty owed by one person to another, and
- that duty has been breached, and
- the breach has caused damage that was foreseeable.

The duty of care not to injure another arises in circumstances where there is a close relationship such that the person owing the duty should foresee that a failure to exercise reasonable foresight may cause injury to the person to whom the duty is owed. Duty of care is an essential element of the law of negligence.7

As outlined in Chapter I, the idea of the duty of care has been captured in the famous dictum by Lord Atkin in *Donoghue v Stevenson*:

> The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer’s question, Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts and omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in

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law is my neighbour? The answer seems to be—persons who are so closely and
directly affected by my act that I ought reasonably to have them in contemplation as
being so affected when I am directing my mind to the acts or omissions which are
called in question.8

Common law establishes that cases that give rise to a duty of care are grounded in
the relationship between the parties, not the conduct by which the injury was
caused.9 For instance, in Vairy, the court recognised that the relationship between
doctor and patient is an example of an established category ‘... in which the
common law imposes a duty on the former ... to take care of the latter.’10

Not only must a duty of care be shown but the court then has to determine the
standard of reasonable care applicable to the circumstances. In the context of
medical practice, medical practitioners rely on the standard as determined by the
Bolam case.11 As discussed below, the courts had been moving to circumscribe the
Bolam test particularly in the context of provision of information and advice.

Having established the existence of a duty and the standard by which it is to be
judged, the plaintiff must then show that a reasonable person in the position of the
defendant should have foreseen that the injury would occur.12 Finally, the plaintiff
must show that the breach of the duty has caused damage to the person injured.13
Damage is an essential ingredient in the action for negligence.14

C THE BOLAM OR PROFESSIONAL STANDARD

The first question to be explored is based on the common law surrounding the
Bolam15 or professional standard. The determination of the content of the doctor’s
duty of care toward a patient, including the doctor’s perception of the patient’s
‘best interests’, has been linked to a standard referable to the opinion of a body of
responsible medical practitioners who are appropriately skilled in the applicable
aspect of medical practice. Whilst courts must, of necessity, be guided by evidence
from medical practitioners about what is acceptable conduct or treatment in the
circumstances, they have also recognised that technical concerns are not the only

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8 Donoghue v Stevenson [1932] AC 562, 580 (Lord Atkin).
9 Vairy v Wyong Shire Council (2005) 223 CLR 422, 434 (McHugh J).
10 Vairy v Wyong Shire Council (2005) 223 CLR 422, 433 (McHugh J).
11 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
12 See eg, Chester v Afshar [2005] 1 AC 134 [74], [85] (Lord Hope).
15 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
factors to be considered. For example, the court in *Montgomery* recognised that what the medical practitioner sees as in the patient’s ‘best interests’ and what the patient sees as important, may differ substantially:

The doctor’s advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient’s entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations).16

Thus the courts have modified the *Bolam* standard to recognise that there are more considerations in play, when determining the doctor’s duty of care to advise a patient about risks, than strictly technical clinical matters. A patient’s choice about whether or not to undergo a particular risk includes a range of matters of which the doctor cannot be aware.

The *Bolam* principle is invoked by medical practitioners when questions arise concerning the standard of care to be provided to a patient. Medical practitioners call on the *Bolam* standard despite its extensive modification over the years. Courts have moved from unquestioning acceptance of a body of responsible medical opinion to recognition of patient autonomy in decision-making. As Lord Walker commented in *Chester v Afshar*:

The surgeon’s duty to advise his patient (and in particular to warn of unavoidable risks of surgery) is a very important part of his professional duty. In *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 88, Lord Scarman described the patient’s right to make his own decision as a basic human right. Lord Scarman was delivering a dissenting speech, but the whole House recognised this right ... and during the 20 years which have elapsed since *Sidaway’s* case the importance of personal autonomy has been more and more widely recognised.17

Likewise, Lady Hale observed:

It is now well recognised that the interest which the law of negligence protects is a person’s interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body ... 18

Yet, despite these endorsements of the patient’s autonomous right to choose whether or not to accept a medical intervention, the *Bolam* standard subjugates the patient’s autonomy to a majority professional opinion.

This discussion commences with the case of *Bolam* and describes the propositions for which it is noted. It proceeds with an account of its influence on subsequent

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16 *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [83].
17 *Chester v Afshar* [2005] 1 AC 134, 163 (Lord Walker).
cases up to the English case of Sidaway\textsuperscript{19} that started to recognise that there was a distinctive aspect to each of a doctor’s three main obligations toward the patient, to diagnose, to treat and to provide advice. Providing advice includes the doctor’s duty to brief a patient concerning risks and benefits of any proposed treatment together with information about what having no treatment might entail.

This section then contrasts the English point of view with Australian cases that had taken a stronger position on the patient’s right to information and finally refers to Montgomery,\textsuperscript{20} a case of the United Kingdom Supreme Court. Montgomery has overturned Sidaway and adopted a position that mirrors the principle laid down in the Australian case of Rogers v Whitaker.\textsuperscript{21} This analysis charts the way patient interests were first supplanted by practitioner interests. However, the strong court endorsement of the patient’s right to make autonomous choices based on comprehensive information about what is acceptable treatment in the patient’s particular circumstances has downgraded the relevance of the Bolam standard.

1 Bolam and its Aftermath

The Bolam standard derives from a direction to the jury by McNair J in the English case of Bolam v Friern Hospital Management Committee.\textsuperscript{22} This was a case brought by an injured plaintiff whose hip had been impacted by convulsions caused by electro-convulsive therapy. The patient had not been warned that convulsions were possible, nor was he sedated during the procedure. In putting to the jury the question as to whether the medical practitioner had been negligent, McNair J’s directions stated that:

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.\textsuperscript{23}

Having put the standard required as ‘the ordinary skill of an ordinary competent man’, he continued: ‘... he is not guilty of negligence if he has acted in accordance

\textsuperscript{19} Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871.
\textsuperscript{20} Montgomery v Lanarkshire Health Board [2015] UKSC 11.
\textsuperscript{21} Rogers v Whitaker (1992) 175 CLR 479.
\textsuperscript{22} Bolam v Friern Hospital Management Committee [1957] WLR 582.
\textsuperscript{23} Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, 586.
with a practice accepted as proper by a responsible body of medical men skilled in that particular art’.\(^{24}\)

Lord Denning was a strong advocate for the medical profession in several cases, as exemplified by his view in *Whitehouse v Jordan* that ‘... in a professional man, an error of judgement is not negligent.’\(^{25}\) In the House of Lords appeal, Lord Fraser was at pains to modify that view by saying that Lord Denning must have meant that an error of judgement is not *necessarily* negligent. The assertion as it stood was not an accurate statement of the law.\(^{26}\)

Lord Denning’s lack of concern for the patient was epitomised in his final remarks in *Whitehouse v Jordan*. The plaintiff had been born grossly brain-damaged, unable to sit up or speak, and was doubly incontinent. Lord Denning commented that the actions of the surgeon were at worst an error of judgment but not negligent. Whilst it was a dreadful outcome for the child, people would sympathise with the mother.

Everyone will rally round to help her as they have already done during these last ten years. She should be grateful for all that has been done for her without laying blame on the doctors.\(^{27}\)

*Bolam* was called upon in many cases as the standard by which a medical practitioner’s duty to his or her patient should be evaluated.\(^{28}\) However, *Sidaway* was the first time that the medical practitioner’s standard of care came before the House of Lords.

2 The Doctor’s Multiple Duties

In *Sidaway*,\(^ {29}\) the court was faced with an attempt by the plaintiff to argue that there was a difference between the doctor’s duty in respect of diagnosis and treatment, and a separate duty to inform the patient about relevant risks. Lord Diplock did not agree:

In English jurisprudence the doctor’s relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgement ... has hitherto been treated as [a] single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement ... [t]his general skill is not subject to

\(^{24}\) *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.

\(^{25}\) *Whitehouse v Jordan* [1980] 1 All ER 650, 658 (Lord Denning).

\(^{26}\) *Whitehouse v Jordan* [1981] 1 WLR 246, 263 (Lord Fraser).

\(^{27}\) *Whitehouse v Jordan* [1980] 1 All ER 650, 658 (Lord Denning).

\(^{28}\) See eg, *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634; *Gold v Haringey Health Authority* [1988] 1 QB 481.

\(^{29}\) *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 1 AC 871.
dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment, advice ... 30

He continued:

[n]o convincing reason has in my view been advanced ... that would justify treating the Bolam test as doing anything less than laying down a principle of English law that is comprehensive and applicable to every aspect of the duty of care owed by a doctor to his patient ... 31

However, he was prepared to make an exception for judges:

[w]hen it comes to warning about risks, the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not.52

In Sidaway, the court was trying to determine whether the surgeon concerned had been negligent in his failure to warn the patient of the risks inherent in the proposed treatment. In his judgement, Lord Scarman summarised the Bolam case by saying:

The Bolam principle may be formulated as a rule 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 short, the law imposes the duty of care: but the standard of care is a matter of medical judgement.33

However, Lord Scarman was not prepared to accede to the idea that the standard of care as a matter of medical judgment by ‘a responsible body of professional opinion’, was the only criterion for determining whether the doctor was under a duty to warn his patient of possible risks in the treatment being suggested to the patient. In his view, this idea was concerning in that it would leave ‘ ... the determination of a legal duty to the judgement of doctors’.

Responsible medical judgement may, indeed, provide the law with an acceptable standard in determining whether a doctor in diagnosis or treatment has complied with his duty. But is it right that medical judgement should determine whether there exists a duty to warn of risk and its scope? It would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognises a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty

30 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 893 (Lord Diplock).
31 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 893 (Lord Diplock).
32 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 895 (Lord Diplock).
33 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 881 (Lord Scarman).
arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes. 34

Similarly, as Gleeson CJ observed in Rosenberg v Percival when referring to Lord Scarman’s dissenting judgement in Sidaway:

[the relevance] of professional practice and opinion was not denied; what was denied was its conclusiveness. In many cases professional practice and opinion will be the primary basis upon which a court may reasonably act. But, in an action brought by a patient, the responsibility for deciding the content of the doctor’s duty of care, rests with the court, not with his or her professional colleagues. 35

Montgomery comments that in the past, many judges and legislators have been reluctant to take from doctors the power to make medical decisions for their patients in the guise of best interests. 36 However, from the high point of the Bolam case, courts have gradually scaled back the almost unquestioned acceptance that the medical practitioner’s decision will be correct if it is based on ‘... practice accepted as proper by a responsible body of medical men skilled in that particular art ... ’ 37 Lord Woolf describes the Bolam test as the ‘any responsible group of doctors knows best’ test. 38 Even so, when faced in a disciplinary case with determining what is the standard of conduct reasonably expected of a professional of equivalent training or experience the court or tribunal will, of necessity, be thrown back upon hearing and choosing whether to accept evidence from different medical practitioners as to what a ‘responsible body of medical men’ would have done in the circumstances. 39 Yet, as the majority held in Rogers: 40

[while] evidence of acceptable medical practice is a useful guide for the courts, it is for the court to adjudicate on what is the appropriate standard of care after giving weight to “the paramount consideration that a person is entitled to make his own decisions about his life”. 41

Deference to the Bolam test has meant that some medical negligence cases have been dismissed on the grounds that the medical practitioner being sued conformed to accepted practice by one or other group of medical practitioners, it did not matter which. For example, in Maynard, Lord Scarman refused to distinguish between different opinions provided they were ‘...truthfully expressed, honestly

34 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 882 (Lord Scarman).
37 Bolam v Friern Hospital Management Committee [1957] WLR 582, 587 (McNair J).
41 The words in quotes are from F v R (1983) 33 SASR 189, 193 (King CJ).
Similarly, in Sidaway, Lord Diplock, speaking about the court, stated that ‘... it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another ...’. Yet by not accepting evidence of differing practices brought by a patient’s medical experts, under the guise of ‘not choosing’, the courts in fact were making a choice in favour of the medical practitioner.

3 The Professional Standard and the Duty to Inform

In Sidaway, the plaintiff had been left severely disabled following an operation on her spine. The surgeon had not warned her about the risks of the proposed operation that included possible damage to spinal column and nerve roots nor that the operation was a matter of choice not necessity. The medical evidence was that a decision about whether and how much to warn the patient was a matter of medical judgement:

[j]it being accepted that a doctor acting in the best interests of his patient would be concerned lest a warning might frighten the patient into refusing an operation which in his view was the best treatment in the circumstances.

The Court of Appeal had followed a strict Bolam line in holding that the provision of information about risks and alternatives was a matter for ‘... professional judgement, to be exercised in the context of the doctor’s relationship with a particular patient in particular circumstances’. Observing that the ‘doctrine of “informed consent” forms no part of English law’, Dunn LJ commented:

I confess that I reach this conclusion with no regret. The evidence in this case showed that a contrary result would be damaging to the relationship of trust and confidence between doctor and patient, and might well have an adverse effect on the practice of medicine.

Likewise, Browne-Wilkinson LJ declared that, in his judgement, ‘there is no ground in English law for extending this limited doctrine of informed consent outside the field of property rights in which it is established’. Kennedy observed

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42 Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634, 639.
43 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 895.
44 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 883 (Lord Scarman).
45 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1984] 1 QB 493, 512 (Sir John Donaldson).
46 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1984] 1 QB 493, 517 (Dunn LJ).
47 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1984] 1 QB 493, 519 (Browne-Wilkinson LJ).
that the Court of Appeal had been anxious to make sure that the American ‘horrors’ of defensive medicine, a flood of litigation and the undermining of patients’ trust in their doctors were not imported into England. 48 The Court of Appeal thought that this could only be achieved if the ‘professional standard,’ that is, Bolam was confirmed so the plaintiff’s case was dismissed. Kennedy has been critical of the Court of Appeal’s anxieties as hyperbole and ‘shroud waving’. 49

Lord Scarman remarked that over the years since Bolam, 50 the House of Lords had affirmed the Bolam test as applicable to treatment 51 and to diagnosis. 52 In Sidaway, 53 the majority of the House of Lords, Lord Scarman dissenting, approved the Bolam test, as the ‘professional standard’ applying to treatment, diagnosis and to the duty to inform. 54 Despite that, Lord Bridge (with whose reasoning and decision Lord Keith concurred) observed:

\[
\text{[e]ven in a case where ... no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of the opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.}\] 55

Similarly, Lord Scarman concluded that:

English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment he is proposing: and especially so if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk. 56

The law was therefore settled for many years in England despite some modifications in cases such as Bolitho 57 and Pearce. 58 Sidaway remained the leading case until Montgomery 59 which overturned Sidaway and introduced a test

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49 Ibid188–190.
50 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 881.
52 Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634.
53 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871.
54 See eg, Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 895 (Lord Diplock).
55 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 900 (Lord Bridge).
56 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 889 (Lord Scarman).
57 Bolitho v City and Hackney Health Authority [1998] AC 232.
of materiality in similar terms to that laid down in the case of Rogers v Whitaker\textsuperscript{60} in Australia, to which we now turn.

4 The Patient’s Right to Information — the Australian Way

While United Kingdom courts had been concentrating on principles laid down in Bolam and Sidaway, in Australia the law had been taking a different tack from the House of Lords majority in Sidaway, commencing with the case of F v R.\textsuperscript{61} King CJ in F v R determined that the law imposes a duty on each medical practitioner to exercise care and skill in providing medical advice and treatment, the standard of care being that of an ordinary careful and competent practitioner. The scope of the duty includes a duty to disclose information about real risks inherent in the treatment proposed and extends to matters that will impact on the decisions of a reasonable person in the position of the patient, especially where a drastic intervention is proposed.\textsuperscript{62} However, he warned about practices that may develop in the medical profession that are more concerned with the interests and convenience of medical practitioners than those of the patient.\textsuperscript{63}

It is for the Court to decide what a careful and responsible doctor would explain to the patient in the circumstance, and I do not regard as decisive the opinions of the medical witnesses on the point or the existence of a practice of non-disclosure in a section of the profession. If the Court thought that that practice involved a failure to exercise reasonable care towards the patient, I would regard it as its duty to give effect to that view.\textsuperscript{64}

The High Court in Rogers v Whitaker\textsuperscript{65} approved the approach taken in F v R and was in substantial conformity with Lord Scarman’s judgement in Sidaway. Mrs Rogers had a childhood injury that had left her almost totally blind in one eye. She had received advice from an ophthalmic surgeon that an operation would improve the appearance of the injured eye and would probably restore some of her sight. However, a rare condition called sympathetic ophthalmia had intervened leading to inflammation and a total loss of sight in the ‘good’ eye.

The High Court’s judgement in the case moved away from unqualified acceptance of medical opinion in terms of the Bolam test. Determination of whether a medical practitioner has breached the requisite standard of care will depend on different factors, depending on whether the question involves diagnosis, treatment or

\textsuperscript{60} Rogers v Whitaker (1992) 175 CLR 479.
\textsuperscript{61} F v R (1983) 33 SASR 189.
\textsuperscript{62} F v R (1983) 33 SASR 189, 192 (King CJ).
\textsuperscript{63} F v R (1983) 33 SASR 189, 194. (King CJ).
\textsuperscript{64} F v R (1983) 33 SASR 189, 196 (King CJ).
\textsuperscript{65} Rogers v Whitaker (1992) 175 CLR 479.
provision of information to the patient. There is a difference between diagnosis and treatment on the one hand and provision of information on the other. The necessity for the patient to consent before undertaking some procedure is dependent on the patient’s choice to do so, and a choice is only valid if the patient has been provided with all relevant information and advice. The law recognises this as a duty of the doctor to warn of all material risks attaching to any proposed treatment:

[a] risk is material if, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

There was an argument that there was a body of medical opinion that was of the view that the rare condition of sympathetic ophthalmia should only be disclosed to a patient who specifically asks about it. Yet, as Sedley LJ has subsequently stated in Wyatt v Curtis, ‘... there is arguably something unreal about placing the onus of asking upon a patient who may not know that there is anything to ask about’. In Rogers, this particular patient had made clear her concern that the operation on her injured eye should not affect the vision in the other eye, making clear that any risk to her ‘good’ eye was a significant event, and thus material to the patient. Consequently, when the injury to the ‘good’ eye occurred, the defendant was liable to Mrs Whitaker for damages.

In a separate judgement, Gaudron J agreed with the reasons for judgment of the majority but went on to comment that whilst evidence of medical practice in diagnosis and treatment may be relevant, even then there was no legal basis to limit the liability of medical practitioners based on the Bolam test. The information to be provided to this particular patient or the ‘hypothetical prudent patient’ does not involve evidence of the practice of medical practitioners. The duty to warn of risks is no different from any other duty to warn of real and foreseeable risks.
5 Montgomery

The United Kingdom case of *Montgomery v Lanarkshire Health Board*\(^{14}\) resoundingly overruled *Sidaway* and adopted a position in line with *Reibl v Hughes*\(^{24}\) in Canada and *Rogers v Whitaker*\(^{76}\) in Australia. In a unanimous judgment of the United Kingdom Supreme Court, the previous endorsement of the *Bolam* test in respect of medical advice was cast aside. The court noted that, whilst lower courts had been bound by *Sidaway*, many had found tacit ways of not following it.\(^{77}\)

The patient was a small pregnant lady with *diabetes mellitus*. It was well known that diabetic women would have larger babies than normal. The medical practitioner did not warn the patient of the possibility of shoulder dystocia — that the baby’s shoulders could become stuck in the birth canal. The patient was obviously anxious about facing vaginal delivery, but the medical practitioner considered that the risk of grave consequences from shoulder dystocia was so small that no warning was necessary.\(^{78}\) Yet the possibility of shoulder dystocia being a factor in diabetic mothers was as high as 10%\(^{79}\). The doctor also gave evidence that if she were to mention to every diabetic mother that there was a small risk of injury to the baby, then every such woman would ask for a caesarian section, and it was not in the interests of women to have caesarians.\(^{80}\)

In the event, almost everything went wrong with the vaginal delivery: the umbilical cord was trapped between the baby and the mother and the baby was starved of oxygen for several minutes, sufficient time for him to be born brain damaged. The lower courts had followed *Sidaway* in deciding that the medical practitioner had not been negligent in not informing the mother of the possibility of shoulder dystocia and that a caesarian delivery was an alternative.\(^{81}\) In the

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\(^{14}\) *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

\(^{24}\) *Reibl v Hughes* (1980) 114 DLR (3rd) 1.

\(^{76}\) *Rogers v Whitaker* (1992) 175 CLR 479.

\(^{77}\) *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [63] (Lord Kerr and Lord Reid).

\(^{78}\) *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [17] (Lord Kerr and Lord Reid).


\(^{81}\) *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [26] - It was not clear why the responsible body of medical opinion on behalf of the defendant was more acceptable than the responsible body of opinion from the plaintiff’s experts. Perhaps, as in *Maynard*, the judge was declining to choose. Yet that of itself was a choice in favour of the defendant’s experts.
plaintiff’s appeal to the Scottish Inner House of the Court of Session,\textsuperscript{82} she ‘... again argued that she ought to have been informed of the risk of shoulder dystocia, and should have been offered, and advised about, the alternative of delivery by caesarian section.’\textsuperscript{83} Lord Eassie dismissed the plaintiff’s arguments and her repeated expression of concerns about the size of her baby as ‘of a general nature only’ commenting:

Too much in the way of information ... may only serve to confuse and alarm the patient, and it is therefore very much a question for the experienced practitioner to decide, in accordance with normal and proper practice, where the line should be drawn in a given case.\textsuperscript{84}

The Supreme Court pointed out that the days of medical practitioners dealing with ‘ignorant’ patients were over and that patients had rights that must be observed,\textsuperscript{85} including the provision of sufficient relevant information so that the patient could make a properly informed choice about how to proceed. The court stated that this view was reinforced by guidelines issued by the General Medical Council that specified the duty of the doctor to provide relevant information to the patient in a way that the patient can understand,\textsuperscript{86} thus permitting the patient to weigh benefits, risks and other options, including that of not acting at all.\textsuperscript{87} As Chapter III explained, recognition by the court that the content of the doctor’s duty can be evidenced by reference to a ‘soft’ law guideline has the effect of bestowing on that guideline the enforceability of ‘hard’ law. The General Medical Council’s guidelines have therefore become enforceable.

The court accepted the judgement of Lord Scarman in Sidaway as correctly stating the law, a test of materiality in similar terms to that declared in Rogers v Whitaker. The court approved the two limbed approach in that the doctor not only had to provide information that the patient would consider material, the doctor also had to provide relevant information if he or she knew or ought to have known that the information would be considered to be material by the patient.\textsuperscript{88} The only reason that a doctor could choose not to inform the patient is the ‘therapeutic privilege’ that permits a doctor to withhold information if, in his or her professional clinical assessment, informing the patient would pose a serious threat to the patient’s

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\textsuperscript{82} The Inner House of the Court of Session is the supreme civil court in Scotland, both a court of appeal and a court of first instance.


\textsuperscript{84} Montgomery v Lanarkshire Health Board [2015] UKSC 11 [33] (Lord Kerr and Lord Reid).

\textsuperscript{85} Montgomery v Lanarkshire Health Board [2015] UKSC 11 [75] (Lord Kerr and Lord Reid).

\textsuperscript{86} General Medical Council, Good Medical Practice (at 22 April 2013) [32].

\textsuperscript{87} Montgomery v Lanarkshire Health Board [2015] UKSC 11 [77] (Lord Kerr and Lord Reid).

\textsuperscript{88} Montgomery v Lanarkshire Health Board [2015] UKSC 11 [73] (Lord Kerr and Lord Reid).
physical or mental health. But courts have warned that any defence of failing to inform on the grounds of the therapeutic privilege is limited.

[I]t is not intended to subvert [the right of the patient to decide whether to undergo a treatment] by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her interests.99

There is no question in this case of Dr McLellan’s being entitled to withhold information about the risk because its disclosure would be harmful to her patient’s health … the “therapeutic exception” is not intended to enable doctors to prevent their patients from taking an informed decision.100

In addition, Lady Hale in a ‘footnote’ judgement that also supported the other justices, was scathing of the medical practitioner as having made a moral judgement about the desirability of caesarian births, and using that moral stance as a reason to deny the patient the information required to make a rational choice.

Whatever Dr McLellan may have had in mind, this does not look like a purely medical judgement. It looks like a judgement that vaginal delivery is in some way morally preferable to a caesarian section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter. Giving birth vaginally is indeed a unique and wonderful experience, but it has not been suggested that it inevitably leads to a close and better relationship between mother and child than does a caesarian section.101

The court in Montgomery commented that:

because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test … is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients.102

6 Conclusion

In F v R, King CJ remarked that:

In many cases an approved professional practice as to disclosure may be decisive. But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of members of the profession.103

King CJ’s statement and the above analysis have shown that unconditional adherence by courts and the law to the Bolam standard could be subjugating the patient’s interests to those of the doctor, thereby undermining the duty of

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100 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [95] (Lord Kerr and Lord Reid).
102 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [84] (Lord Reid and Lord Kerr).
103 F v R (1983) 33 SASR 189, 194 (King CJ).
doctor to make the care of the patient the doctor’s first concern. Rogers and Montgomery particularly have confirmed that failure to provide a patient with details of relevant risks and appropriate alternatives is no longer acceptable as a denial of the patient’s autonomous right to choose whether or not to undergo a particular treatment. Similarly, Montgomery has endorsed the principle that reliance on the therapeutic privilege is no excuse for an omission to fully advise the patient. Invoking therapeutic privilege as a reason to take decision-making away from the patient is paternalistic and should only rarely occur, and when it does, the medical practitioner must be prepared to justify the decision to call upon it.

Having provided evidence of the law’s early predisposition to support the position of the medical practitioner in how much information is provided to a patient, it is now instructive to examine how the law has dealt with the related question of the medical practitioner’s obligation to seek consent before initiating any treatment or procedure.

C THE REQUIREMENT FOR CONSENT

1 Introduction

The requirement that the patient consent before any medical treatment is commenced is relevant to a number of legal principles. The common law confirms that any unjustified touching of another without consent may be a trespass in tort or a criminal act of battery. There is no general exception for medical practitioners. However, consent provides a defence to those charges. The courts have also determined that the obligation for medical practitioners to seek consent before undertaking any medical intervention arises from respect for the patient’s autonomy. Respect for autonomy implies providing sufficient information to patients so they can be aware of risks, and take responsibility for the

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64 See eg, Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam); Montgomery v Lanarkshire Health Board [2015] UKSC 11.  
65 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [95] (Lord Reid and Lord Kerr).  
67 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, 889 (Lord Scarman).  
69 In re F. (Mental Patient: Sterilisation) [1990] 2 AC 1, 30 (Neill LJ). Neill LJ stated: ‘... the general rule that the patient’s consent must be obtained before an operation can be carried out...’.  
70 Collins v Wilcock [1984] 1 WLR 1172, 1177 (Goff LJ).  
71 See eg, Montgomery v Lanarkshire Health Board [2015] UKSC 11 [108] (Lady Hale); Chester v Afshar [2005] 1 AC 134 [77] (Lord Hope).
choices made, thereby reducing the prospect of a negligence action.\textsuperscript{102} However, despite the existence of the fundamental right of a competent adult patient to accept or refuse medical treatment, the patient’s legal capacity may be questioned where a patient’s decision does not accord with that of the medical team.\textsuperscript{103} Practitioner and patient interests may conflict leading to a requirement for judicial intervention to resolve the matters in dispute.

As Neill LJ observed: ‘The fact that as a general rule the consent of the patient must be obtained before any operation or other treatment on his body is carried out means that the patient has the right to refuse’.\textsuperscript{104} Even if a refusal of treatment may endanger the patient’s life, it is a well-established principle that an adult of sound mind is entitled to refuse that treatment.\textsuperscript{105} Lord Keith stated the principle:

\begin{quote}
The first point to make is that it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind without his consent ... [s]uch a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die.\textsuperscript{106}
\end{quote}

However, a refusal in face of medical opinion may suggest to the medical team that the patient is not mentally competent to make a decision of that type, especially if it may lead to the death of the patient. There is evidence that where the patient accepts recommended medical treatment, no question of the patient’s competence arises. As Kennedy observed when commenting about the case of \textit{Re MB},\textsuperscript{107} ‘[n]otice, and this has been said before, that it is when a patient does not accede to the doctor’s advice that the question of capacity arises.’\textsuperscript{108} The law accepts that the patient’s choice need not be rational, yet courts have, on occasion, overridden patient decisions, thus discounting the patient’s autonomy in the face of a practitioner’s assessment of the patient’s ‘best interests’.

The legal requirement that the patient consent is also a reflection of respect for the patient’s autonomy. As Judge LJ said in \textit{St George’s Healthcare NHS Trust v S}:

\begin{quote}
Even when his or her life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it. This reflects the autonomy of each individual and the right of self-determination.\textsuperscript{109}
\end{quote}

\textsuperscript{102} \textit{Montgomery v Lanarkshire Health Board} [2015] UKSC 11 [93] (Lord Kerr and Lord Reid).

\textsuperscript{103} See eg, \textit{M v A NHS Hospital Trust} [2002] EWHC 429 (Fam).

\textsuperscript{104} \textit{In re F. (Mental Patient: Sterilisation)} [1990] 2 AC 1, 29 (Neill LJ).

\textsuperscript{105} \textit{St George’s Healthcare NHS Trust v S} [1999] Fam 26, 43 (Judge LJ).

\textsuperscript{106} \textit{Airedale NHS Trust v Bland} [1993] AC 789, 857 (Lord Keith).

\textsuperscript{107} \textit{Re MB} [1997] EWCA Civ 3093.


\textsuperscript{109} \textit{St. George’s Healthcare NHS Trust v S} [1999] Fam 26, 43 (Judge LJ).
Respect for patient autonomy is embedded in patient-centred care principles as discussed in Chapter I and is the first of the principles of biomedical ethics as part of medical professionalism as considered in Chapter II. Respect for autonomy is exemplified by this requirement that patients must consent before the medical practitioner embarks on any medical treatment or procedure. As the court in Montgomery remarked, patients must be treated

\[\text{[as] far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.}\]

This section will show that, despite the requirement for the patient to consent before any medical treatment is commenced, the patient’s right can be undermined in practice. The patient’s right to determine what happens to his body has an intimate connection with the principles of self-determination. As stated above, the right to consent also implies the right to refuse consent, or to demand the withdrawal of treatment. However, having refused consent or demanded treatment withdrawal, the consequence of which being that the patient might die, the question then can arise as to whether the particular patient has the mental capacity to make that decision, especially in the face of contrary medical opinion. There is evidence that acceptance of recommended medical treatment does not trigger a question of the patient’s competence, the question usually arising where the doctor’s instinct to save life runs up against a patient’s choice to refuse recommended treatment. As Kennedy points out:

‘Everything turns on the capacity of the patient and, just as important, who makes the final determination as to that capacity. My position is that the law is so constructed that in all probability, only the lucid, self-assertive patient who has a sympathetic, understanding doctor is able in most circumstances to have his way, and be left alone, free from further interference.’

This section will show that despite carefully formulated tests for mental competence, sometimes it is the nature of the refusal that triggers an assessment that the patient is mentally incompetent, rather than accepting the patient’s autonomy to make that particular decision. Autonomy or self-determination is lauded by the courts as a prime value for the rational individual. Yet, exercise of

100 Montgomery v Lanarkshire Health Board [2015] UKSC 11 [81] (Lord Reid and Lord Kerr).
that autonomy by refusing treatment, especially that which may prolong life, can lead to subjecting a patient to an assessment of mental competence.

2 Self-Determination

The requirement for medical practitioners to obtain the patient’s consent before any medical procedure is instituted, is a recognition by the law of the individual autonomy and self-determination of the person that will be upheld almost invariably.\(^{114}\) The House of Lords in Airedale NHS Trust v Bland, confirmed that the right to self-determination is paramount and overrides other ethical principles such as the ‘sanctity of life’.\(^{115}\) As Judge LJ commented in St George’s Healthcare NHS Trust v S, quoting several of the Law Lords from Bland, their speeches ‘... did not establish the law, but rather underlined the principle found in a series of authoritative decisions.’\(^{116}\)

The courts have confirmed that provided the threshold conditions of competence, voluntariness and informed consent have been satisfied, they will not step in to override a decision, no matter how foolish, illogical, or unreasonable it may appear to the medical treatment team or any dispassionate observer. Referencing Sidaway, Lord Donaldson had stated in In re T:

> This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.\(^{117}\)

In Ms B v An NHS Hospital Trust, Dame Elizabeth Butler-Sloss reviewed the cases that confirmed the fundamental legal principle of the right of a person ‘of full age and capacity’ to determine what should be done with his or her body.\(^{118}\) She went on to observe that:

> Unless the gravity of the illness has affected the patient’s capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy. There is a serious danger ... of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient.\(^{119}\)

\(^{114}\) See eg, St George’s Healthcare NHS Trust v S [1999] Fam 26, 43 (Judge LJ). In addition, Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.5.2] requires a medical practitioner to obtain informed consent ‘... before any examination, investigation or provision of treatment ...’. Patient Examination Guidelines - 1996. Revised 2012 of the Australian Medical Association advises that patient consent must be obtained before commencing any examination of the patient [1.3], [2.1].

\(^{115}\) Airedale NHS Trust v Bland [1993] AC 789, 864 (Lord Goff).

\(^{116}\) St George’s Healthcare NHS Trust v S [1999] Fam 26, 44 (Judge LJ).

\(^{117}\) In re T (Adult: Refusal of Treatment) [1993] Fam 95, 102 (Lord Donaldson).

\(^{118}\) Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [16]–[21].

\(^{119}\) Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [94].
In the case of *In re C (Adult: Refusal of Treatment)*,\textsuperscript{120} the court found that a paranoid schizophrenic was entitled to refuse to have a gangrenous foot amputated. The court considered that the presumption of the patient’s right to self-determination had not been displaced as he understood the nature, purpose and effects of the treatment being refused, despite his schizophrenia.

In order for a consent to be valid, the patient must be supplied with all information necessary to make a genuine choice and that includes the risks and benefits of each option presented, together with risks and benefits of not undertaking any treatment at all.\textsuperscript{121} As Kirby J in *Rosenberg v Percival* confirmed, ‘... to some extent, the legal obligation to provide warnings may sometimes help to redress the inherent inequality in power between the professional provider and the vulnerable patient ...’ \textsuperscript{122} Kennedy claims that informed consent flies the flag of self-determination against the otherwise ever-present paternalism of the doctor.\textsuperscript{123}

However, despite the rhetoric that the right to self-determination is paramount, the reality is that, as Jones comments, too often the requirement for consent is seen as a medico-legal formality rather than as an acknowledgement of the patient’s autonomy in choosing whether or not to submit to medical treatment.\textsuperscript{124}

\section{The Right to Refuse and Mental Capacity}

As noted above, the requirement that the patient consent before any medical procedure or treatment is instigated also has the corollary that the patient has the right to refuse treatment. As Neill LJ has commented: ‘... the right to refuse exists even where there are overwhelming medical reasons in favour of the treatment and

\begin{thebibliography}{99}
\bibitem{120} *In re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290, 295 (Thorpe J).
\bibitem{122} *Rosenberg v Percival* (2001) 205 CLR 434, [145(4)] (Kirby J).
\bibitem{123} Ian Kennedy, *The Unmasking of Medicine* (George Allen and Unwin, 1981) 130.
\bibitem{124} Michael A Jones, ‘Informed Consent and Other Fairy Stories’ (1999) 7 Medical Law Review 103, 130. In similar vein, in the case of *Medical Board of Australia v Adams* [2017] VCAT 796 the medical practitioner was suspended for six months for having forged multiple patient consent forms over a period of 12 months because obtaining consent created too much work for himself and his staff ([41]) and it would be unnecessary duplication of effort ([42]).
\end{thebibliography}
probably even where if the treatment is not carried out the patient’s life will be at risk.125

However, a leading example of the readiness to equate a refusal with lack of mental capacity was the English case of Ms B.126 Following a medical history that included a collection of abnormal blood cells in the brain or spinal column, Ms B became a quadriplegic. Following surgery that minimally improved her condition, she asked for her ventilator to be turned off, repeating the request a few days later. After a formal request through her solicitors, she was assessed by two consulting psychiatrists who eventually concurred that she did not have capacity. She agreed to a rehabilitation plan, but following a lung collapse, she wished for ventilation to be discontinued. An independent psychiatrist certified that, at that time, she had capacity. Whilst she had made it clear that she wished no more ventilation to be provided, the clinicians were not prepared to turn it off.

Ms B’s evidence confirmed ‘... that she had never changed her view that she wanted the ventilator withdrawn.’127 The court found that Ms B had been treated unlawfully and that she had been placed in an impossible position by the treating clinicians who refused to remove the ventilation. Ms B testified that, whilst accepting the right of a medical practitioner to refuse, she was angered by their arrogance and refusal to refer her to a medical practitioner who would accede to her request.128 In light of the finding of unlawful treatment, the trust was ordered to pay damages.129

In the case of NHS Trust v T (adult patient: refusal of medical treatment),130 a woman who used to cut herself causing blood loss to a dangerous level, refused a blood transfusion. The question of the patient’s capacity arose. The court disregarded the refusal on the basis of a ‘borderline personality disorder’ considering that it was in the patient’s best interests to treat her.

125 In re F (Mental Patient: Sterilisation) [1990] 2 AC 1, 29 (Neill LJ). For example, Jehovah’s Witnesses will usually refuse blood transfusions, even if the lack of access to additional blood may lead to the patient’s death and the courts generally accept such a decision. In both HE v A Hospital NHS Trust [2003] EWHC 1017 [4] and Hunter and New England Area Health Service v A [2009] NSWSC 761 [42], the Jehovah’s Witness patient had purported to make an advance directive refusing, on religious grounds, transfusions of blood or any blood products. In Airedale NHS Trust v Bland [1993] AC 789 at 827, Lord Hoffman refers to the Jehovah’s Witness who refuses a blood transfusion.
126 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam).
127 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [39] (Dame Elizabeth Butler-Sloss).
128 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [50] (Dame Elizabeth Butler-Sloss).
129 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [99] (Dame Elizabeth Butler-Sloss).
130 NHS Trust v T (Adult Patient: Refusal of Medical Treatment) [2004] 3 FCR 297.
The finding of a ‘borderline personality disorder’ as the justification for overriding refusal of treatment contrasts with the outcome in both In re C\textsuperscript{131} and Wye Valley NHS Trust v B\textsuperscript{132} where the refusal of amputation of a gangrenous foot by a patient diagnosed as a chronic paranoid schizophrenic and one with a long-standing mental illness respectively, was upheld by the relevant court. The court in In re C determined that the patient’s capacity was not so impaired that he did not understand the nature, purpose and effects of the proposed treatment. In the Wye Valley case, the court recognised that the patient did not have decision-making capacity, but he had made his feelings abundantly clear. Consequently, it would not be in the patient’s ‘... best interests to take away his little remaining independence and dignity ... ’ by enforcing treatment on him.\textsuperscript{133}

An illustration closer to home where refusal of treatment was equated with lack of mental capacity was provided by the Victorian Inquiry into Options for Dying with Dignity. A former waterski champion, John McEwan who died in April 1986 had been rendered quadriplegic by a swimming accident. He was totally dependent on life support that he found intolerable. He refused food and some medication and signed a document saying that he did not want to be resuscitated if he became unconscious for any reason. He had also put himself on hunger strike. Therefore, he was certified insane at the Austin Hospital because of having made a plea to die.\textsuperscript{134} He was subsequently determined to be mentally stable, both by his medical practitioner and a psychiatrist.\textsuperscript{135}

As the above cases show, where a patient does not agree with the advice of the medical team and where the patient’s life is at risk from the refusal, a question of mental capacity can arise. This, in turn, raises the issue of how competency is assessed. One common law test for competency was prescribed by Thorpe J in Re C \textit{(adult: refusal of medical treatment)} as follows:

(i) could the patient comprehend and retain the necessary information;  
(ii) was he able to believe it; and  
(iii) was he able to weigh the information, balancing the risks and needs, so as to arrive at a choice.\textsuperscript{136}

\textsuperscript{131} In re C \textit{(Adult: Refusal of Treatment)} [1994] 1 WLR 290.  
\textsuperscript{132} Wye Valley NHS Trust v B [2015] EWCO 60.  
\textsuperscript{133} Wye Valley NHS Trust v B [2015] EWCO 60 [45] (Peter Jackson J).  
\textsuperscript{134} Social Development Committee, Parliament of Victoria, \textit{Inquiry into Options for Dying with Dignity} (1987) 16.  
\textsuperscript{135} Social Development Committee, Parliament of Victoria, \textit{Inquiry into Options for Dying with Dignity} (1987) 102.  
\textsuperscript{136} In re C. \textit{(Adult: Refusal of Treatment)} [1994] 1 WLR 290, 292 (Thorpe J).
In the later case of *Re MB (an adult: medical treatment)*, Butler-Sloss LJ discussed the relevant tests for mental capacity as follows:

1. Every person is presumed to have the capacity to consent to or refuse medical treatment unless and until the presumption is rebutted.
2. A competent person with capacity, may for any reason, whether rational or irrational, choose to consent to or refuse medical intervention and the court does not then have the jurisdiction to substitute its own decisions for those of the patient in deciding his or her own best interests.
3. An irrational decision is one that no person who applied his or her mind to it, could possibly have reached. The decision may be coloured by panic, fear, or indecision but these are only symptoms or evidence of incompetency.
4. A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision.
5. Temporary facts such as confusion, shock, fatigue, pain or drugs, may operate to render a patient unable to decide.
6. Panic induced by fear may also paralyse the will and make it impossible for the patient to make a decision.

The court in *MB* took as the test for the question of capacity to refuse, the formulation of Thorpe J in *Re C*. The court did not equate outcome and rationality of a decision with incompetence. The judge recognised the conflict between respect for patient autonomy and the medical team’s conception of what would be in the best interests of the patient. Further, the court connected incompetence to mental impairment but also recognised, that mental incapacity may be temporary and may be induced by external factors such as fear, pain or fatigue. In addition, ‘... the graver the consequences of the decision, the commensurably greater the level of competence is required to take the decision.”

Yet, these tests can themselves be subverted. They are not necessarily in step with Lord Donaldson’s judgement in *In Re T*, that any decision made need not be made for rational reasons. They are not crafted for the protection of the patient’s autonomy that is inherent in Lord Donaldson’s judgement. The apparently absolute principle that the competent, adult patient is entitled to refuse treatment has been hemmed in with conditions that detract from its categorical certainty. To reiterate, in referencing *Sidaway*, Lord Donaldson stated:

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137 *Re MB* [1997] EWCA Civ 3093.
140 *Re MB* [1997] EWCA Civ 3093 [30,3]; This principle is also stated in *In re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Donaldson MR); *HE v A Hospital NHS Trust* [2003] EWHC 1017 [24].
This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.142

Kennedy takes up this theme when he argues that there are two aspects to determination of competency, the patient making the decision and the decision itself that is set up as a manifestation of the lack of competency of the patient if the medical practitioner does not agree with it. As Kennedy contends:

The two, the patient and the decision, are inextricably intertwined. The trouble is that the moment we admit this, that the content of a patient’s decision is relevant in the determination of capacity, we face the problem of autonomy simply being overwhelmed by paternalism. Disagree with your medical adviser and ipso facto you are incompetent, at which point, well meaning ... others will decide for you.143

Thus, it is possible that at any one time, the patient can be both competent and incompetent depending on the nature of the decision made and the court’s view as to the rationality of the patient.

A further dimension of the problem is the care that must be taken to ensure that the value system and cultural background of the assessor of a person’s competency does not bias the assessment in favour of a decision that would be accepted by and comprehensible to the assessor, rather than that of the person being assessed.144

This danger of personal values and beliefs of an assessor impinging upon a competency assessment was expressed by Dame Elizabeth Butler-Sloss as follows:

If there are difficulties in deciding whether the patient has sufficient mental capacity, particularly if the refusal may have grave consequences for the patient, it is most important that those considering the issue should not confuse the question of mental capacity with the nature of the decision made by the patient, however grave the consequences. The view of the patient may reflect a difference in values rather than an absence of competence and the assessment of capacity should be approached with this firmly in mind. The doctors must not allow their emotional reaction to or strong disagreement with the decision of the patient to cloud their judgment in answering the primary question whether the patient has the mental capacity to make the decision.145

The imposition of an objective test based upon the demonstrated rationality of the patient flies in the face of the common law doctrine that the patient’s decision need not be rational at all. As McDougall J remarked in the Hunter case:

It cannot be correct to recognise, on the one hand, an individual’s right of self-determination; but, on the other, effectively to undermine or take away that right by over-nice or merely speculative analysis.146

142 In re T (Adult: Refusal of Treatment) [1993] Fam 95, 102 (Lord Donaldson).
145 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [100].
4 Conclusion

The requirement for the doctor to seek consent from a patient before any medical treatment is instigated is based on two legal principles. Firstly, it is a reflection of the ancient common law principle that touching of another without consent is unacceptable and may be considered a criminal act of battery or a tortious act of trespass. However, the courts have never related this principle to the activities of doctors. Rather, they base their insistence on patient consent upon the human right of self-determination and the entitlement of the patient to determine what should be done with his or her body. Long gone are the days when medical practitioners could presume to make all decisions for a patient on the practitioner’s perception of the patient’s ‘best interests’. The ethical value of patient self-determination runs up against medical assessment of ‘best interests’. As Kennedy argues:

[the basis of paternalism—that decisions concerning a particular person’s fate are better made for him than by him, because others wiser than he are more keenly aware of his best interests than he can be — conflicts with the notion of a right to self-determination, whereby a person is deemed entitled to make his own decisions concerning himself ... free from the interference of others.]

The common law emphasis on recognition of patient autonomy conflicts with the practical problems that arise when a theoretically independent, competent adult makes a decision that, not only medical practitioners but, sometimes the courts consider, is evidence of lack of mental capacity. The principles of patient-centred care give precedence to the patient’s right to respect for his or her autonomy. Yet, the medical practitioner’s perspective on prioritising the patient can lead to paternalistic attitudes to best interests that override patient self-determination.

Having considered how the common law has elevated practitioner concerns above patient interests when interpreting the Bolam standard, or when adjudicating on patient capacity to refuse medical treatment, it is now time to scrutinise the clearest case of a statutory bias away from patient concerns towards those of medical practitioners. Civil liability legislation is designed to impede access to

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147 Ian Kennedy, Treat Me Right (Clarendon Press, 1988) 333.
compensation for negligently caused injury, including where negligence is alleged against medical practitioners.

D CIVIL LIABILITY LEGISLATION

The common law action for professional negligence has been extensively modified by statute to restrict the access by injured patients to full compensation. Pressure on the law from professional liability insurers and medical practitioner lobbies has led to civil liability legislation that affects and constrains claims for personal injuries. These modifications have meant that many patients who have been injured by the alleged negligence of their medical practitioners are either prevented from access to compensation, or any compensation awarded is strictly limited.

Civil liability legislation exemplifies the dichotomy between patient and professional interests. Despite the insistence in medical codes that good medical practice is patient-centred, a prime example of the law’s involvement in the discounting of patient concerns lies in its deference to medical practitioner interests where patients have been injured in the course of medical treatment. Legislation in all Australian jurisdictions has been enacted to limit claims for personal injury including medical mishaps.

Civil liability legislation was adopted in response to a perception promoted by the media, following the collapse of the biggest professional indemnity insurer, that professional indemnity insurance was too expensive. The reason given was that courts had awarded to large payouts for negligence to ‘unworthy’ plaintiffs. Therefore, this section evaluates the Ipp Panel’s influence on changes in the law in New South Wales intended to reform the law of negligence.

The following changes to the law are analysed:

1. the Ipp Panel’s interpretation of the Bolam or professional standard as the standard of care;

148 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
149 See Appendix IVA.
2. the requirement for the injury to have been ‘caused’ by the alleged negligence;
3. the question of the foreseeability of harm;
4. constraints on awards of damages from time limits on commencing action; and
5. quantum of damages if negligence is proven.

The discussion then proceeds to a consideration of the fairness of the reforms and concludes that the main result of these changes has been to shift the burden of care from the insurance company of the person alleged to be negligent to the community-funded health system. Yet, whilst the legislation relieves many doctors from liability for negligent conduct, there is no evidence that fewer patients are being injured.  

1 Background

In March 2001, HIH Insurance Company collapsed. At the time it was Australia’s largest general insurer. One of its subsidiaries, United Medical Protection, was the professional liability insurer for many professional groups, including many medical practitioners. As was stated in the Report of the HIH Royal Commission, the collapse caused great hardship for many and left thousands of people and businesses exposed to liability. In the wake of the collapse, professional liability insurance was difficult for professional people and community groups to obtain, leading to proposals for tort law reform.

2 The Insurance ‘Crisis’

Historically, doctors took out their professional indemnity insurance through mutual medical defence organisations, run by and for doctors. As these were mutual funds they were not regulated at that time by the Australian Prudential Regulation Authority (APRA) the way insurance companies were. The cover provided was on a ‘claims incurred’ basis, that is, any incident that occurred during the year for which the medical practitioner had paid the contribution was covered, no matter when the claim was actually made.

153 Fiona Tito Wheatland, Medical Indemnity Reform in Australia: "First Do No Harm" (2005) 33 Journal of Law, Medicine & Ethics 429, 430.
Owing to competition between these medical defence organisations, premiums were kept relatively low. Depending on jurisdiction, every medical practitioner paid the same premium despite speciality and the greater risks attaching to some specialties. While times were good, the investment income of these organisations was making up any shortfall between income received and outgoings for claims. This feature was assisted by the fact that money was coming in sometimes many years before any potential claim had to be paid. Consequently, medical defence organisations were not making any provision for those claims that had been incurred but not reported. When investment income was reduced in the early 1990s because of lower investment returns generally,\textsuperscript{154} the shortfall started to become apparent.

Mutual organisations cannot simply raise capital. They either have to raise premiums or make a call on their members.\textsuperscript{155} As the unfunded liabilities became more glaring, many of these organisations did either or both to generate sufficient income to create adequate reserves. In the mean time, some smaller commercial insurers came into the market offering ‘claims made’ products.\textsuperscript{156} These products were priced more cheaply as the cover applied to claims actually made in the year the premium was paid. There was no provision for future claims. If the insurer did not continue in the market, medical practitioners were left with no cover for those claims that had been incurred but not yet notified and had to take out additional insurance for security.

When some practitioners realised that they were cross-subsidising specialists who were earning considerably higher incomes and incurring greater risks, they argued that this situation was unfair. Thus, as the large pool of undifferentiated medical practitioner risks began to crumble, those in higher risk specialties were faced with substantially increased premiums.\textsuperscript{157} The previous relatively-stable and loyal membership of medical defence organisations started to break down as members changed to try to obtain cheaper cover.\textsuperscript{158}

\textsuperscript{155} Ibid.
\textsuperscript{156} Ibid.
United Medical Protection was the major insurer for medical practitioners in New South Wales and the Australian Capital Territory. It had pursued an aggressive strategy aimed at increasing its market share including undercutting the premiums of other insurers\(^{159}\) before revealing to its members the extent of its unfunded liabilities.\(^ {160}\) Several medical defence organisations had been using HIH insurance as a reinsurer. When HIH collapsed in March 2001, the extent of exposure by United Medical Protection was revealed. In 2002, United Medical Protection collapsed. Because these collapses were seen as a pressing problem, and as a result of lobbying by the medical profession, the Commonwealth Government stepped in to cover the unfunded liabilities of medical defence organisations,\(^ {161}\) of which United Medical Protection was the largest.

3 The Ipp Panel

Frantic lobbying by the medical profession and the insurance industry, plus hysteria generated by newspaper reports about undeserving plaintiffs, was instrumental in convincing parliamentarians.\(^ {162}\) The public alarm goaded the Commonwealth Government into being seen as ‘doing something’ to enable reforms. A review panel (the Panel) was established by the Australian Treasury under the leadership of Justice Ipp, ‘to undertake a “principles-based” review’ of the law of negligence.\(^ {163}\) At the time, Justice Ipp was an Acting Judge of the New

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\(^{160}\) Fiona Tito Wheatland, ‘Medical Indemnity Reform in Australia: ”First Do No Harm”’ (2005) 33 *Journal of Law, Medicine & Ethics* 429, 432.

\(^{161}\) Peter Cane, ‘Reforming Tort Law in Australia: A Personal Perspective’ (2003) 27 *Melbourne University Law Review* 649, 656. The influence of the medical profession on government policy was manifest in that it convinced the government to pay out taxpayer funds to prop up the medical defence organisations, whose ‘problems’ were largely of their own making. It also provided premium support for medical practitioners when professional indemnity insurance was expensive and hard to obtain. That paying to maintain insurance of medical practitioners out of taxpayer funds was successful is reflected in the fact that the Commonwealth had still been providing money in respect of claims, over ten years after the medical indemnity ‘crisis’ was revealed. The National Commission of Audit Report reflected the ongoing nature of Commonwealth Government support in subsidising premiums for medical practitioners and providing financial assistance to medical indemnity insurers and medical practitioners in respect of high cost claims. This report noted that players in the medical defence industry had been making substantial profits. It recommended that the premium support scheme be ceased. Whilst in 2012–3, the scheme supported fewer than 2000 medical practitioners to the tune of over nine million dollars, in addition the Commonwealth paid out nearly two and a half million dollars in administration costs. (National Commission of Audit, *Towards Responsible Government*, Appendix Volume 2 (February 2014) [10.16 Medical Indemnity] <http://www.ncoa.gov.au/report/docs/appendix_volume%202.pdf>.)


South Wales Court of Appeal. The Panel, which reported in 2002, made wide-ranging recommendations for legislation to be enacted to include substantial reform of the law of torts and limitation of the size of damages awards. The Panel recognised that its recommendations may shift the burden to injured people from those who injured them. Some who might have been compensated under the current system would not be so compensated under a system legislated following their recommendations. Whilst the Panel substantially adopted ‘principles-based’ review, by its own admission some recommendations chose arbitrary figures. As the Panel stated: ‘The choice of a long-stop period is necessarily arbitrary’. It also stated:

The problem of ‘arbitrariness’ is not so great when ... limitations are imposed by statute because they can be justified on grounds of distributive and social justice to which the courts are wary of appealing. But this may not remove the perception that ... limitations are essentially arbitrary, and to that extent, unfair.

The terms of reference for the inquiry recited: ‘The award of damages for personal injury has become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another.’ As Faunce relates, the Panel was not permitted to examine the true nature of the insurance market nor the reasons for the so-called insurance crisis. It could not inquire into the insurance industry to determine whether the difficulties being experienced by some companies were not, in fact, due to increasing civil liability litigation and the size of damages awards. The difficulties may have been the result of poor investment and financial decisions being made by the companies themselves.

All states and the Australian Capital Territory passed legislation to amend the common law so as to limit liability for death or personal injury caused by negligence. Whilst in most of the jurisdictions the legislation referred to all professionals, rather than just medical practitioners, at the time it was the medical

164 Spigelman CJ and the Judges of the Supreme Court of New South Wales, Farewell Ceremony for The Honourable Justice Ipp AO upon the Occasion of his Retirement as a Judge of the Supreme Court of New South Wales (13 November 2009) [12].
166 Ibid [1.20].
167 Ibid [6.36].
168 Ibid [9.24].
169 Ibid ix.
171 Civil Law (Wrongs) Act 2002 (ACT), Civil Liability Act 2002 (NSW), Civil Liability Act 2003 (Qld), Civil Liability Act 1936 (SA), Civil Liability Act 2002 (Tas), Wrongs Act 1958 (Vic) and Civil Liability Act 2002 (WA). Northern Territory legislated some aspects of the Ipp Review but not others e.g there is no reference to standard or duty of care, causation, or burden/onus of proof.
172 Thomson Reuters (Professional) Australia, The Laws of Australia [27.2].
practitioners who were being heard most clearly and who wanted their liability capped.

4  Tort Law ‘Reform’

In consequence of the Ipp Panel’s recommendations, tort law ‘reform’ has led to extensive changes to civil liability legislation that has had the effect of constraining patient access to adequate injury compensation, including for medically caused injury. In consequence, patient interests appear to have been pushed aside from their position as the core of patient-centred care in favour of interests of medical practitioners. The actual legislation varies from jurisdiction to jurisdiction, despite the wishful thinking of the Panel that uniform, or at least consistent legislation should be enacted in all Australian jurisdictions. Far from making personal injury practice more uniform throughout Australia, the legislative changes have made it much more complicated than it already was.

Because New South Wales is the most populous state, some sections of the Civil Liability Act 2002 (NSW) as passed in response to the Ipp recommendations, will be analysed to show how valid claims of some injured patients can be discounted in the face of medical practitioner concerns. Those sections chosen particularly exemplify the dichotomy between patient and professional interests. However to provide a fuller picture of the civil liability changes, Appendix IVA lists how legislation for some specified matters differs from jurisdiction to jurisdiction.

(a) The ‘Professional’ Standard of Care

Whilst content to accept the common law principles for the existence of a duty of care, the Panel spent a substantial amount of time looking at what the standard of care should be. The question was whether the court should be the final arbiter of the standard required or whether the Bolam formulation should be accepted. Under the law in force at the time of the Panel’s deliberations, it was clear that the courts will never be required to defer to a reasonable body of expert opinion as

174 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, 587.
such but could accept that opinion in the circumstances unless there was a good reason to reject it.\textsuperscript{175}

The Panel debated several ideas about how a court should determine between views of groups of expert medical opinion, those that are widely accepted, those that are generally held or should the court make its own decision. The Bolam test gave too much opportunity for irrational views to prevail, even though this was rare. Which body of opinion represented best practice could not be determined under the classic Bolam formula but the principle may be acceptable if the test were redefined.\textsuperscript{176} The Panel therefore determined that the Bolam test as the measure for determining the standard of care where a medical practitioner has been alleged to be negligent should be:

A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.\textsuperscript{177}

This formulation does not take into account the substantial modification of the reach of the Bolam standard, particularly by Rogers and Montgomery.

Kirby J has criticised the legislation passed in New South Wales in the wake of the Ipp recommendations. In Harriton v Stephens, he observed: ‘[T]he legislation is fundamentally restrictive. The obstacles for plaintiffs seeking damages in tort, especially where the damages are sought in respect of personal injury, have been considerably increased’.\textsuperscript{178} According to Kirby J: ‘[t]his Court's decision in Rogers v Whitaker has been partly confined. The principle in Bolam v Friern Hospital Management Committee has been resurrected in a modified form’.\textsuperscript{179}

The Bolam standard has been criticised on many fronts. Firstly, it gives too much weight to extreme opinions.\textsuperscript{180} The case of Hucks v Cole\textsuperscript{181} was provided as an example where the court was given evidence that a body of opinion would not have prescribed penicillin. However, the court determined that the medical practitioner

\textsuperscript{176} Ibid 40.
\textsuperscript{177} Ibid 1 (Recommendation 3).
was negligent in that he could have been provided penicillin cheaply and easily and, if so, the plaintiff’s problems would not have arisen.\textsuperscript{182}

Secondly, the ‘opinion widely held by a significant number of respected practitioners’ may well be out-of-date. Healy and Braithwaite argue that medical practitioners are slow to translate evidence into practice.\textsuperscript{183} Similarly, as mentioned in Chapter III, Gawande reports a US study that found that it took 17 years for doctors to adopt new treatments for half of American patients.\textsuperscript{184} Therefore, the opinion of a group of practitioners about a certain treatment may well be wide of the mark without being irrational as required by the \textit{Bolam} formulation recommended by the Ipp Panel.

Thirdly, the \textit{Bolam} test would be inconsistent with any move to evidence-based care. The majority of members of the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group was against reintroduction of the classic \textit{Bolam} test.\textsuperscript{185} They were adamant that the \textit{Bolam} test should not be reintroduced.

A move back towards \textit{Bolam} would be inconsistent with the move to improved quality and safety through systemic change based on data and more evidence based care. It could lead to the unacceptable result that a practice favoured by a small body of doctors would not be regarded as negligent, even if a substantial majority of doctors were [sic] critical of that practice.\textsuperscript{186}

The group had observed that even in the United Kingdom, the cases had been moving away from the strict \textit{Bolam} standard\textsuperscript{187} toward the Australian view exemplified by \textit{Rogers v Whitaker}.\textsuperscript{188} This move has now been concluded through the case of \textit{Montgomery}.\textsuperscript{189}

\textsuperscript{182} \textit{Hucks v Cole} [1993] 4 Med L Rev 393, 397 (Sachs LJ). Also presented to the court was the example from New Zealand’s National Women’s Hospital where the group of medical practitioners concerned took the decision not to treat some women whose pap smears indicated cervical cancer. Women were divided into two groups, one of which was treated whilst the other group was ‘observed’ to follow the progress of the disease. This caused outrage in the public because of the deliberate omission to treat those women.(Ipp Panel 39).


\textsuperscript{184} Atul Gawande, \textit{The Checklist Manifesto} (Profile Books, 2011) 133.

\textsuperscript{185} Australian Health Ministers Advisory Council, \textit{Responding to the Medical Indemnity Crisis: An Integrated Reform Package} (2002)[6.37]. The representative of the AMA supported its return.

\textsuperscript{186} Ibid [6.39].

\textsuperscript{187} Ibid [6.38].

\textsuperscript{188} \textit{Rogers v Whitaker} (1992) 175 CLR 479.

\textsuperscript{189} \textit{Montgomery v Lanarkshire Health Board} [2015] UKSC 11.
The Victorian Law Reform Committee had earlier recommended that ‘[t]he common law standard of reasonable care in medical negligence cases is appropriate and should not be replaced by a statutory standard ... ’. 190 It had received submissions that argued that a return to the Bolam standard provided the ‘ultimate sanction of peer review’. Otherwise health care providers were being judged on inappropriately high standards of care. 191 Nevertheless, the AMA Victoria Branch had accepted that the profession recognised that it was accountable to patients ‘not by reference to a body of peer opinion but by reference to a reasonable person in the patient’s position’ in accordance with Rogers. 192

The New South Wales legislation has gone further than the Ipp recommendation. Section 5O of the Civil Liability Act 2002 (NSW) is in the following terms:

(1) A person practising a profession (a professional) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

Sub-sections (3) and (4) particularly are additions to the Ipp formulation and, given the criticism of Healy and Braithwaite, and Gawande above, leaves the court with a choice among many ‘widely accepted’ opinions that may, in the light of scientific evidence, no longer be good medicine, but yet are not irrational. 193 It is submitted that failure by medical practitioners to be conversant with the latest scientific evidence, is itself negligent. The evidence of slow uptake of new treatments is supported by the fact of the introduction in 2013 in the United Kingdom of a system of revalidation of medical practitioners designed to ensure that each is up-to-date and fit to practise. The idea and process of revalidation was explored in more detail in Chapter III.

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191 Ibid [2.37].
192 Rogers v Whitaker (1992) 175 CLR 479.
193 The option to choose among differing widely accepted views comes back to the court’s choice, believe the plaintiff’s experts or believe those of the defendant.
(b) Causation

Even when a claimant has provided evidence that has shown that the conduct of the defendant has been negligent, the claimant must overcome a further hurdle by showing that the conduct in question actually caused the injury being complained of. In its consideration of Causation and Remoteness of Damage, the Ipp Committee commented that

[There appears to be a perception amongst various groups that courts are too willing to impose liability for consequences that are only “remotely” connected with the defendant’s conduct. In other words, there is a feeling that the net of responsibility for the consequences of negligence is being cast too widely.]

The whole issue of determination of causation is complex. The first matter that a claimant must show is that the injury would not have occurred ‘but for’ the conduct of the defendant, that is that the conduct was a necessary condition for the harm. In Chester v Afshar, Lord Bingham summarised the problems with the ‘but for’ test as follows:

It is now ... generally accepted that the “but for” test does not provide a comprehensive or exclusive test of causation in the law of tort. Sometimes, if rarely, it yields too restrictive an answer ... [m]ore often, applied simply and mechanically, it gives too expansive an answer.

Stapleton’s analysis of the principles of causation was undertaken because of the cumulative effect of vague terminology that had plagued this area of the law. She reflected on the American Law Institute’s examination of Liability for Physical Harm and noted that it had separated the factual issue of cause from the question of scope of liability. In her view there were two questions to be determined, the factual historical question of whether the tortious conduct of the defendant led to the injury sustained by the claimant, and whether the defendant should be held liable for those consequences.

Stapleton’s analysis was adopted by the Ipp Panel. The Panel resolved that the law surrounding causation should be clarified and recommended that the two aspects of causation, factual causation (entirely factual) and scope of liability (entirely normative), should be spelled out in legislation. It was relevant to

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198 Wallace v Kam (2013) 87 ALJR 648, 651 (The Court).
199 Wallace v Kam (2013) 87 ALJR 648, 651 (The Court).
consider the circumstances in which liability should be imposed or whether the circumstances meant that the harm and damage should lie where it fell.

The normative question leaves wide scope for the court to deny liability for admittedly negligent conduct. In both Chappel v Hart and Chester v Afshar, the relevant courts held that, if the patient had been properly warned, neither would have undertaken the operation at the time when it did occur. Consequently, the medical practitioner in each case was liable for the injury that occurred, even though injury would be unlikely to be sustained on another occasion. As Skene and Luntz comment:

Essentially the normative judgement is that it is necessary to modify the ordinary rules of causation in order to reinforce the obligation which the law places on the doctor to take reasonable care in disclosing material risks.

Yet in Rosenberg v Percival a failure to warn did not lead to a finding that it caused the injury, as the court decided that the patient would have proceeded anyway.

The NSW Parliament has legislated the two pronged analysis in its section 5D(1). Section 5D(1) of the Civil Liability Act 2002 (NSW) provides:

(1) A determination that negligence caused a particular harm comprises the following elements:
(a) that the negligence was a necessary condition of the occurrence of the harm (factual causation), and
(b) that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (scope of liability).

In applying section 5D, the court in Wallace v Kam spelled out how the Stapleton analysis clarified the law:

[a] determination inevitably involves two questions: a question of historical fact as to how a particular harm occurred; and a normative question as to whether legal responsibility for that particular harm occurring in that way should be attributed to a particular person. The distinct nature of those two questions has tended … to be overlooked in the articulation of the common law. In particular, the application of the first question, and the existence of the second, have been obscured by traditional expressions of causation for the purposes of the common law of negligence in the conclusory language of “directness”, “reality”, “effectiveness” and “proximity”.

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201 Chester v Afshar [2005] 1 AC 134.
204 Wallace v Kam (2013) 87 ALJR 648, 651 (The Court).
The court in *Wallace v Kam* found that, despite the fact that the surgeon had failed to disclose two risks, one more potentially catastrophic than the other, the claimant could only establish causation if the actual injury was caused by the undisclosed risk. Mr Wallace had argued that he would not have proceeded if the potentially catastrophic risk had been disclosed. However, the less damaging risk was the one that occurred, and so Mr Wallace could not succeed.

Faunce was highly critical of the outcome of this case. He argued that

> [t]he final tragic irony may be that the structures of the modern medico-legal system are so obsessed with the pursuit of individual blame and the increasingly dominant private corporate architecture so focussed on risk and liability minimisation and profit maximisation, that those working within it ... continue to suffer a systemic blindness ... concerning their ability to change them to better reflect a genuine commitment to upholding ... foundational professional virtues ... [i]t is unlikely that such a situation will long be tolerated.\(^{205}\)

(c) **Foreseeability of Harm**

In *Wyong Shire Council v Shirt*, the High Court had specified that, to be real, a foreseen risk must not be ‘far-fetched or fanciful’.\(^{206}\) The fact that a risk is foreseeable does not necessarily justify a finding of negligence against a person who failed to take action to avoid the risk.\(^{207}\) Even where a risk is foreseeable, a reasonable person might disregard it.\(^{208}\) Once the foreseeability of the risk has been established then the action that a defendant should have taken is subject to the ‘negligence calculus’,\(^{209}\) formulated by Mason J in the *Shirt* case, that has four elements:

(a) the probability that the harm would occur if care was not taken;  
(b) the likely seriousness of the harm;  
(c) the burden of taking precautions to avoid the harm; and  
(d) the social utility of the risk-creating activity.\(^{210}\)

The court does not consider these elements separately but asks what would be obvious to the ‘reasonable person’ in the position of the defendant. The fact that a risk is foreseen does not necessarily make the defendant liable and similarly, a defendant cannot be held liable for unforeseen consequences when it would have been reasonable for the defendant not to have actually foreseen what, in the result,

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\(^{209}\) Referred to in *Vairy v Wyong Shire Council* (2005) 223 CLR 422 as the ‘Shirt calculus’ – see eg, 442, 447, 455 (Gummow J); 456, 460, 462, 464, 466 (Hayne J).

occurred. As the Panel observed: ‘The fact that a risk is foreseeable (even as a not insignificant possibility) does not, by itself, justify the conclusion that the reasonable person would have taken precautions against it.’

The Panel was concerned that the ‘far-fetched or fanciful’ test might be followed by lower courts to hold a defendant responsible where he or she had not taken precautions to prevent the risk from occurring. The Panel therefore suggested that the test be modified to one of a ‘not insignificant’ risk though the Panel warned that all limbs of the ‘negligence calculus’ should be taken into account in determining the liability of a defendant. The panel therefore proposed that legislation for the test for foreseeability should not only embody the ‘not insignificant’ formula but should also repeat the four elements of the ‘negligence calculus’. The Ipp modification of the test for foreseeability means that defendants are only liable where the foreseeability of the risk is not insignificant. Yet, a comparatively insignificant risk could have devastating consequences.

Spigelman had suggested that, rather than legislate to prescribe the test for foreseeability, what may be appropriate in respect of modification of the tests for foreseeability was

[I]legislation that permits reappraisal and future development of the common law, rather than a code that prescribes a test. A provision which states that, in determining whether a duty of care was breached, a court must always have regard to the remoteness of a risk irrespective of how readily it could be avoided, would probably be enough.

However, despite that, New South Wales has legislated the Ipp formulation as section 5B of the Civil Liability Act 2002 (NSW). Section 5B(1) is as follows:

(1) A person is not negligent in failing to take precautions against a risk of harm unless:
   (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and
   (b) the risk was not insignificant, and
   (c) in the circumstances, a reasonable person in the person’s position would have taken those precautions.

Once again, the formula will be applied relying on ‘expert’ evidence to decide what was ‘foreseeable’, whether a risk was ‘significant’ and what a ‘reasonable’

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212 Ibid 105.
213 Ibid 106 (Also see Recommendation 28).
214 Ibid 106.
person would have determined in the circumstances. This is exchanging one set of vague terms for another and it is not clear whether these interpretations will have made any difference to the determination of negligent conduct.

(d) Damages

Even if an injured patient has shown that, not only was a duty of care owed, the defendant’s standard of care was inadequate, that the conduct had caused the injury and that the defendant should have foreseen its occurrence, there still may be no right to be adequately compensated. Recovery of damages is limited in accordance with civil liability legislation some of which was in existence prior to the report of the Panel — certainly in New South Wales. The Panel had recognised that, in the context of awards of damages for injury, the most important aspect is to obtain adequate funds for necessary ongoing support and assistance for the most seriously injured and that the basic principle for assessment of damages should be the ‘full compensation principle’.216

The second term of reference for the Ipp Panel was: ‘Develop and evaluate principled options to limit liability and quantum of awards for damages’. The Panel noted that, despite this term of reference, it did not think that change should be ‘recommended merely for the sake of reform or to reduce liability’.217

This part of the Panel report must have been a nightmare for the panelists. Each jurisdiction had its own tariffs, thresholds and caps both in statute and through court decisions.218 The fact of jurisdictional differences causes great difficulties both for lawyers advising clients in different jurisdictions and for insurers who are trying to set prices for insurance premiums.219 These prices are difficult to determine when each jurisdiction is so different from the next, and within some jurisdictions where the damages that can be obtained will depend on whether the injury has been caused by a medical mishap, a motor vehicle accident or an accident at work.220 Other injuries caused by negligence may be treated very differently again. The Panel had expressed support for the aspiration that the law

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217 Ibid 181.
218 Ibid 184.
219 Ibid 187.
relating to negligence should be nationally consistent, especially with regard to
the quantum of damages. Despite this observation, the consequent legislation has
only served to make the jurisdictional variations in damages awards more
disparate.

Tariffs can be developed for death or loss of a limb, or a percentage of loss of
function, but damages for pain and suffering are impossible to specify. People
have differing thresholds for pain and the way inconvenience affects their
amenity. Similarly how does a court assess a loss of expectation of life. The
Panel has recommended that a set of guidelines should be developed and updated
at regular intervals so that some sort of guidance can be given to the courts.

Not only are there tariffs for the various injuries, but there are also thresholds
below which compensation for general damages may not be awarded and caps on
the amount of general damages. The Panel chose to adopt the New South Wales
threshold on the grounds that ‘it is now well-understood in practice and is regarded
as reasonably fair’.
Similarly, with respect to caps, the Panel chose a cap that is
in the middle range of caps payable in various state and territory jurisdictions. As
Spigelman wrote before the Panel reported:

[w]here proposed schemes such as a cap on recovery for a head of damage such as
general damages, with a statutory deeming of this amount to be a fictional worst
case to which all cases must be adjusted. There is no principle in such a cap.
Similarly, thresholds, as variously expressed, are said to be based on a policy to
refuse small claims, but it is hard to discern any principle in determining the cut-off
point.

As the above analysis shows, the Panel’s recommendations have little to do with
principle and are based on what seems to be fair choice among jurisdictional
offerings. An examination of relevant state and territory legislation shows that the
Panel’s recommendations concerning harmonisation of legislation have been
ignored and each state and territory has continued to determine its own level for
thresholds and caps on general damages.

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(the Ipp Report) 183.
222 Ibid 186.
223 Ibid 188.
224 Ibid 192.
Journal 432, 440.
(e) **Limitation of Actions**

Another area where the Panel appears to have departed from principle is in respect of time limits for initiation of actions for compensation for negligently caused injury. As the Panel stated, limitation periods should not be considered as arbitrary cut off points totally unrelated to justice or the society in which they operate. The choice of the time limit must be applied to both plaintiff and defendant and justice is best served if litigation is conducted as close as possible to the occurrence of the event that has led to the litigation. The longer the time goes, the more difficult it is for both parties, but particularly for defendants. Witnesses may die and reliable evidence may be difficult to obtain the longer the time delay. And there is a justice issue for professional people to be able to say that they are no longer liable to be sued for something that happened a long time ago. This is particularly important if claims made cover is all that protected a professional and the question is then how long a retired professional should have to maintain run-off cover. Yet, the Panel clearly stated that its choice of a long-stop time limit was ‘necessarily arbitrary’.

The next question is to determine the date from which the time period should run. There are several choices:

(a) The date of the incident resulting in the damage
(b) The date when the damage occurs
(c) The date when the plaintiff’s cause of action accrues
(d) The date when the plaintiff becomes aware or should have become aware that some damage has been caused.

In the interests of justice between the parties, the Panel suggested that the time period should run from the date of discoverability of the damage. This choice would take into account circumstances where injuries had taken many years to be discovered. The Panel also specified a time limit of three years in accordance with the Terms of Reference. Whilst this time limit was arbitrary, it seemed to the Panel that it gave adequate time for the plaintiff and was more fair to the defendant. The Panel also suggested that there should be no discretion in the court to extend the period as three years from the date of discoverability was more than

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229 Ibid [6.36].
231 Ibid 91.
232 Ibid x.
adequate time to initiate an action. However, it is incongruous that a time limit of six years applies to suing for a debt, whereas the more serious action to obtain care for a person who has been injured, particularly by the negligence of another, should be limited to three years.

Given the fact that some damage does not manifest itself until many years later, the Panel recommended that there should be a long stop period beyond which the plaintiff should not be able to initiate litigation. The Panel chose a figure of 12 years as the most just between the parties. However, in some circumstances where the condition could not be found for many years, the court should be given a discretion to override the long stop provision in the interests of justice, also recognising that the wider the time gap from the original damage, the more difficult it will be for both parties. In this circumstance, the court will take into account the extent of loss to the plaintiff and the seriousness of the lapse in the conduct of the defendant.

The setting of limitation periods to apply nationwide is one area of the ‘reforms’ that appears to have been adopted fairly consistently throughout the country. There is no compulsion on any jurisdiction to fall into line but the reasoning of the Panel seems to have been accepted by the legislators in each jurisdiction.

In New South Wales, limitation periods are governed by the Limitation Act 1969 (NSW) and reflect the Panel’s recommendations. Section 50C(1) provides:

(1) An action on a cause of action to which this Division applies is not maintainable if brought after the expiration of a limitation period of whichever of the following periods is the first to expire:
   (a) the 3 year post discoverability limitation period, which is the period of 3 years running from and including the date on which the causes of action i discoverable by the plaintiff,
   (b) the 12 year long-stop limitation period, which is the period of 12 years running from the time of the act or omission alleged to have resulted in the injury or death with which the claim is concerned.

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233 The Panel of Eminent Persons, Review of the Law of Negligence, Final Report (September 2002) (the Ipp Report) 91. Whilst the panel stated that the choice of time limits for initiating an action for negligent personal injury should not be regarded as arbitrary because of ‘the demands of justice or the general welfare of society’ [6.1], the same considerations apply to breaches of contract where time limits are much more generous. Why is it that witnesses in breach of contract matters have longer memories than those involved in personal injuries?
235 Ibid 94.
5 Criticism of Tort Law ‘Reforms’

The reforms to the law of torts have been criticised by many commentators. Justice Ipp himself commented that in many ways the reforms had gone much further than those recommended by the Panel. The Australian reported Justice Ipp as saying that tort reform had gone too far and that he intended to take the message to the insurance industry. Toomey Pegg, writing in Findlaw Australia, commented that tort reform had not been approached in a comprehensive and principled way.

Governments wanted the quickest fix for skyrocketing premiums without looking at the other side of the equation: what compensation do victims of negligence need and how best can that need be met?

The requirement to find ways to reduce insurance premiums was one of the terms of reference for the Ipp panel and was referred to in the Introduction to the Ipp Report where the interaction between the law of negligence and insurance was noted. The Panel commented that the assertion in a communiqué from a meeting of Ministers from the Commonwealth, states and territories that there was a relationship between the law at that time and rises in insurance premiums, was not investigated and the Panel made no finding about it.

Faunce has criticised both the composition of the Panel and its findings. He argued that the members of the Panel were on the insurers’ ‘wish list’. Because the Panel was not permitted to examine the work of APRA, it was not possible to investigate whether in fact there had been an insurance crisis at the time of the change to legislation. If there had been a crisis, then APRA was responsible for failing to check the management and investment decisions of the insurers.

Chief Justice of Queensland, Paul de Jersey and president of the Australian Lawyers Alliance, Tom Goudkamp both were reported as stating that, in their


view, tort law reform had gone too far.241 Faunce tells of an extra-curial speech of Chief Justice Paul de Jersey remarking that the fundamental right to personal safety and the patient’s right to receive compensation for injury had been compromised by legislation enacted following the Ipp recommendations.242 Justice Anthony Whealy, reviewing the law of negligence, had commented that there was a gap between the rhetoric of law reform and the substance of the reform in fact achieved.243

As Faunce observes:

[ ]he tragedy for patients and their relatives involved in disclosure of material risk cases has been compounded by a raft of recent legislation in Australian States that has resulted in fewer claims and more profits for medical indemnity insurers, but not fewer patients being injured as a result of adverse events.244

The fact that the insurance industry is making profits while the taxpayer is responsible for looking after the majority of injured persons suggests that the tort law ‘reforms’ have been a method of throwing these obligations onto the public purse. To the extent that insurers do pay some damages, the taxpayer is also subsidising the insurance industry through the taxation system because premiums for professional liability insurance are fully deductible from the taxation of the professional person paying them.245

6 Conclusion

According to Spigelman, one of the motivations for the tort law reforms was that plaintiffs were receiving unnecessarily high payouts, partly because the defendant was insured, and partly because people in the general population were not taking responsibility for their actions.246 Whilst these ideas may well apply to some actions alleging negligence, those arguments do not apply to injury caused by medical practitioners. Firstly, whilst medical practitioners are insured, that should

245 Ibid 63.
not be a motivating factor to reform the law as all professionals must have professional liability insurance. Secondly, when allegedly negligent activities of medical practitioners occur, it is in the context of medical treatment to which patients have consented. Agreeing to a medical procedure is outside the context of people taking responsibility for their own actions unless they have been provided with full and relevant information in order to decide to consent or not. Yet, patients have placed themselves in the care of medical practitioners and are entitled to expect that all conduct of the medical practitioner and all treatments to which they have agreed will be undertaken with due care.

There are just as many injuries to patients from negligent conduct by medical practitioners as before the statutory changes.\(^2\)\(^4\) It has been estimated that 10% of admissions to acute care hospitals in Australia are linked to adverse events that are probably preventable.\(^2\)\(^8\) Yet, as this section has shown, access to adequate compensation has been compromised by the changes to civil liability legislation. The *Bolam* standard has been reintroduced partly because the courts had downgraded its ambit. Whilst clarification of the law respecting causation and foreseeability of damage has been beneficial, the apparently arbitrary time limits on initiating legal actions for compensation and the similarly arbitrary caps on quantum of damages has meant that fewer injured patients are compensated through the tort system. Consequently, injured patients have to seek care through the publicly-funded health system.

In light of the above, the question arises as to whether many of the problems associated with tort actions in personal injury negligence could be eliminated by moving away from them. It is to an exploration of arguments concerning the possibility of ‘no fault’ liability for personal injury to which this thesis now turns.

**E ‘NO FAULT’ INJURY COMPENSATION — HAS THE TIME COME?**

The system is now out of alignment with other policy initiatives on quality and safety: in fact it serves to undermine those policies and inhibits improvements in the safety of the care received by patients. Ultimately, we take the view that it will not be possible to achieve an environment of full, open reporting ... when, outside it,
there exists a litigation system the incentives of which press in the opposite
direction. We believe that the way forward lies in the abolition of clinical negligence
litigation, taking clinical error out of the courts and the tort system.249

1 Introduction

As the analysis in Chapter VI will show, a significant barrier to implementation of
open disclosure of medical errors is the failure to disclose a possible adverse event.
Fear of being blamed and subject to litigation, or embarrassment over being seen
by colleagues as clinically and personally deficient, lead to reluctance to report
adverse events. Consequently, as the aviation industry has demonstrated,250
introduction of a blame-free culture may lead to better reporting and the
consequent opportunity to learn from the error and improve the system.251 As
Studdert and Brennan observe: ‘Fear of blame among those individuals closest to
errors ... poses a major obstacle to design and implementation of patient safety
initiatives’252

2 Goals of ‘No Fault’ Systems of Injury Compensation

Notwithstanding, the opportunity for regulators, health service organisations and
medical practitioners to learn through increased reporting is not the only argument
in favour of a ‘no fault’ medical injury compensation scheme. Whilst that is
certainly one goal for ‘no fault’ systems, it is not the only one. Studdert and
Brennan list five goals to ‘... address the need to prevent medical errors and
efficiently compensate medical injuries once they occur’.253

- the program should encourage physicians and other health care providers to report errors,
  especially those that cause medical injury;
- the program should strive to send strong quality improvement signals (including with
  financial incentives - or enterprise liability254);
- mechanisms must be in place even in a ‘no fault’ compensation system for those rare
  occasions where patients are harmed by physicians who are incompetent, dangerous, or
  malevolent;

249 Ian Kennedy, Learning from Bristol, Report of the Public Inquiry into Children’s Heart Surgery at
250 See eg, Paul Barach and Stephen D Small, ‘Reporting and Preventing Medical Mishaps: Lessons
from Non-Medical Near Miss Reporting Systems’ (2000) BMJ 759, 762; Lucian L Leape, ‘Reporting
251 P Davis et al, ‘Preventable In-Hospital Medical Injury under the “No Fault” System in New
252 David M Studdert and Troyen A Brennan, ‘Toward a Workable Model of “No-Fault”
Compensation for Medical Injury in the United States’ (2001) 27 American Journal of Law &
Medicine 225, 228.
253 David M Studdert and Troyen A Brennan, ‘No-Fault Compensation for Medical Injuries: The
254 C Vincent, ‘Compensation as a Duty of Care’ (2003) 12 Quality and Safety in Health Care 240,
241.
the compensation program should reinforce rather than undermine the honesty and openness of the patient-physician relationship;

• where appropriate, patients should be compensated in a manner which is speedy, equitable, affordable, and predictable.\(^ {255} \)

The educational value of reporting, appropriate compensation, the doctor-patient relationship, the ability to discipline the incompetent and quality improvement are all goals of patient-centred care as outlined in Chapter I.

3 Other ‘No Fault’ Injury Compensation Systems

One observation made by the Ipp Review was that there may be an argument for developing a no-fault system to deal with personal injuries including medical injuries. As the report states:

\[ \text{[i]t needs to be said that many of the people and organisations we consulted and who have made submissions to us argued that there is a strong case for a no-fault system of compensating injured persons. This is clearly not an issue within our Terms of Reference, and we make no comment on it save to draw attention to the fact that there is a significant body of opinion that supports the implementation of such a system.} \(^ {256} \) \]

There is experience in other countries in various types of no-fault schemes. New Zealand has the most comprehensive scheme but there are also comprehensive ‘no fault’ schemes for medical injury operating in the Nordic countries, Sweden having implemented its system first.\(^ {257} \) However, there are also no-fault schemes for workers compensation in all Australian jurisdictions, and motor vehicle injuries of people resident within the jurisdiction, are covered by no-fault schemes in New South Wales, Victoria and Tasmania.

The 2011 Productivity Commission Report into care and support for people with a disability\(^ {258} \) recommended the establishment of a National Disability Insurance Scheme. The report also raised the possibility of a National Injuries Insurance Scheme to deal with all sorts of physical injuries caused by accident whether in the

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\(^ {257} \) The Nordic countries base their principal eligibility criterion on ‘avoidability’. (Anne-Maree Farrell, Sarah Devaney and Amber Dar, No-Fault Compensation Schemes for Medical Injury: A Review (Scottish Government Social Research, 2010) 37–38). The scheme aims to promote good relations between health practitioners and injured patients so it is estimated that Swedish medical practitioners facilitate 60–80% of all claims under its system. As Vincent points out: ‘Physicians in Sweden appear to regard assisting with compensation claims as a continuation of the duty of care and as a natural part of their responsibilities to their patients’. (C Vincent, ‘Compensation as a Duty of Care’ (2003) 12 Quality and Safety in Health Care 240, 240).

\(^ {258} \) Productivity Commission, Disability Care and Support, Inquiry Report No 54 (31 July 2011).
home or elsewhere. This would include medical injuries.\textsuperscript{259} It could be funded by agreement between the Commonwealth and the various States and Territories that have some type of no fault scheme for injuries.\textsuperscript{260} Funds from existing mandatory insurances plus contributions from insurance arrangements for hospitals, levies on passenger carrying vehicles and rail tickets, and criminal injuries compensation schemes could also be included.\textsuperscript{261} In whatever way an injury is sustained, any system should focus on making sure that the needs of every injured person are provided for without the additional cost and stress of proving negligence.\textsuperscript{262}

4 Universal ‘No Fault’ Injury Compensation in New Zealand

The Accident Compensation Corporation (ACC) in New Zealand provides personal injury cover to all people, including visitors, who are injured in that country. Both physical and mental injuries can be compensated. As the web site of the ACC advises:

Everyone in New Zealand is eligible for comprehensive injury cover:

- no matter what you’re doing or where you are when you’re injured, eg driving, playing sport, at home, at work
- no matter how the injury happened, even if you did something yourself to contribute to it
- no matter what age you are or whether you’re working – you might be retired, a child, on a benefit or studying.\textsuperscript{263}

The New Zealand system’s focus is on long term care. It was established after an investigation and report by Sir Owen Woodhouse in 1967.\textsuperscript{264} Over the years it has been modified to take account of some problems that have become clear but its original focus is still in place. A person coming under the scheme has strictly limited rights to pursue litigation through the courts. Ongoing care is the most important aspect of the scheme, though income replacement is also dealt with.\textsuperscript{265} There are also rules about the fact that in some circumstances, the incentive to

\textsuperscript{259} Ibid 44.
\textsuperscript{260} Ibid.
\textsuperscript{261} Ibid 45.
\textsuperscript{265} There are limits to the levels of income replacement possible under the system.
return to work is adversely affected. Regulations are in place to make sure that abuse of the system is minimised.

Whilst some ideological concerns have been brought to bear to criticise the system and to suggest that it should be dismantled or privatised, it remains popular. It would be a brave government that would seriously curtail the system that has generally worked well over the past forty years. The scheme provides necessary care and also adopts processes to make sure that the injured person can achieve as much independence as possible. There will always be people who abuse publicly funded systems, but eventually most of those who do are found out.

As Bismark and Paterson comment, in light of the extended period of time during which the New Zealand scheme has been operating, together with the rise of ‘... systems thinking about the causes of adverse events, the tort system is looking increasingly anachronistic.’

5 Costs and Wastage in the Current Fault-Based System

Luntz observes that; ‘[t]he purposes of tort law are said to be to pass moral judgement on the wrong committed, respond to the victim’s needs, and encourage future safety.’ He goes on: ‘Instead of trying to fulfil all three of these purposes in a single tort action, that often results in none of them being achieved, it would be better to separate these three functions.’ He concludes: ‘Determining whether a patient is entitled to compensation in these cases takes an inordinate time and is horribly expensive.’

The tort-based compensation system has been built on a philosophy of ‘full compensation’ of all costs associated with the injury. Income replacement plus care costs and the costs of rehabilitation calculated over actuarially determined

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268 For example, in Australia, debts to the social security system through fraud and inadvertence are not wiped out in any bankruptcy but remain outstanding for the life of the person concerned.
expectancy of life can mean that an insurer may face many millions of dollars in compensation costs, especially when a young person is injured.

The current fault-based system of compensation for personal injuries is highly inefficient.272 A great deal of money is spent on the investigation process undertaken by an insurer when a claim is made.273 Those costs are passed on to the community through higher premium costs for insurance. It also makes the whole tort system slow as it is in the interests of some insurers to dispute every aspect of a claim.274

Legal costs have been estimated to consume up to 40% of any pay out275 whereas administrative costs in the New Zealand system only amount to 10%.276 These legal costs include payment of court costs, legal costs of each party and employment of expert witnesses for each side of the action. A cost that is well-known but less able to be quantified is the stress on injured plaintiffs caused by the court proceedings. All these costs are largely unnecessary when the tort fault-based system is bypassed in favour of no fault liability.

Some commentators have raised concerns about the fairness and operation of civil liability legislation passed in wake of the Ipp Report recommendations. Personal injury compensation through tort negligence actions in the court has now been altered by this legislation that aims to reduce the amount of compensation that a person can receive. Not only is this unfair to the injured person, but it means that the full costs of a negligent act are not borne by the body or person responsible for the injury. The argument is that the awarding of costs provides a deterrent so that people will be more careful.277 In fact, because the costs are actually paid by the insurer, this direct influence on behaviour is minimal. In recommending limits on quantum of damages, the Ipp committee took into account that few negligence

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claims are brought in actions through the courts and that the bulk of injuries is compensated through the social security system that is much less generous.\(^{278}\)

An important aspect of wastage in tort law compensation is the fact that awards of damages can, even with the best actuarial information, be inadequate to provide compensation, care and where possible, rehabilitation for the life of the patient. However, if the patient dies earlier than anticipated, the family or other beneficiaries may make a windfall. In a no-fault system, because there is reimbursement of the actual costs of care, there is less wastage.

Other factors can cause an award to be inadequate. The actuarial calculations can only marginally take account of economic factors and government policies that will affect the amount of money available to provide ongoing care and rehabilitation. In addition, some people are just not good managers or are profligate with the money so it is dissipated.\(^{279}\)

Ultimately, any shortfall comes back to a community cost. Where an injured person has insufficient funds for care costs, that person will be forced into the public medical system and have to be maintained by the social security safety net. Considering the costs that are borne by the community in this way it becomes sensible to look at how the systems for caring for injured people could be streamlined. The most important factor is that the injured person should receive proper care for the whole of life.\(^{280}\) Proper care includes nursing assistance, other personal help, various aids to make life more acceptable and where possible, to provide a degree of independence.

6 Equity of Access to Compensation

Under the current profusion of laws and regulations that deal with injured people there are many discrepancies. Depending on the jurisdiction, a person who has been injured by a motor vehicle accident, a workplace accident, or a medical injury in a hospital, may be treated in a dramatically different fashion\(^{281}\) even though the injuries may be comparable. Disabilities caused by accident are going to be the same and require the same amount of care whatever their cause. Similarly, there is

\(^{279}\) Ibid [13.124].
\(^{280}\) Ibid [13.2].
\(^{281}\) Ibid [13.10].
a large number of people who cannot access any compensation for an injury. Accidents in the home are a prime example. If there is no-one to sue, or if there is no scheme to which to apply, the social security system is the only way that these people can survive and have their care needs recognised.

The money currently wasted in the tort system, as outlined in the previous section, could be available to fund public care services. Luntz bemoans the fact that there was a missed opportunity to ‘ ... achieve a comprehensive administrative compensation scheme that would have freed medical practitioners from the fear of being sued [that] was presented by .. the Woodhouse Committee Report in 1974’. The Australian Medical Association at the time vigorously opposed the introduction of such a scheme.

Cane also criticises the fault-based tort system by suggesting that: ‘ ... the evidence we have about the positive regulatory impact of tort law is patchy and inconclusive’ and suggests that dissatisfaction in the community with the current tort system could be mobilised to demand legal change. Of course, there will be strong opposition from various lobby groups. For example, the Australian Plaintiff Lawyers Association and insurers will probably be resistant to change. Currently the insurers collect premiums knowing that their liability for large payments to injured people is limited by the civil liability legislation. Whilst premiums have stabilised, it may well be due to improved prudential oversight from the Australian Prudential Regulation Authority as well as the limits on liability for payments of compensation to injured plaintiffs. Either way, profits of insurers have increased. Insurance companies thus have an incentive to still insur in the fields where personal injuries compensation is a cost.

So long as there is no political appetite for legal review to introduce a no fault system for injury compensation in Australia, nothing is going to change. This is particularly the case given pressure from lobby groups, such as those mentioned above, opposing any attempt to alter the current system. Any move to rectify this

283 Ibid 393.
situation would require vocal community pressure on parliamentarians. It would be necessary to convince legislators that the costs of the current (fault-based tort) system are unsustainable. — the very motivation for instigating the Ipp Review in the first place, and reflected in its Terms of Reference.287

7 Social Justice

What is apparent is that the current patchwork of negligence litigation, no fault schemes and social security leads to a sort of compensation lottery.288 This outcome has social justice implications. There is no logical or principled reason for the differences in consequences for the injured people concerned. Implementation of a National Injuries Insurance Scheme would mean that similar injuries would lead to comparable care for the injured person. However, such a scheme would be dependent on getting the states and territories to agree that it is in their interests to divert money currently available for their limited no fault schemes towards funding the national scheme. There is also the parochial attitude that protects existing state and territory fiefdoms. Having a scheme centrally administered would possibly not be acceptable to many jurisdictions perhaps depending on political alignment of the state or territory concerned.289

8 Fault as a Behaviour Modification Incentive

A fiction in the law of the tort of negligence is that the prospect of being subject to legal liability will make practice more safe. As Vincent comments:

the likelihood of being sued is supposed to inject a certain caution into clinical practice and decision making which is supposed to improve patient care. If this were so, one might think that countries operating tort systems would have a lower level of adverse events.290

However, Davis et al suggest that ‘... the underlying level of serious risk to patient safety is relatively uniform across medicolegal systems.’ 291

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289 For example, the Ipp Panel’s expressed wish that law around tort liability should be, if not identical then harmonised, was in vain.
291 P Davis et al, 'Preventable In-Hospital Medical Injury under the "No Fault" System in New Zealand' (2003) 12 Quality and Safety in Health Care 251, 255.
Cane comments that there are two views of the function of ‘... tort law as a regulatory mechanism to promote health and safety’, downplaying its ‘regulatory potential’ and attribution to it of ‘a significant regulatory role’. Luntz observes that ‘... moral judgement is withheld when the clearest cases of medical negligence are quickly settled on confidential terms’. For almost the whole period of independent practice, professional people have been able to insure against professional liability. This means that the prospect of having to pay out huge sums of money is not a concern. More likely to modify behaviour is the publicity, the stress, the possibility of being named as uncaring, let alone incompetent before one’s peers, loss of career prospects and sometimes livelihood together with the prospect of disciplinary proceedings rather than fear of having to pay out money.

9 Conclusion

The adoption of no fault schemes for compensation for personal injury has many more arguments in favour than against. The costs to the community of the existing matrix of the fault-based tort of negligence determined through the court system and various schemes to compensate victims of workplace accidents and motor vehicle accidents, are not going to be any greater than from rejigging the moneys washing through those systems to create a more equitable system of care for injured people. The inherent inequity of some injured people being treated differently depending on the source of the injury, and others having no access at all to any compensation scheme and depending on social service, suggests that access to a no fault system should be available for all injured people. If adopted, a National Injury Insurance Scheme would ensure that the care needs of those injured were the primary community concern. The social security system could be enlisted to provide some income support for injured people. Like New Zealand, access to a no fault scheme should mean that the person concerned would be limited in the opportunities for taking action through the courts. It could even be argued that once the statutory no-fault scheme was accessed, litigation through the court system should be curtailed or prohibited.

Another advantage of a no fault scheme, particularly for medically-caused injuries is the ability of the system to provide information about the incidence and reasons for an injury. This information can then be used as an additional learning tool to feed into recommendations for modification of some procedures and the elimination of others. To the extent that an adverse medical event might not have been reported, the application by a claimant provides accurate relevant information.

Yet, it has been argued that the scheme operating in New Zealand has been no more effective in reducing the incidence of adverse events than the tort systems in place in Australia and the United States. Similarly, Vincent suggests that there is little evidence to support the view that ‘no fault’ systems encourage reporting of errors. On the other hand

the most important criterion for assessment of any compensation system should be its impact on injured patients ... not just in providing appropriate financial recompense where necessary but in ensuring that explanations, apologies, and long term support and care are regarded as the expectation rather than the exception.

The fact that some medical practitioners fail to report adverse events or that the incidence of medical errors is no less in New Zealand under a ‘no fault’ system is no argument against introducing such a scheme. It is the patient-centred aspects of a good ‘no fault’ system of liability upon which attention must be focussed.

Whilst there are constitutional and political barriers to introduction of an overriding National Injury Insurance Scheme, it would be far more sensible and equitable to have a national system provided for in Federal legislation, even if administered by the various states and territories. Trying to get ‘matching’ legislation for general no fault schemes through the eight parliaments of the different jurisdictions is not an easy task. Australia’s federal system has some advantages, but in matters where uniformity between jurisdictions would be most efficient, it can act as a barrier.

This chapter has shown how the professional obligation to practise patient-centred care that is at the heart of laws that endorse respect for patient autonomy can be undermined by some case law and statute. The doctor-patient relationship is one that requires ‘high standards of professional conduct’ including being courteous, respectful, compassionate and honest\(^{299}\) as a way to minimise the inherent power balance between medical practitioner and patient.

Firstly, by insisting that proposed medical treatment must always be based on the judgement of a ‘responsible body of medical opinion’, medical practitioners are ignoring the fact that, for every patient, there are non-medical factors that a patient will be weighing up when making a decision about what treatment to accept or reject.\(^{300}\) The days when paternalistic attitudes and decisions were invoked by doctors have long gone and the courts have firmly rejected any suggestion that ‘Doctor Knows Best’.\(^{301}\) Patients are much better informed and they also assert the right to be involved in decision-making, that is required not only by codes,\(^{302}\) but also by Standard 2—Partnering with Consumers— in the National Safety and Quality Health Service Standards.\(^{303}\) Over the years since the Bolam standard was first adopted, courts have gradually scaled back its reach, but it is still asserted by the medical profession as determining the patient’s best interests.

Secondly, the responsibility of medical practitioners to obtain consent before initiating any medical procedure is dependent on providing sufficient information so that the patient can make an informed choice about whether to proceed or not. Seeking consent is not a mere formality that protects the medical practitioner from litigation, it is a way of recognising the patient’s right to self-determination.\(^{304}\) A consent is not effective if the patient’s decision is made on incomplete information about relevant risks and benefits. The patient’s choice must also be respected whether or not the medical practitioner agrees, as the patient may have conflicting
moral and ethical constraints on what is proposed. However, the tendency to query
the patient’s mental capacity when the patient chooses a course of action not
recommended by the medical practitioner has been assisted by courts that have
carefully formulated detailed tests to determine mental capacity. These tests ignore
the declaration by Lord Donaldson in In re T. (Adult: Refusal of Treatment), that
the decision of the patient should be respected whether it appears rational or not, an
endorsement of the overriding principle of self-determination.

This chapter has also shown how valid claims by injured patients have been
deflected by provisions of civil liability legislation. Legislators reacted to a ‘crisis’
mentality generated by difficulties in obtaining professional indemnity insurance at
a reasonable rate and perceptions that courts were being overgenerous to plaintiffs
at the expense of the doctor’s insurer. Substantial impediments lie in the way of
patients seeking compensation for negligent treatment by a medical practitioner
meaning that many patients can no longer obtain appropriate compensation for
their injuries through the fault-based tort system and have to be supported by the
social service safety net. Rather than a set of principled changes, many proposed
changes are arbitrary as the Ipp Panel acknowledged. In addition, there are no
rational reasons for the differences between general limitation periods and those
imposed for personal injury.

Finally, this chapter raised the question of whether the time has come to institute a
system of ‘no fault’ injury compensation. The limiting factors of Civil Liability
legislation criticised in Section D above, suggest that many such problems could be
overcome by a National Injuries Insurance Scheme.

The values of integrity, truthfulness, dependability and compassion are promoted
by medical practitioner bodies and their codes as being as important as technical
competence. However, the paradox of the medical profession’s conflict between
its ethical commitment to altruism and its self-interest has been a constant theme in
this chapter. The courts have insisted that patient autonomy be respected but the

305 James Munby, ‘Rhetoric and Reality: The Limitations of Patient Self-Determination in
306 As previously mentioned, The Panel of Eminent Persons, Review of the Law of Negligence, Final
307 See eg, Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in
Australia (at March 2014) [1.4]; General Medical Council, Good Medical Practice (at 22 April 2013)
[1]; Royal College of Physicians, Doctors in Society: Medical Professionalism in a Changing World
(Report of a Working Party, December 2005) xi; ABIM Foundation, ACP-ASIM Foundation and
European Federation of Internal Medicine, Medical Professionalism in the New Millennium: A
Physician Perspective (2002).
evidence in this chapter has revealed resistance by medical practitioners where they have perceived that their clinical discretions are being curtailed. As Sir Donald Irvine has observed: ‘The obvious question is why a profession with so many conscientious people could act so defensively. How does this behaviour fit with a profession committed to putting patients first?’\textsuperscript{308}

\textsuperscript{308} Donald H Irvine, ‘Everyone Is Entitled to a Good Doctor’ (2007) 186 MJA 256, 257.
CHAPTER V: ADVANCE DIRECTIVES — WISHES FOR FUTURE CARE

A INTRODUCTION

The gap between the rhetoric of patient-centred care and the reality of medical practice can be on display if patients’ validly created advance directives are not observed by medical practitioners. A desideratum of patient-centred care centres on satisfying patients’ needs, wants and values. Satisfying the patient’s needs, wants and values is accomplished in the context of a partnership between patient and medical practitioner, in an atmosphere of open communication where the patient is treated with dignity and respect — in other words, a convergence of patient-centred care principles. This chapter documents the frustrations and dissatisfaction experienced by some mentally competent patients who, having made decisions about their preferred medical treatment in the future, find their wishes, as expressed in the form of a valid advance directive, overridden or ignored.

It is a primary task of this chapter to suggest ways in which validly-created advance directives might be more fully honoured in medical practice. As a step in this direction, the chapter explores reasons commonly given for disregarding validly-created advance directives. The requirement for consent by a patient before any medical or surgical treatment is administered is a reflection of respect for patient autonomy, a pillar of patient-centred care and an ethical obligation for medical practitioners. In principle, if a competent adult’s right to consent to or refuse medical treatment is accepted for contemporaneous decisions, it should be acceptable for a competent adult to give directions for a future time in anticipation of being then unable to exercise that right. This principle has been recognised by the law, both in legislation\(^1\) and by the common law.\(^2\) Recognition of this principle

\(^1\) See eg, Powers of Attorney Act 1998 (Qld); Advance Personal Planning Act 2013 (NT); Guardianship and Administration Act 1990 (WA).

has also provided the rationale for encouragement by governments of advance care planning.  

Buchanan reports that there are two answers usually given when the value of an advance directive is queried. Firstly, an advance directive is supposed to protect the individual from unwanted medical treatment that may be futile and burdensome and that ‘may prolong a miserable or meaningless existence’. Secondly, as an advance directive allows self-determination, it is valuable in itself.  

The Australian Health Ministers’ Advisory Council recognises that ‘[m]any people fear a loss of autonomy, dignity and the ability to make their preferences known when crucial health and other personal decisions are required after they have lost decision-making capacity’. Thus advance directives provide evidence of patient wishes when medical practitioners are unclear as to what course of action the patient would want in the circumstances.  

Section B explores the legal arrangements that establish the validity and aims of advance directives. A description of the requirements for creation of advance directives at common law is followed by an examination of statutory schemes that have been legislated in order to bolster a patient’s common law rights to give directions about desired future health care. These legislated arrangements are intended to provide clarity to the law that underpins them and to provide some directions to health professionals who must comply with their instructions.  

Even accepting the putative value of advance directives for specifying patient wishes for treatment, some voices have expressed concerns about their defensibility. Thus, Section C investigates some practical difficulties in the implementation of the directions set out in advance directives. In addition, some more philosophical objections have been aired and these will be explored.  

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1 See eg, Department of Health, Advance Care Planning: Have the Conversation (A Strategy for Victorian Health Services 2014-2018) 11; Department of Health and Human Services, Simplifying Medical Treatment Decision Making and Advance Care Planning (January 2016) 14; Australian Health Ministers’ Advisory Council, A National Framework for Advance Care Directives (at September 2011) 5.  
Section D suggests some future directions for the systematic management of advance directives consistent with patient-centred care principles. At the very least, communication of one’s wishes for future care is essential, whether it be by having discussions with family or with medical practitioners, preferably all together. Documenting those wishes in an advance directive formalises the process and underlines the significance of those wishes to the person expressing them.

Section E provides the summary of and conclusions to the chapter. It recapitulates several ways that wishes recorded in advance directives might be better honoured in practice.

B THE LAW UNDERPINNING CREATION AND USE OF ADVANCE DIRECTIVES

1 What Are Advance Directives?

An advance directive is a notice, usually in writing, that is made whilst a person is competent and is intended to give instructions for a future care. Where the person is no longer able, whether through unconsciousness or mental incapacity, to give directions regarding treatment choices, it aims to provide suggestions to guide the person’s management by medical practitioners, hospitals and other health professionals. Many directives also make provision for non-medical preferences, such as whether to refuse to go into a hospital or care facility.

2 Other Less-Controversial Mechanisms for Managing Future Care

(a) Surrogate Appointments by Patient

Whilst this chapter is primarily concerned with advance directives, the other main method for giving directions for medical treatment in a future contingency of losing consciousness or competence is to appoint a surrogate decision-maker. Each jurisdiction has statutory provisions for enduring powers of attorney or guardianships that are intended to remain valid even though the donor of the power has become ‘of unsound mind’. At common law, a general power of attorney authorises the attorney to act under the conditions specified if the donor of the power is absent but it is automatically revoked upon the ‘unsoundness of mind’ of the donor. This fact was not generally known by the members of the public who were surprised when a power of attorney was invalidated precisely at the time
where it was most needed.\textsuperscript{5} This problem has now been remedied by the
enactment of legislation that provides that these appointments, if made in the way
specified by the relevant legislation, will remain valid following the unsoundness
of mind of the donor. Each jurisdiction now also recognises the validity of an
enduring power of attorney or equivalent made under the legislation of another
Australian jurisdiction.\textsuperscript{7}

(b) \textit{Surrogate Appointment by Court or Tribunal}

Each jurisdiction also has provision for appointment of a guardian by a court or
tribunal. That court or tribunal also has supervisory powers to make sure that
directives and appointments are validly made by the appointor and properly
exercised by any appointee. In addition, these bodies can step in if there is any
question as to the validity of an advance directive or enduring power of attorney, or
if someone questions decisions being made or proposed under their terms.

(c) \textit{The Supreme Court’s Parens Patriae Jurisdiction}

As a final point of decision or appeal, the Supreme Court in each State and
Territory has an inherent parens patriae jurisdiction that can be exercised when
necessary.\textsuperscript{8} The parens patriae jurisdiction may arise in circumstances where
resolution of disputes has not been achieved through the lower level judicial
processes or where there has been no other provision made for an appointment of a
surrogate in the circumstances of the particular patient.\textsuperscript{9}

However, this chapter is primarily concerned with advance directives that do not
appoint another person to make necessary treatment decisions. This is because
there are problems that relate to advance directives, such as relevance and
applicability of the medical decision, that only arise when there has been no
appointment of a competent, contemporaneous, surrogate decision-maker or the
matter has not gone to the Supreme Court for a decision.

\textsuperscript{5} See eg, Queensland, \textit{Parliamentary Debates}, Legislative Assembly, 8 October 1997, 3686 (Hon D
E Beanland).

\textsuperscript{7} See eg, \textit{Powers of Attorney Act 1998} (Qld) s 34; \textit{Powers of Attorney Act 2003} (NSW) s 25; \textit{Powers
of Attorney Act 2006} (ACT) s 89.

\textsuperscript{8} This jurisdiction is the court’s power to act in the sovereign’s stead, as a type of caring parent of
citizens.

\textsuperscript{9} Courts in England have bemoaned the fact that their parens patriae jurisdiction for incompetent
adults has been taken away. See eg, \textit{In re F (Mental Patient: Sterilisation)} [1990] 2 AC 1, 51 (Lord
Bridge). This jurisdiction remains in Australian Supreme Courts.
3 Why are Advance Directives Required?

The circumstances under which the powers conferred under advance directives will normally arise are in three medical situations:

- where a treatment is being offered – the power to consent to or refuse treatment, or, when treatment has already commenced, whether it should be withdrawn;
- where the only proposed treatments would be futile in not providing even a minimum of benefit to the patient;
- in an emergency, where the patient is unable to make a decision as to whether life-sustaining treatment should be withheld or withdrawn.\(^\text{10}\)

Notwithstanding, refusal of consent to commencement of treatment or a demand for its withdrawal after commencement may, on occasion, run up against the principle of the ‘sanctity of life’.\(^\text{11}\) Respect for the sanctity of life is the rationale behind the state interest in protecting and preserving the lives of its citizens. However, when this conflict between two ethical principles has come to be resolved before the courts, the principle of respect for individual autonomy should outweigh that for preserving the sanctity of life. As Hoffman LJ in *Bland* affirmed:

> But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self-determination.\(^\text{12}\)

In *Bland*, Lord Goff approved the words of Hoffman LJ and added: ‘To this extent, the principle of the sanctity of human life must yield to the principle of self-determination.’\(^\text{13}\)

4 Self-Determination

The Australian Medical Association (AMA) has issued a policy that states that advance care planning has an important role to play in the recognition of patient

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\(^\text{11}\) There does not appear to be any judicial discussion of what is involved in the concept of the sanctity of life, courts merely referring to the principle without comment. Life has not always been seen as inviolable but Christian ideas of human life as precious, holy and sacred lie behind the attitude in Western legal traditions towards protection of human lives against being ‘wrongfully’ terminated. The two main bases for the principle lie in the belief that all human life is inviolable, and that all human lives have equal value. (Helga Kuhse, *The Sanctity-of-Life Doctrine in Medicine* (Clarendon Press, 1987) 6).

\(^\text{12}\) *Airedale NHS Trust v Bland* [1993] AC 789, 826 (Hoffman LJ).

\(^\text{13}\) *Airedale NHS Trust v Bland* [1993] AC 789, 864 (Lord Goff).
self-determination, a goal of medical practice in the 21st Century,\textsuperscript{14} and one of the pillars of patient-centred care. The policy documents an awareness that, as the Australian population ages, the likelihood of the occurrence of some unfortunate medical emergency increases.\textsuperscript{15} It also recognises the process of preparing an advance care plan as involving ‘... reflection, discussion and communication ... in an environment of shared decision-making ... ’ between patient and medical practitioner.\textsuperscript{16}

Currently the law governing advance directives varies between jurisdictions and it can be difficult for medical professionals in one jurisdiction to determine the validity of an advance directive from another jurisdiction.\textsuperscript{17} The AMA policy call for Australia’s states and territories to enact legislation ensuring legal enforceability of interstate advance directives\textsuperscript{18} has been realised in most jurisdictions. In New South Wales where there is no specified form, forms from interstate can be used\textsuperscript{19} and guidance issued by NSW Health advises that interstate advance directives can be recognised in New South Wales.\textsuperscript{20} A New South Wales directive in whatever form it takes should be recognised in most jurisdictions, certainly where specific recognition legislation applies.\textsuperscript{21} Tasmania has no legislation governing advance directives but the Tasmanian government endorses a form to be used when making advance care decisions.\textsuperscript{22}

The Australian Health Ministers’ Advisory Council (AHMAC) in its ‘A National Framework for Advance Directives’ has also called for the varying regimes relating to advance directives within the Australian States and Territories to be aligned\textsuperscript{23} but there are notable differences between each jurisdiction.

\textsuperscript{14} Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning* - 2006.
\textsuperscript{15} Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning* - 2006 [1.2].
\textsuperscript{16} Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning* - 2006 [3.4].
\textsuperscript{17} Australian Health Ministers’ Advisory Council, *A National Framework for Advance Care Directives* (at September 2011) 1.
\textsuperscript{18} Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning* - 2006 [1.4].
\textsuperscript{19} NSW Health, *Using Advance Care Directives New South Wales* (22 March 2005) 7.
\textsuperscript{22} *Advance Care Directive for Care at the End of Life*.
The recognition of patient self-determination as exemplified in the AMA Policy and the *National Framework for Advance Directives* together with the legal requirement of patient consent to medical treatment, also an aspect of patient autonomy and self-determination, may be challenged, both by decisions of medical practitioners who fail to honour an advance directive and by the provisions of statutes. The weakening of patient autonomy in this way may also be practised by courts when adjudicating on interpretations of patient refusals of treatment, provisions of advance directives or relevant legislation governing these situations. Between them, the United Kingdom and the eight Australian jurisdictions show instances of limitations to the theoretical primacy of patient self-determination when patient wishes are not honoured.24 On the other hand, it must be acknowledged that some failures to comply with advance directives relate to lack of understanding about their validity or relevance or indeed, to inability to know whether or not an advance directive exists.

Similarly, the AMA Policy on Advance Care Planning appears to significantly restrain patient autonomy in the name of clinical discretion. The policy recommends that each state and territory enact legislation to protect medical practitioners who comply with advance orders.25 Some states and territories have done so.26 The policy also recommends that the legislation should protect medical practitioners who do not comply on the grounds that the patient’s decision is inconsistent with good medical practice or advances in medical science, thereby preserving the clinical judgement and discretions of medical practitioners.27 Queensland has obliged by authorising medical practitioners to refuse to follow provisions in an advance directive where they consider that the direction is contrary to ‘good medical practice’.28

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24 For example, New South Wales Supreme Court overrode a decision by a Jehovah’s Witness teenager, just a few months short of his eighteenth birthday, refusing a blood transfusion. Despite finding that the boy was highly intelligent and a mature minor, Gzell J called on the ‘sanctity of life’ as being more powerful than the dignity of the individual and required the making of the order to authorise giving a blood transfusion. Antonio Bradley and AAP, ‘Court Allows Transfusion for Religious Teen’, *Australian Doctor* (Online) (30 September 2013) <http://www.australiandoctor.com.au/news/latest-news/courtallows transfus ionforreligious teen>.  
25 Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning - 2006* [1.4].  
26 See eg, *Advance Care Directives Act 2013* (SA) s 9(f); *Guardianship and Administration Act 1990* (WA) s110ZL(2); *Advance Personal Planning Act 2013* (NT) s 45; *Medical Treatment Act 1988* (Vic) s 9.  
27 Australian Medical Association, *The Role of the Medical Practitioner in Advance Care Planning - 2006* [1.4].  
28 *Powers of Attorney Act 1998* (Qld) s 103.
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**Advance Directives under the Common Law**

At common law, a competent adult person is entitled to refuse medical treatment even if that treatment is necessary to maintain the person’s life.\(^{29}\) Similarly, the competent adult can decide in advance what treatment he or she wishes to accept, or to refuse for the future when otherwise unable to choose, even if that treatment is life-sustaining.\(^{30}\)

No formal requirements exist for creating a common law advance directive and it can be revoked at any time while the donor of the power is competent.\(^{31}\) However, when capacity is lost, any advance directive will ‘... in effect become ... irrevocable’ unless or until the patient regains capacity.\(^{32}\) There is no statutory provision for advance directives in New South Wales or Tasmania, but they have been recognised as valid under the common law.\(^{33}\) The common law requirements for validity of an advance directive are:\(^{34}\)

1. The person making the directive must be an adult with mental capacity at the time the directive is made;\(^{35}\)
2. There must be no undue influence or other vitiating factor;\(^{36}\)
3. The person must have intended the directive to continue to operate in the medical circumstances which have arisen.\(^{37}\)

The question of the validity of a common law advance directive in New South Wales was examined in *Hunter and New England Area Health Service v A*.\(^{38}\) This case will be considered further later in this chapter. Some cases suggest that there are judges who are reluctant to uphold advance refusals of treatment on the grounds that a vulnerable patient will die.\(^{39}\) However, as held by McDougall J in *Hunter and New England Area Health Service v A*:

> [t]he analysis should start by respecting the proposition that a competent individual’s right to self-determination prevails over the State’s interest in the preservation of life even though the individual’s exercise of that right may result in his or her death.\(^{40}\)

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\(^{29}\) See eg, Airedale NHS Trust v Bland [1993] AC 789, 864 (Lord Goff).


\(^{31}\) *HE v A Hospital NHS Trust* [2003] EWHC 1017, [37] (Munby J).

\(^{32}\) *HE v A Hospital NHS Trust* [2003] EWHC 1017, [38] (Munby J).


\(^{40}\) *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [36].
6 Statutory Schemes

(a) Australia

All jurisdictions in Australia, other than New South Wales and Tasmania, now have statutory recognition of advance directives, whatever called, and prescribe some formalities. Several of the Australian jurisdictions have suggested that the object of their particular legislation was to enshrine the common law in statute and rights under the common law were to be preserved.41 There is no reference in the Advance Care Directives Act 2013 (SA) to preserving the common law, but as this act expands on the Natural Death Act 1983 (SA) that confirmed the common law right to refuse treatment, it is submitted that common law rights are preserved.42 Because of conflicting legislation in Queensland, it is possible that the Queensland legislation ousts the common law, whilst it has been preserved in Victoria, Western Australia, the Australian Capital Territory and the Northern Territory.43 It is not clear how the preservation of common law rights will interconnect with advance directives legislation.44

Despite the deference to patient dignity and autonomy stated by courts, some of the legislated systems hinder this in various ways. Similarly, England has common law and statutory arrangements that are supposed to bolster patient dignity and autonomy but that can, on occasion, frustrate clear directions made by competent adults. England is included in this examination as an additional common law

42 South Australia, Parliamentary Debates, House of Assembly, 17 October 2012, 990 (The Hon S J Baker).
44 For example, will an unwritten common law advance directive be acceptable when a statute specifies a particular form?
jurisdiction particularly as its cases and legislative directions amount to persuasive common law authority in Australia.

(b) Legal Restrictions on Patient Autonomy

(i) Terminal Illness

Northern Territory, ACT, South Australia and Western Australia do not impose any restriction on when an advance directive can function. Section 36(2)(a)(i) of the Powers of Attorney Act 1998 (Qld) clearly places the power to access the Act’s provisions into the hands of the treating medical practitioner. The patient must have a terminal illness and ‘... in the opinion of a doctor treating the principal and another doctor, the principal may reasonably be expected to die within 1 year’. When the bill went to committee, the 1 year time limit was specified.\(^{45}\) The only reference to terminal illness in the Queensland Second Reading debate was to the ‘terminal phase of a terminal illness’.\(^{46}\) In neither the committee nor the debate was any reason given for the limitation. This restriction means that a person who is not suffering from an illness that is likely to cause death within the defined period of time may have to endure indefinitely. This situation is exemplified by dementia where the patient can live on healthily, if not mentally engaged, for many years before a terminal illness arises. Similarly, if the patient is afflicted with something like multiple sclerosis or motor neurone disease, the inexorable advance of the deterioration may still mean sustained suffering as patients can live for some time after diagnosis. Where the patient is incompetent and suffering from that type of condition, a prior order by the patient refusing antibiotic treatment for any intervening infection could not be observed by medical staff.

(ii) Good Medical Practice

Queensland permits a medical practitioner to override the wishes of a patient expressed in an advance directive where, in the judgement of the medical practitioner, complying with the patient’s wishes would be inconsistent with good medical practice.\(^{47}\) This provision is intended to prevent a person from giving a direction to withhold or withdraw life-sustaining medical treatment where the

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\(^{45}\) Queensland, *Parliamentary Debates*, Legislative Assembly, 12 May 1988, 1019 (Hon D E Beanland).

\(^{46}\) Queensland, *Parliamentary Debates*, Legislative Assembly, 8 October 1997, 3687 (Hon D E Beanland).

\(^{47}\) Powers of Attorney Act 1998 (Qld) s 103.
person’s health could be restored by ‘ ... simple medical procedures.’\textsuperscript{48} Yet section 103 of the Act was also ‘ ... designed to enable a patient to indicate that he or she does not wish the natural course of the dying process to be impeded.’\textsuperscript{49} These purposes as enunciated are contradictory. The Queensland Parliamentary Debates correctly state that it is a fundamental principle that a ‘ ... doctor can never be required to carry out medical treatment that would be contrary to good medical practice.’\textsuperscript{50} However, there was no reference to this provision in the Second Reading Debate. There was also no provision in the legislation for what ‘good medical practice’ in this context encompasses.

Permitting a medical practitioner, on the grounds of inconsistency with good medical practice, to override an advance directive takes away from the patient the right to determine what he or she would want to be done to his or her body. It places the decision squarely within the clinical discretion of the medical practitioner, ignoring the whole rationale for permitting patients to make advance directions about their medical treatment in the first place. If the advance care directive has been prepared in partnership with the medical practitioner in accordance with the AMA Policy concerning Advance Care Plans,\textsuperscript{51} overriding an advance directive is also a derogation from the shared decision-making that is fundamental to the ideal of patient-centred care.\textsuperscript{52} It is submitted that the rhetoric of a patient-centred partnership must exclude the right of the medical practitioner to override the patient’s directions about proposed future care, particularly if the medical practitioner has been involved in the discussions concerning advance care planning.

(iii) Current Condition

Victoria has a restriction in section 5(1)(c) of its Medical Treatment Act 1988 (Vic) that requires medical information to be sought and provided for the patient’s condition before the advance directive can be signed. The information must relate

\textsuperscript{48} Queensland, Parliamentary Debates, Legislative Assembly, 12 May 1988, 1020 (Hon D E Beanland). There is no explanation of the concept ‘simple medical procedures’ in the Act nor was it discussed in the Legislative Assembly.

\textsuperscript{49} Queensland, Parliamentary Debates, Legislative Assembly, 12 May 1988, 1020 (Hon D E Beanland).

\textsuperscript{50} Queensland, Parliamentary Debates, Legislative Assembly, 12 May 1988, 1025 (Mrs Cunningham).

\textsuperscript{51} Australian Medical Association, The Role of the Medical Practitioner in Advance Care Planning - 2006 [3.4].

\textsuperscript{52} It is also contrary to Standard 2 of the National Safety and Quality Health Service Standards as discussed in Chapter III.
to that condition only. Thus, in Victoria, an advance directive can only be made
for a ‘current condition’.\textsuperscript{53}

It was declared during the second reading debate that the right to refuse medical
treatment should not be in the form of an advance declaration made while the
patient was healthy about what the patient wished if he or she became ill.\textsuperscript{54} This
provision was in response to the findings of the Social Development Committee
that considered that advance declaration legislation in Victoria was neither
appropriate nor necessary.\textsuperscript{55} The Social Development Committee was concerned,
following submissions, that a healthy person could not possibly know in advance
what he or she would wish at some future time if incompetence intervened.\textsuperscript{56}

However, the 2016 report of the Victorian Legislative Council’s \textit{Inquiry into End
of Life Choices} noted that:

\begin{quote}
[t]he Committee believes that the complex end of life care legal framework in
Victoria needs to be simplified and clarified.’
\end{quote}

There are several aspects to the end of life legal framework in Victoria that are
confusing, unclear and need to be updated. In particular the enforceability of
advance care plans, the limitation in refusal of treatment certificates to current
conditions and substitute decision making framework.

The \textit{Medical Treatment Act 1988} was introduced in response to the Social
Development Committee’s final report on the \textit{Inquiry into Options for Dying with
Dignity} (1988), nearly 30 years ago.

A refusal of treatment certificate was favoured at the time due to concerns that
allowing for treatment conditions relating to future conditions would lead to
uninformed decisions.

The narrow scope of the \textit{Medical Treatment Act 1988}, however, has since become
apparent, with concerns that the Act does not adequately support the community’s
belief in the principle of individual autonomy and the human right to self-
determination.\textsuperscript{57}

On 15 September 2016, the Medical Treatment Planning and Decisions Bill 2016
was tabled in the Victorian Legislative Assembly by the Minister for Health, Ms
Hennessy, who also moved that the bill be read a second time. Debate was
adjourned. At the time of writing, the bill had not been passed into law.

\textsuperscript{53} \textit{Medical Treatment Act 1988 (Vic) s 5(1)}.
\textsuperscript{54} Victoria, \textit{Parliamentary Debates}, Legislative Assembly, 5 May 1988, 2167 (Mr McCutcheon).
\textsuperscript{55} Social Development Committee, Parliament of Victoria, \textit{Inquiry into Options for Dying with
Dignity} (1987) 122.
\textsuperscript{56} Social Development Committee, Parliament of Victoria, \textit{Inquiry into Options for Dying with
Dignity} (1987) 121.
\textsuperscript{57} Legal and Social Issues Committee, Parliament of Victoria Legislative Council, \textit{Inquiry into End of
Life Choices} (Final Report, June 2016) 155–156.
The Minister’s second reading speech on 15 September 2016 acknowledged ‘... that health practitioners do not understand their legal obligations ...’ and that the bill was intended to ‘... remedy this by providing a single definition of medical treatment and clarifying the obligations of health practitioners’. The Minister went on to state that:

[the bill allows a person with capacity to make an advance care directive. An advance care directive will only come into effect if the person loses capacity to make a medical treatment decision’.38

(c) Summary

Patient autonomy can be compromised by restrictions present in some legislative schemes. Any restriction on withdrawal of treatment limits the autonomy of the conscious and competent person who executed an advance directive or refusal of treatment certificate in anticipation of later incompetence.

The power of a medical practitioner, in his or her assessment of patient ‘best interests’, to override patient wishes as expressed can be a constraint on patient autonomy and appears to be inconsistent with the patient-centred principle of shared decision-making. Overriding patient wishes can also occur in jurisdictions that do not have the legislative backing existing in the Powers of Attorney Act 1998 (Qld). For example, the Social Development Committee of Victoria noted that there is a general lack of knowledge by people in the community about their rights, particularly in their most vulnerable situation at the end of life. Many people feel powerless to refuse treatment or even to disagree with their medical practitioner.39

The autonomy of the patient expressed in an advance directive does not imply the right to demand a particular treatment in the face of the expertise of a medical practitioner30 who determines that the proposed treatment is either not indicated, or is futile. But this is a different situation from an advance direction that consents to or refusals a specified proposed treatment whether or not the medical practitioner was involved in the discussion leading to the preparation of the directive.

(d) England

In England, there is an absolute right for a competent adult patient to refuse medical treatment. The patient must have been provided with information about the proposed procedure, there was no undue influence or other vitiating

38 Victoria, Parliamentary Debates, Legislative Assembly, 24 September 2016 (Proof) 32.
circumstance at the time the advance directive was made and the refusal was intended to apply in the circumstances that ultimately arose.61

The Mental Capacity Act 2005 (UK), has introduced formal requirements where the donor of the power wishes to give directions about life-sustaining treatment. Where life-sustaining treatment is to be refused, it is necessary for the advance decision to explicitly state this in writing, and also to specify that the refusal is to be valid even if the life of the patient is at risk. The advance decision must then be signed and witnessed.62

A provision in an advance directive is no longer valid if the donor has withdrawn the provision when he or she has capacity to do so.63 This implies that an advance directive is irrevocable once the donor has lost capacity.64 As Munby J declared: ‘... this is not because the advance directive as such either is or has become irrevocable — it has not. It is simply because there is now no-one who is able to revoke it’.65 Revocation also occurs if the donor has done anything that is clearly inconsistent with the terms of the advance decision.66 There is no requirement that the donor have mental capacity at that time.

Advance directives should be correctly interpreted as valid or not, as some patients may be subjected to unwanted treatment that prolongs an intolerable existence, whereas others may be denied life-sustaining treatment.67 However, any doubt as to what alternative is to apply is resolved, both by the common law68 and by statute,69 by a presumption to preserve life. This may be based on a ‘best interests’

61 In re T (Adult: Refusal of Treatment) [1993] Fam 95.
62 Mental Capacity Act 2005 (UK) ss 25(5)–(6).
63 Mental Capacity Act 2005 (UK) s 25(2)(a).
64 See also, HE v A Hospital NHS Trust [2003] EWHC 1017 [38] (Munby J).
65 HE v A Hospital NHS Trust [2003] EWHC 1017 [38] (Munby J).
66 Mental Capacity Act 2005 (UK) s 25(2)(c).
69 For example, Mental Capacity Act 2005 (UK) s25(5) has special provisions where the outcome of following an advance directive may be that the patient will die.

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assessment made by the medical practitioner on behalf of the patient in accordance with the principle of necessity as in Re F.70

The Mental Capacity Act 2005 (UK) provides that a person is ‘... assumed to have capacity unless it is established that he lacks capacity.’71 On the other hand, there is some inconsistency in the way liability for continuing treatment is assessed, compared with liability for withholding treatment. Avoiding liability for continuing treatment only requires that the person be satisfied that a valid advance decision is not in existence.72 However, avoiding liability for withholding or withdrawing treatment requires a reasonable belief that a valid and applicable advance direction is in existence,73 a more stringent test, leading to a possible bias against advance refusals of life-saving treatment.74

Michalowski argues against the interpretation by courts of advance refusals of treatment through the lens of the sanctity of life. She criticises the interpretation by Chief Justice Rehnquist of the United States Supreme Court in Cruzan v Director, Missouri Department of Health,75 that ‘... an erroneous decision in favour of continued treatment merely upholds the status quo ...’ and that a wrong decision ‘... will eventually be corrected or its impact mitigated.’76 She contends that the usual reason that an advance directive is made is because the patient fears, more than dying, an application of burdensome life-sustaining treatment and wishes to give advance instructions for it to not be applied in the first place, or withdrawn in circumstances where it has become patently intolerable.77 Rather than an incorrect decision to treat being corrected, violation of an autonomous decision to refuse

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70 In re F (Mental Patient: Sterilisation) [1990] 2 AC 1. The principle of necessity, where touching of another without consent is not unlawful is explained by Lord Goff at 75 as ‘the basic requirements, applicable in these cases of necessity, that, to fall within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.’ At 77, he continues: ‘[b]ut where the state of affairs is permanent or semi-permanent, as may be so in the case of a mentally disordered person, there is no point in waiting to obtain the patient's consent. The need to care for him is obvious; and the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do. Were this not so, much useful treatment and care could, in theory at least, be denied to the unfortunate.’

71 Mental Capacity Act 2005 (UK) s 1(1). Clause 4(2) of the Medical Treatment Planning and Decisions Bill 2016 (Vic) also provides that ‘... an adult is presumed to have decision-making capacity unless there is evidence to the contrary’.

72 Mental Capacity Act 2005 (UK) s 26(2).

73 Mental Capacity Act 2005 (UK) s 26(3).


75 Cruzan v Director, Missouri Department of Health, 110 S Ct 2841 (1990).


life-sustaining treatment by treating in disregard of clearly expressed wishes not to be kept alive, is irreversible. The patient may well have to endure sustained suffering that would have otherwise been avoided.

Thus, while an erroneous decision to withdraw life-sustaining treatment which results in the patient’s death is obviously irreversible and not susceptible to correction, this does not justify the conclusion that an error in favour of life is reversible and therefore always less harmful than an error resulting in death.78

Michalowski comments that she agrees with the dissent of Justice Brennan in *Cruzan* that an error either way is irrevocable, and even a later decision to comply with the patient’s wishes cannot undo the harm that may have occurred in the mean time.79

Michalowski’s argument continues that the law has given the patient the right to decide, in his or her own best interests, whether to refuse life-sustaining medical treatment so it is then inconsistent for the state to argue that the principle of the ‘sanctity of life’ should prevail over the patient’s autonomous decision. Once such a decision has been made, the interest in preservation of life ceases and the state should only be interested to ensure that this is what the patient really wants, and that it is evidenced by the existence of a validly made advance directive.80

Where there is no doubt about validity of an advance refusal of life-sustaining treatment, the patient’s autonomy should trump the state’s interest in preservation of life. Where there is doubt, consideration of best interests should be made by taking a disinterested approach, with no bias either way, taking into account the patient’s ‘... known values and preferences ...’ and being aware that it might be as harmful to disregard the autonomous decision of a patient not to have life-sustaining treatment as not to administer such treatment if the patient did not make an autonomous treatment refusal.81

Furthermore, Munby maintains that the ‘so-called’ right of self-determination can be cramped by the tendency of English judges to downplay the amount of information a patient requires and a tendency to impose an unrealistically stringent test of capacity.

In short, English law in practice tends to “talk down” the patient’s need for information, while at the same time paradoxically tending to “talk up” the patient’s need for capacity. The practical effect in both cases is to weigh the balance against the patient in favour of the doctor.  

He further considers that

[t]he patient whose decision in a potentially life-threatening situation is felt to be unwise [or] unreasonable ... may find himself ... categorised by the doctor and the court as incompetent; and consequently subjected to the treatment that the doctor, or the court feels, or chooses to assert, is the patient’s best interests

and goes on to suggests that: ‘Where the obstacle in the doctor’s way is the existence of an apparent “advance directive” the court can be ... astute to find reasons for declining to give effect to it’.  

The question of how to best respect the autonomy and dignity of a demented patient who has changed his or her mind where there exists a clear and unambiguous advance directive is a highly contentious one and will be explored later in this chapter. Whatever decision is reached will not satisfy everybody. Michalowski concludes that the apparently unlimited protection of patient autonomy in refusals of treatment specified in advance directives only exists as a matter of legal principle.

This brief survey of the English situation bolsters the arguments concerning Australian advance refusals of treatment. Patient autonomy, whilst absolute in theory, can be undermined both by restrictions on advance directives in legislation and on their interpretation by the courts. The upholding of an advance directive where possible is in keeping with recognition of patient autonomy. However, the courts are not infrequently swayed by arguments and predispositions that have the effect of invalidating advance directives. Maclean comments that advance directives are only upheld where the judge considers that this result would be reasonable. Where the medical practitioner does not consider an advance directive is valid and applicable, he or she is protected by the *Mental Capacity Act*

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2005 (UK) that neither requires the medical practitioner’s decision to be reasonable nor that an application to a court for a ruling must be made.88

(e) Comparison of Legislation

A comparative table of the law in the Australian jurisdictions and the United Kingdom is attached as Appendix VA. It outlines similarities and differences in several major categories. Whilst most Australian jurisdictions have legislation establishing the validity of advance directives, provisions in some of the legislation also place limits on what they can require. The Victorian requirement that use of a refusal of treatment certificate is only triggered by a current condition, the Queensland requirement that an advance directive can only be used in the terminal phase of a terminal illness and the Queensland provision that permits the medical practitioner to override a directive on the basis of a conflict with ‘good medical practice’ all restrict the patient’s right to make comprehensive advance treatment decisions. It should be noted that until 2013, when the Advance Care Directives Act 2013 (SA) was passed, South Australia restricted the use of an advance directive to the terminal phase of a terminal illness.89 Until the Northern Territory passed the Advance Personal Planning Act 2013 (NT), the Natural Death Act 1989 (NT) required the patient to be suffering a terminal illness and for death to be imminent before an advance directive could be implemented.90

7 Cases

Though not all advance directives are overridden, cases from both Australia and England show that judges have, on occasion, disregarded clear and unambiguous patient directions. Medical practitioners and hospitals bring cases where they are unsure of the law. Patients bring cases where the medical authorities do not comply with a valid advance directive.


89 Department for Health and Ageing, Advance Care Directives Bill 2012 and Related Amendments (Explanatory Guide, October 2012) – the bill was designed to ‘...preserve the right of individuals to direct in advance what quality of life means to them ... ’ (at page 2) and ‘ ... supports a person-centred model of decision-making ... ’. (at page 3).

90 The Advance Personal Planning Act 2013 (NT) was enacted to fill in gaps in Northern Territory whereby it was not possible to appoint a medical attorney or to make a binding advance health directive. Department of the Attorney-General and Justice, Advance Personal Planning Bill 2013 - Issues Paper (June 2013) 6.
(a) Australia

The question of the validity of a common law advance directive in New South Wales arose for determination in *Hunter and New England Area Health Service v A*.\(^9^1\) The patient had been admitted to hospital unconscious and in a serious condition and was transferred to intensive care where he received artificial ventilation and kidney dialysis treatment. It was discovered that he had signed a common law advance directive specifying that he did not wish to receive kidney dialysis. The Health Service sought a declaration in the Supreme Court of New South Wales that it could legally comply with the patient’s wishes. McDougall J surveyed several Australian and international cases that confirmed that the individual has a general right to determine what should be done with his body or life.\(^9^2\) He concluded that if there is a conflict between the individual’s right of self-determination and any state interest in the preservation of life, the individual’s interests must prevail.\(^9^3\) McDougall J held that the directive did reflect the patient’s wishes and made a declaration that the Health Authority could comply with those wishes even though the outcome would be the death of the patient.\(^9^4\)

A contrary result was reached in the Victorian case of *Qumsieh v Guardianship and Administration Board*.\(^9^5\) In that case, a Jehovah’s Witness had signed a consent to anaesthetic and also an advance medical directive, in both cases making it clear that under no circumstances was she to be given a blood transfusion or any blood products. She had also signed an enduring power of attorney, appointing a Mr Ibrahim but this document was held invalid as it was not in compliance with section 5A(2) of the *Medical Treatment Act 1988* (Vic).\(^9^6\) This invalid enduring power of attorney was produced to the Board, but not the advance medical directive nor the consent to anaesthetic. The Board, reminding itself that the best interests of the patient were the overriding factor to be considered, appointed the Public Advocate to take over protection of the patient.\(^9^7\) The patient’s husband asked to be appointed as the delegate of the Public Advocate. The order was made\(^9^8\) and the husband gave consent for a blood transfusion to be given.\(^9^9\) A subsequent application by the patient to review the orders of the Board and declare

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\(^9^5\) *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45.
\(^9^6\) *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 [8].
\(^9^7\) *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 [7].
\(^9^8\) *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 [9].
\(^9^9\) *Qumsieh v Guardianship and Administration Board* [1998] VSCA 45 [10].
them invalid was refused at first instance by the Supreme Court of Victoria.\textsuperscript{100} On appeal by the patient to the Full Court of the Supreme Court of Victoria, the decision of the first instance judge was upheld. The fact that the patient had made a direction that she did not want a blood transfusion in different circumstances from the present situation was not a reason to deny jurisdiction in the instant case.\textsuperscript{101} However, there was ample evidence that the patient was adamant about refusing blood products in all circumstances. A further reason given by the court was that making an order that held the Board’s original decision invalid would bring the patient into dispute with her husband.\textsuperscript{102} This is clearly not a factor required by either the relevant statutes or the common law. Subsequently, the High Court refused leave to appeal.\textsuperscript{103}

\textbf{(b) England}

In the English case of \textit{Re C (Adult: Refusal of Medical Treatment)},\textsuperscript{104} a man who was a paranoid schizophrenic, serving a prison sentence for a stabbing offence, refused amputation of his foot that had become gangrenous. He stated that he would prefer to die with two feet than to live with only one.\textsuperscript{105} Despite the mental condition of the applicant and the fact that he exhibited certain delusions, he was held to be capable of making the decision and his application for an injunction was approved. His refusal was held by the court to be a valid advance directive.\textsuperscript{106} Whilst this appears to be an endorsement of the patient’s self-determination, Maclean proposes an alternative explanation. The patient was a dangerous schizophrenic. Therefore a cynic might suggest that since it did not matter to anyone other than the patient whether he lived or died, he should be permitted to make an irrational decision.\textsuperscript{107}

A more recent case with similar facts was similarly determined in England where a man with a gangrenous foot, but also a long-standing mental illness, was found to

\begin{itemize}
\item \textsuperscript{100} \textit{Qumsieh v Guardianship and Administration Board} [1998] VSCA 45 [11].
\item \textsuperscript{101} \textit{Qumsieh v Guardianship and Administration Board} [1998] VSCA 45 [17] (Winneke P).
\item \textsuperscript{102} \textit{Qumsieh v Guardianship and Administration Board} [1998] VSCA 45 [19] (Winneke P).
\item \textsuperscript{103} \textit{Qumsieh v Pilgrim} [2000] HCATrans 34. As McHugh held: The decision in a case of this nature depends, as would any future case affecting the applicant, on its own facts. This consideration and the fact that the events are in the past militate against the grant of special leave. The Court of Appeal gave a number of reasons for refusing the decision. It is unnecessary for us to say anything about them. It is sufficient to say that having regard to the facts of the case, nothing about it warrants the grant of special leave to appeal. The application is dismissed.
\item \textsuperscript{104} \textit{In re C. (Adult: Refusal of Treatment)} [1994] 1 WLR 290.
\item \textsuperscript{105} \textit{In re C. (Adult: Refusal of Treatment)} [1994] 1 WLR 290, 291 (Thorpe J).
\item \textsuperscript{106} \textit{In re C. (Adult: Refusal of Treatment)} [1994] 1 WLR 290, 295–296 (Thorpe J).
\end{itemize}
have sufficient capacity to refuse amputation even though the outcome would be almost certain death. Peter Jackson J spoke to the patient himself and was satisfied that the patient’s arguments refusing amputation were clear and unequivocal. He therefore ordered that an amputation would not be in the best interests of the patient as any other order would take away what remaining dignity and independence the patient had. 108

Another case where an advance directive was upheld was that of a young man, AK, suffering from motor neurone disease. 109 His only form of communication was blinking one eyelid. He wished for ventilation to be removed, meaning his death, two weeks after he had lost any ability to communicate. The doctors asked whether it was lawful for them to comply with the patient’s wishes. The court determined that AK was of full capacity and had let it be known that he would refuse treatment and also confirmed that any continuation of treatment after the refusal took effect would be positively unlawful. 110

A further English case where the court upheld the patient’s advance directive was that of Ms B. 111 The patient was a quadriplegic who required ventilation to be kept alive. Despite the terms of her advance directive, and despite requests from the patient, the hospital refused to discontinue mechanical ventilation. Ms B applied to the court for a declaration that the hospital comply with her wishes even though the outcome would be her death. The court determined that the patient was competent and that she had been treated unlawfully for at least the previous six months. 112 It also made a small award of damages against the hospital. 113

Despite the declarations of the House of Lords in Bland 114 concerning the supposed pre-eminence of patient self-determination over the sanctity of life, some courts have found ways to question the validity of advance directives on the basis that the directive does not deal with the circumstances that have arisen. 115 When this question occurs, the courts have on occasion applied a presumption in favour of

108 Wye Valley NHS Trust v B [2015] EWCOP 60 [45].
109 Re AK (Medical Treatment: Consent) [2001] 1 FLR 129.
110 Re AK (Medical Treatment: Consent) [2001] 1 FLR 129, 135 (Hughes J).
111 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam).
112 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [95] (Dame Elizabeth Butler-Sloss).
113 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [99] (Dame Elizabeth Butler-Sloss).
life. This is despite the confirmation in *Re T*\(^{116}\) that a competent adult patient may refuse medical treatment on any grounds, whether rational or not. Lord Donaldson stated: ‘... for if the individual is to override the public interest he must do so in clear terms.’\(^{117}\)

The court did not agree with the self-determination manifest in the patient’s advance directive and chose the presumption in favour of life in the English case of *HE v A Hospital NHS Trust*.\(^{118}\) The patient had signed an advance directive refusing blood transfusions. She had also purported to make the directive irrevocable unless any revocation was in writing. About 18 months after having signed the directive she had seen a medical practitioner whose notes recorded that the patient was a Jehovah’s Witness and that an alternative treatment to blood transfusion was to be provided for planned future surgery. Six months after that, the patient was admitted to hospital, and despite aggressive treatment, it was determined that a blood transfusion was necessary to save her life. The hospital said that it could not override the advance refusal without court order. The patient’s father brought the action to override the refusal because of the rapidly deteriorating condition of the patient. Her mother, a Jehovah’s Witness was adamant that the advance directive should be obeyed. It was clear that the patient had been competent at the time the directive was made.

Munby J surveyed the many cases where the validity of refusing life-sustaining treatment had come to a court. He endorsed the following propositions:\(^{119}\)

1. a competent adult patient has an absolute right to refuse to consent to medical treatment;
2. a competent adult’s advance refusal remains binding notwithstanding the subsequent incompetence of the person;
3. an adult is presumed to have capacity and the burden of proof is on those who assert that capacity has been lost.

Munby J confirmed that there are no formal requirements for the validity of an advance directive.\(^{120}\) An advance directive can be made informally and equally can be revoked informally. He was adamant that there was no possibility of making an irrevocable advance directive as this was contrary to public policy. However, he was concerned that any advance directive was still the considered view of the


\(^{117}\) *In re T (Adult: Refusal of Treatment)* [1993] Fam 95, 112 (Lord Donaldson).

\(^{118}\) *HE v A Hospital NHS Trust* [2003] EWHC1017.


\(^{120}\) *HE v A NHS Hospital Trust* [2003] EWHC1017 [33] (Munby J).
patient and stated that any doubt must be resolved in favour of life.\textsuperscript{121} He therefore threw the burden of proof onto those asserting the continuing validity of the advance directive\textsuperscript{122} despite his earlier endorsement of the principle that the onus of proof should fall on those asserting invalidity. He was persuaded by the father’s evidence that the patient was no longer a Jehovah’s Witness, and considering the probability that she would die without the blood transfusion, ordered that the advance directive be overridden. This decision was made despite having been presented with a valid advance directive and the words of Lord Goff that sanctity of life should yield to the principle of autonomy.\textsuperscript{123} Unlike Burke’s case,\textsuperscript{124} Munby J’s judgment in \textit{HE v A NHS Hospital Trust} was not appealed so there was no comment by a higher court on this clear inconsistency.

The court was also not moved to support an advance directive refusing blood transfusions in the case of \textit{NHS Trust v T (Adult Patient: Refusal of Medical Treatment)}.\textsuperscript{125} The patient was diagnosed with a borderline personality disorder. She harmed herself by cutting and blood letting to the extent that her haemoglobin levels would fall to dangerous levels requiring emergency blood transfusions. She refused blood transfusions so the hospital applied to the court for a declaration that it could provide treatment when needed. The patient opposed the grant of the declaration. The court held that the patient lacked capacity to make this advance directive and gave permission for the hospital to give transfusions if required.

\textbf{(c) Conclusion}

Cases that make their way to the courts invariably have difficult and contentious issues to be determined. What the above analysis shows is that, on occasion, there can be a discrepancy between some principles of patient-centred care and the reality. The principle that autonomy trumps sanctity of life issues has been continually endorsed by the courts\textsuperscript{126} as has the principle that a competent adult patient can direct what treatment to accept or refuse, and that this principle is valid when the directions are in an advance directive.\textsuperscript{127} Recognition of the patient’s

\begin{footnotesize}
\textsuperscript{121} \textit{HE v A NHS Hospital Trust} [2003] EWHC1017 [23] (Munby J).
\textsuperscript{122} \textit{HE v A NHS Hospital Trust} [2003] EWHC1017 [42] (Munby J).
\textsuperscript{123} \textit{Airedale NHS Trust v Bland} [1993] AC 789, 864 (Lord Goff).
\textsuperscript{124} \textit{R (Burke) v General Medical Council} [2005] QB 424.
\textsuperscript{125} \textit{NHS Trust v T (adult patient: refusal of medical treatment)} [2004] 3 FCR 297.
\textsuperscript{126} See eg, \textit{Airedale NHS Trust v Bland} [1993] AC 789, 864 (Lord Goff); \textit{Hunter and New England Area Health Service v A} [2009] NSWSC 761 [17].
\end{footnotesize}
right to make a choice in advance is an acknowledgement by the courts of the patient’s dignity and autonomy. Where the medical practitioner has been involved in the decision-making process, it is an acknowledgment of the partnership aspect of the doctor-patient relationship.\textsuperscript{128}

Michalowski argues that there appears to be a predisposition to make these vexed decisions with a bias towards ‘sanctity of life’ considerations rather than take a more disinterested approach and look at all evidence including evidence of the patient’s beliefs and values. However, whilst not necessarily a deliberate policy by courts to override advance directives, when faced with an emergency with the possible death of the patient in issue, it is perhaps difficult for courts not to be swayed by the idea that death is irrevocable, whereas continuing life is not. However, as Michalowski contends, either decision is irrevocable, so courts should be more prepared to uphold validly made advance directives that refuse life-sustaining treatment.

C  PRACTICAL AND PHILOSOPHICAL PROBLEMS CONCERNING ADVANCE DIRECTIVES

Good end-of-life care that primarily respects the dignity and autonomy of the individual patient can reduce suffering by both patient and family.\textsuperscript{129} Whilst advance directives are in increasing use and have been promoted by medical professionals, health administrators, social workers and aged-care advocates, their utility and validity has been questioned on many grounds. A ‘vignette study’ in Scotland found that, even when the medical practitioners surveyed knew an advance directive was in existence and its terms, only half of them were prepared to abide by its provisions though none was prepared to ‘... withholding treatment in the absence of the advance directive’.\textsuperscript{130}

\textsuperscript{128} Australian Medical Association, \textit{The Role of the Medical Practitioner in Advance Care Planning - 2006} [3.5].

\textsuperscript{129} Australian Health Ministers' Advisory Council, \textit{A National Framework for Advance Care Directives} (at September 2011) 4.

\textsuperscript{130} Trevor Thompson, Rosalie Barbour and Lisa Schwartz, 'Adherence to Advance Directives in Critical Care Decision Making : Vignette Study' (2003) 327 \textit{BMJ} 1011, 1012. Data were generated through interviews with 12 participants, and six focus groups involving 34 participants. Participants were given a hypothetical advance directive and then provided with a hypothetical clinical vignette that was ‘... designed to create dissonance between the ethics of beneficence and respecting autonomy’. ‘Opinion was also equally divided between and within focus groups’.
1 Practical Problems

Medical practitioners do not always simply ignore advance directives. There is a series of practical problems that must be addressed to achieve the ideal of having an advance directive that will ensure that the individual’s needs, wants and preferences will be honoured.131 These practical problems can mean that, even without any conscientious reason in the health professional not to comply, an advance direction is not actually followed.

(a) Rarity

The first problem in the practical use of advance directives is that so few people have prepared them. Thus, hospital staff and medical practitioners are not used to making sure that they check that there is one in existence, where it is and its provisions.132 Even where the patient has prepared one and left copies with the general practitioner or specialist, even a lawyer or a family member, the overriding demands of an admission under emergency conditions can also mean that searching for any advance directive is subordinated to other priorities. Where a common law oral advance directive is in existence it is even more difficult for medical staff to be aware of its provisions. Therefore, the likelihood of treatment being provided that is contrary to the expressed wishes of the patient is high.133

(b) Completion of Legal Requirements

Lack of completion of advance directives also causes problems for their implementation. Whilst common law advance directives do not need writing and have no formal requirements, it is still necessary to make sure there is no invalidating factor and that the directive is applicable to the circumstances that have arisen.

This problem becomes more acute if a statutory advance directive has been prepared as all formal requirements such as dating, witnessing and execution must be correct. Some jurisdictions prescribe detailed forms that must be completed. These may specify that the maker has received particular advice, or has chosen not

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132 Clause 50(1)(a) of the Medical Treatment Planning and Care Bill 2016 (Vic) requires a medical practitioner, before giving any treatment to a person without decision-making capacity, to make reasonable efforts in the circumstances to ascertain whether the patient has an advance care directive.
133 This problem may well diminish as computerisation and centralisation of patient medical records becomes established. The existence and terms of any advance directive can be entered onto the patient record and readily accessed by all personnel dealing with that patient.
to seek advice at all. Witnessing is another minefield as statutory schemes may require special or qualified witnesses. Witnesses may have to be independent. Some forms require certification by a legal practitioner and others require the signature of a medical practitioner. Sometimes the formal requirements are so stringent that people require legal and/or medical help to prepare directives. That necessity may make advance directives expensive. On the other hand, too much informality may leave directives incomplete.

Another difficulty is the lack of education of medical practitioners and healthcare staff. Few know the conditions under which they are valid. Making sure that medical practitioners and health care staff are educated in the formal requirements for advance directives for their particular jurisdiction may reduce this problem.

(c) Specificity
A substantial problem with many advance directives is that they are not specific enough to be of practical use to medical staff. Simply saying ‘no life support’ or ‘no heroic measures’ does not give any real guidance to medical practitioners or hospital staff. Case law confirms that the directions where an advance directive is to be used must be clear, must be applicable to the circumstances that have arisen and expressed in language understandable enough for there to be no doubt about what the patient requires. If life-sustaining medical treatment is to be withheld or withdrawn the patient must specify that this is to apply even if the outcome may be the death of the patient. For example, Jehovah’s Witnesses who decline blood transfusions must be clear in spelling out whether or not this direction applies even in cases where death is possible.

Whilst it is not possible for every contingency to be documented, it is possible to lay down some principles and guidelines that could apply to a wide range of

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136 Similarly, on page 6 of AHMAC, A National Framework for Advance Care Directives (at September 2011) one of the identified problems is that ‘decision-makers try to interpret written medical directions that are uninformed, too specific to account for new treatments or too non-specific to guide medical decisions’.
137 On the other hand, the necessity for a blood transfusion usually implies some sort of emergency where the patient’s life will be threatened if the transfusion does not proceed which means that death is possible. See also eg, HE v A NHS Hospital Trust [2003] EWHC1017.
medical circumstances. South Australia has prepared a kit to assist people in completing their advance directives, and makes provision for the person to set out general values and wishes. Proposed Victorian legislation is also designed for people to be able to document their values. In addition, medical practitioners faced with making a treatment decision when the patient is unable to give directions should no longer necessarily use the subjective ‘best interests’ test. Where there is no advance directive, the medical practitioner should consider preferences expressed by the person, or if none have been expressed, must consider the patient’s values.

(d) Capacity

The question of whether the person had full legal capacity at the time the advance directive was made may lead to doubt as to whether a directive presented on admission to hospital should be honoured. On the other hand, every person is presumed to have mental capacity unless the presumption is rebutted. Differences in views as to what medical treatment is acceptable may relate to differences in values between clinicians and the patient, rather than the incapacity of the patient.

(e) Patient Understanding

A further question arises as to whether the patient, at the time the advance directive was made, had sufficient information about possible future contingencies to make the decisions concerning acceptance or rejection of particular proposed treatment. For example, a cancer sufferer may not understand the efficacy of proposed treatment such as a bone marrow transplant, and have specified that no invasive procedures should be undertaken. This problem is compounded by the fact that lay persons are not necessarily able to understand and integrate the information that has been provided to them by a medical practitioner.

140 Department of Health and Human Services, Simplifying Medical Treatment Decision Making and Advance Care Planning (January 2016) 9.
141 Department of Health and Human Services, Simplifying Medical Treatment Decision Making and Advance Care Planning (January 2016) 11.
143 Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam) [100] (Butler-Sloss LJ).
144 NHS Trust v T (Adult Patient: Refusal of Medical Treatment) [2004] 3 FCR 297 [59] (Charles J); Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80 [74] (Macdonald J).
medical information is highly technical and may not even be fully understood by medical practitioners who are not specialised in the relevant field, let alone lawyers or other advisers.

(f) Conclusion
The above catalogue of possible problems shows the difficulties that are faced by both patients and medical practitioners when the validity of an advance directive is in question. Neither medical practitioners nor patient relatives want to be having to consult courts to determine whether or not a particular direction should be observed. However, most of the problems detailed can be gradually overcome as the preparation and use of advance directives becomes better established. The ageing population wants its wishes to be followed and advance directives are recommended by aged persons organisations and other bodies who are confronted with demented patients who can no longer express their wishes. Centralised, computerised patient records will also reduce the possibility that the existence of an advance directive goes unnoticed.

2 Moral Authority of Advance Directives

As outlined above, the law permits a competent adult to make an advance directive specifying the sorts of medical treatment that are acceptable if the individual becomes incompetent. The law lays down that valid advance directives are binding to the extent that they refuse various forms of medical treatment provided they apply to the medical circumstances that have arisen. For example, refusal of life-sustaining treatment will not be honoured unless it is clear that the patient has specified that the refusal applies even if death may be the result.145

Advance directives also respect the individual’s right to self-determination. However, advance directives cannot be used to demand any particular form of treatment. This barrier is in conformity with the existing legal position where the courts will not impose on an unwilling medical practitioner any duty to provide a treatment that the medical practitioner considers is futile, or is not in conformity with proper medical practice.146

145 See eg, Mental Capacity Act 2005 (UK) s 25(5)-(6).
146 See eg, Isaac Messiha (By His Tutor Magdy Messiha) v South East Health [2004] NSWSC 1061; Medical Treatment Planning and Decisions Bill 2016 (Vic) cl 8.
However, there is a body of academic work that disputes the legal principle that the autonomous wishes of the competent adult must be honoured and it is these that this section reviews. It is submitted that these arguments must be rejected. Not honouring the wishes of a competent adult patient is a rejection of the patient-centred principle of respect for autonomy. In any case, this argument is academic only. The only jurisdiction where the medical practitioner has the legal right to override wishes in a valid advance directive is Queensland. Elsewhere in Australia, the legal obligation is to comply with advance directives. As this chapter has emphasised however, compliance with legal advance directives may be avoided. The concern is that some of the following arguments will gain traction among those doctors who are reluctant to comply with a directive where the consequence is that the patient will die.

(a) **Relationship between Competent and Incompetent Person**

Notwithstanding the lawfulness of advance directives, questions have been raised by some bioethicists and philosophers as to whether the autonomous competent individual who makes an advance directive has the authority to bind the future incompetent individual, especially to the extent of refusing life-sustaining treatment. These commentators argue that the binding nature of an advance directive will be imposing on the incompetent, the wishes of the previously competent person. For example, Buchanan forcefully argues that the legal principle, that a competent individual has the right to refuse life-sustaining treatment and that individual can make that decision for the future through an advance directive, is dubious as it overlooks several morally significant asymmetries.\(^{147}\) He contends that the very conditions that bring an advance directive into play are those where the conditions necessary for the existence of personal identity have been impaired, thus undermining the moral authority of the advance directive.\(^{148}\) Thus an advance directive, even if validly prepared by a competent adult would be giving directions as to the treatment of a different person as the original person no longer exists.\(^{149}\)

Kuhse contends that the argument that the issue of whether one person has been replaced by another is vague. She maintains that so long as strong psychological

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connections continue to exist, there is little reason to doubt that the maker of an advance directive and the patient are the same person. Where the maker of the directive is irreversibly incapable of experiencing a state of consciousness, then he or she is not the same person. However, the reason is not that the person is different, but where the degree of incompetence is so severe as to deprive the individual of any cognitive facilities, there is no longer a person.\textsuperscript{150}

\textit{(b) Precedent or Prospective Autonomy}

The question of whether the autonomy of the previously competent patient should take precedence over any interests of the subsequent incompetent, though biologically identical, person is particularly vexed. Dworkin insists that the competent person’s directions should take precedence. He maintains that a change once the patient has lost mental capacity is not valid as it is not a true reflection of the autonomous choice of the original directive. Whilst there is no connection of memory or personality between the demented person and the formerly competent person,\textsuperscript{151} Dworkin champions the right to individual autonomy. Not only does the individual know best what he or she wants for the future, but also each person as a moral agent has an interest in coherently shaping his or her life in accordance with that person’s character, values, commitments, convictions, critical and experiential interests.\textsuperscript{152} He sees the competent and the demented person as stages in a single life where the value of the autonomy of the individual as expressed in an advance directive is in respecting the person’s integrity and choice.\textsuperscript{153}

Cantor, similarly, contends that respect for the person’s prospective autonomy requires that advance directives be honoured as a demonstration of the individual’s concern to be remembered consistently with character. This concern includes ensuring that remembrance by others is not deflected by memory of a demented individual existing in a demeaned or undignified state.\textsuperscript{154}


\textsuperscript{152} Ronald Dworkin, \textit{Life’s Dominion} (Alfred A Knopf, 1993) 224.


\textsuperscript{154} Norman L Cantor, \textit{Advance Directives and the Pursuit of Death with Dignity} (Indiana University Press, 1993) 105.
(c) Psychological Continuity

Kuhse contends that psychological continuity derives from the idea that personhood is exhibited by a competent, rational human being who is self-conscious and purposive and sees himself or herself as existing over time.\(^\text{155}\)

Locke’s famous quote reflects the same concept of rationality and purpose and a consciousness of existing over time.

This being premised, to find wherein personal identity consists, we must consider what person stands for; — which, I think, is a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking, and, as it seems to me, essential to it: it being impossible for any one to perceive without perceiving that he does perceive.\(^\text{156}\)

Therefore the argument runs, in order for an advance directive to be observed, there must be some sort of psychological continuity between the person who has made the advance directive and the person who is being treated in accordance with its directions. The person who has no memory or connection with the former competent person lacks this psychological continuity.\(^\text{157}\) Quante argues that the incompetent is a different person and the advance directive should be treated as if it had never been made.\(^\text{158}\) This reasoning applies even if the competent person has specified that withdrawal or withholding of life-sustaining treatment is to be observed in full knowledge that death may ensue.

Dresser argues that while autonomy and control are important values, they are not the only values at stake when a competent individual purports to direct, by an advance directive, the withholding or withdrawal of life-sustaining medical treatment.\(^\text{159}\) She claims that demented persons have experiential interests that should be respected over the interests of the former competent person. She maintains that physicians and families should make the sort of decision that if the demented person were given the opportunity for one brief lucid moment to express his or her interests, the person would make.\(^\text{160}\)

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Dresser further asserts that the incompetent person is so different from the competent person who originally made the advance directive that the parens patriae jurisdiction of courts must be exercised to protect the vulnerable, incompetent person who is at the mercy of the directions of the previously competent person.\textsuperscript{161} The courts should make a ‘best interests’ or objective judgement to oust the individual’s previously declared demands about future treatment. Dresser considers that, because of scientific advances combined with observations made by caregivers grafted onto the literature about dementia, the court will know best what the patient feels and can make its decision accordingly.\textsuperscript{162}

Dresser’s claim flies in the face of the reality articulated by Nagel, that no-one can ever possibly know precisely what is is like to be some-one else as no-one can be party to the conscious experiences of anyone else.\textsuperscript{163} Even twins cannot have precisely the same experiences as each other. Dresser goes so far as to say that the courts should not permit the competent person to exercise tyranny over the incompetent\textsuperscript{164} and that individuals should not have the authority to alter longstanding conventions governing the practice of medicine, such as the duty of the physician to protect the patient from the physician’s conception of harm.\textsuperscript{165}

(d) Irrevocability of Advance Directives

The relationship between the competent and incompetent individual comes into particular focus when an advance directive comes to be implemented. As an advance directive is designed to take effect upon the future contingency of incompetence,\textsuperscript{166} it necessarily becomes irrevocable upon the contingency being realised. Once the maker becomes incompetent, he or she is no longer in a position to make any other advance directive or to revoke the one in existence.\textsuperscript{167} As Dworkin has argued, the wishes of the incompetent person should not be permitted to override the rationally made choices of the competent person.\textsuperscript{168}

\textsuperscript{163} Thomas Nagel, ‘What Is It Like to be a Bat?’ (1974) 83 Philosophical Review 435, 437.
\textsuperscript{166} See eg, Medical Treatment Planning and Decisions Bill 2016 s 12(1).
\textsuperscript{167} \textit{HE v A Hospital NHS Trust} [2003] EWHC 1017 [38] Munby J.
The individual person is not a stable conception as each person changes subtly over time, experience shaping attitudes and desires. Thus the person who has made the advance directive today is different from the person who will be subject to any advance directive tomorrow. If the arguments for denial of legitimacy of the wishes of the person for the future are accepted, it is almost impossible to conceive of any situation where a competent, rational, adult person would be permitted to make plans for future contingencies. That sort of interpretation contradicts the reality of societal and legal expectations. A person’s obligations and duties can be later enforced because of a ‘contract’ or agreement made. The right to enforce these obligations can also be exercised against the person’s estate so endure after death, let alone after loss of mental capacity. If this were not so, every will, contract, insurance policy or other agreement intended to take effect now or at some future time, would be invalid, an unthinkable consequence in modern society.

Many interests of the competent individual must survive the intervention of mental incapacity including financial provisions. The competent person is also concerned about how that person’s property will be dealt with, how his or her mortal remains, whether living or dead, will be treated and what burdens will fall on the family. If the competent person cannot bear the prospect of being viewed with pity, or as a burden or even as a nuisance because the competent individual is no longer in existence, the competent person will wish to direct what will be acceptable or unacceptable medical treatment. The imposition of medical treatment in patient ‘best interests’ may be a paternalistic concern for welfare, but may also condemn the person to suffering that that person is powerless to stop. As Cantor observes, any suffering is subjective and can be attenuated.

\[^{170}\text{Allen Buchanan, 'Advance Directives and the Personal Identity Problem' (1988) 17 Philosophy & Public Affairs 277, 287.}\]
\[^{171}\text{Norman L Cantor, Advance Directives and the Pursuit of Death with Dignity (Indiana University Press, 1993) 12.}\]
Quante’s argument that incompetent patients who can feel pain and suffer should be treated as ethically neutral\textsuperscript{172} and that complying with advance directives may imply causing pain and suffering to an incompetent person cannot be maintained. Complying with a request not to be kept alive with life-sustaining technologies, such as intravenous antibiotics or artificial hydration and nutrition, does not condemn the patient to suffer. The general principle of beneficence would mandate that suffering be minimised in all circumstances. Subjecting a permanently incompetent person to indefinite kidney dialysis in contravention of a specific advance directive is not treating the patient as ethically neutral.

Experiential interests of the incompetent patient should be irrelevant when considering whether to comply with an advance directive. Despite these experiential interests, the incompetent patient cannot consent to or refuse any treatment so any treatment may be on the instructions of some medical practitioner determining the best interests of the patient. Any paternalistic determination by a doctor in these circumstances could undermine the wishes of the competent individual who originally made the decisions communicated in the advance directive.\textsuperscript{173}

\section*{D FUTURE DIRECTIONS}

\subsection*{1 Introduction}

Advance directives are used to express individual wishes and values.\textsuperscript{174} Knowledge that one has made provision for any situation where one can no longer express one’s wishes or desires, is a comfort to many people. These people like to be in control of their lives and to take responsibility for themselves and their loved ones.\textsuperscript{175} Under these conditions, arguments as aired above, that competent patients should not be able to prescribe, in an advance directive, treatment for the contingency of that patient becoming demented but still having experiential interests, are contentious.

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\textsuperscript{173} Michael Quante, ‘Precedent Autonomy and Personal Identity’ (1999) 9 Kennedy Institute of Ethics Journal 365, 372. Quante contends that advance directives must be weighed against the ‘experiential interests of the patient so should not be definitive in every situation.
\textsuperscript{174} Australian Health Ministers' Advisory Council, A National Framework for Advance Care Directives (at September 2011) 10.
\textsuperscript{175} Department of Health, Advance Care Planning: Have the Conversation (A Strategy for Victorian Health Services 2014-2018) 16.
\end{flushright}
The existence of the practical problems with advance directives, also as detailed above is not an argument for their abandonment. More to the point, sustained efforts could be made to reduce the impact of these problems. The following sections make simple proposals of ways to increase knowledge about how and why advance directives should be used and will lead to better understanding for both patients and health practitioners.

2 Communication

The mere fact of thinking about death or incapacity makes it easier to talk to one’s family, and legal and medical advisors. Providing well-considered directions indicates that the difficult questions have been faced so future wishes are more likely to be honoured. It also means that the patient is more likely to have been informed of relevant future options.

*Good Medical Practice: A Code of Conduct for Doctors in Australia* (the MBA Code) specifies that, in the context of end-of-life care, good medical practice involves medical practitioners in ‘[f]acilitating advance care planning.’ This obligation is a recognition of the value of good communication between medical practitioner and patient.

Among other recommendations, the Victorian Legal and Social Issues Committee proposed that there should be Commonwealth and State government public awareness campaigns concerning end-of-life choices including advance care directives. It also proposed education for health care practitioners to facilitate their undertaking conversations with patients about end of life choices.

3 Compulsion and Education

As stated earlier, the AMA’s policy, *The Role of the Medical Practitioner in Advance Care Planning* recognises the importance of advance directives in the

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176 Australian Health Ministers’ Advisory Council, *A National Framework for Advance Care Directives* (at September 2011) 4. In its issue of 27 April 2017, *The Economist* argues for more conversations about people’s wishes as death approaches, as a way to make the dying process less traumatic for most patients.
177 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [3.12.8].
acknowledgement of patient self-determination. There have even been calls to make them compulsory. Whilst these calls from the medical fraternity are encouraging, what happens in reality as surveyed above suggests that more needs to be done to educate the medical practitioners ‘on the ground’ about their obligations. Education can be undertaken both at medical schools and as part of continuing medical education.

The Victorian Legal and Social Issues Committee recommended that the adequacy of compulsory teaching in medical schools concerning substitute decision-making should be examined by the Australian Medical Council and that the Victorian Government should require doctors and nurses to ‘undertake continuous professional development in advance care planning’.

4 Harmonisation

It would be of great benefit to both medical practitioners and their patients for the laws covering the creation and implementation of advance directives and enduring powers of attorney be harmonised among the varying jurisdictions in Australia. One of the substantial benefits is that health practitioners in different jurisdictions would be less confused about their obligations respecting advance directives so that patient wishes are more likely to be honoured. It is another question as to how harmonisation can be achieved in a federated polity where state fiefdoms exert such influence.

5 Practical Steps on Admission to Health Care Institutions

Centralised, electronic medical records, as examined in detail in Chapter III, may assist by making the fact of the existence of advance directives or other wishes for

182 Legal and Social Issues Committee, Parliament of Victoria Legislative Council, Inquiry into End of Life Choices (Final Report, June 2016) 152. There is no reason why the Medical Board of Australia should not implement this recommendation on a national basis.
future care and their terms readily searchable. As the Victorian Legislative Council’s *Inquiry into End of Life Choices* reported:

The National Lead Clinicians Group has noted that the My Health Record can enable advance care plans to be easily accessible across hospital, community and residential aged care settings. Using the My Health Record for advance care plans allows for the development of a system of alerts that indicate to health staff and ambulance officers when an advance care plan exists and how it can be accessed.185

However, it would also be helpful to make the existence of any future care documents part of the admission process for hospitals and for new patients in health practitioner surgeries. A question about the existence of an enduring power of attorney is currently part of the admission process for aged care facilities and could be extended to the existence of any advance care directive.

Whether future care documents have been prepared should be as standard a question for hospitals and general practitioner surgeries186 as that of the question about next-of-kin in all contacts between the individual and the health system. Where possible, copies should be made available at the same time. Not only would the importance of having prepared one of these documents be brought home to people of all ages and provide an opportunity to discuss the difficult questions of life and death, the health practitioners or hospital administrators would also be put on notice about what is required in an emergency. Making this question routine would make it less confronting for both patient and health service providers to commence a conversation. Those who do not want to have the conversation or whose religious or ethnic predispositions avoid these questions can simply answer the question about the existence of future care documents in the negative.

**E CONCLUSION**

The principle of patient autonomy confirmed by judicial declarations can be, on occasion as outlined above, limited by medical, common law and legislative obstacles to the observance of instructions given in advance directives. The requirement for consent of the competent patient before any medical treatment is commenced is well-understood by health practitioners. Processes to permit

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competent individuals to direct choices when no longer competent have been recommended by the Australian Health Ministers’ Advisory Council and have been endorsed by parliaments throughout Australia and the United Kingdom. The requirements for validity of advance directives have been laid down through the cases.\(^\text{187}\) Prima facie, there should be no difficulty in adhering to directions for future health care as specified in a valid advance directive. However, the principle of the ‘sanctity of life’ has, as Munby and Michalowski have reported, from time to time been called in aid to justify overriding of advance directives.\(^\text{188}\) Lord Donaldson in \textit{In re T (Adult: Refusal of Treatment)}\(^\text{189}\) acknowledged the conflict between the patient’s right to self-determination and the society’s interest in upholding the idea of the sacredness of human life. Whilst recognising that the right of the individual is ‘paramount’, the way that the right is exercised calls for careful examination and ‘[i]n case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms’.\(^\text{190}\)

As outlined above, legislation, that varies from jurisdiction to jurisdiction, can incorporate barriers to implementation of advance directives. Whilst new legislation in Australian jurisdictions is gradually becoming less restrictive, there are still barriers in Queensland and Victoria, though Victorian legislation is being liberalised following a parliamentary report.\(^\text{191}\) Likewise, the wide-ranging \textit{Mental Capacity Act 2005} (UK) in the United Kingdom, whilst mostly clarifying the law, still exhibits a subtle bias towards the sanctity of life in the differing provisions whereby persons are relieved of liability for either treating or not treating in accordance with valid advance directions.\(^\text{192}\)

Ways of making the consulting of advance care documents part of all medical practice have been proposed in Section D above. They include making these documents compulsory and including details of them in medical records especially


\(^{189}\) \textit{In re T (Adult: Refusal of Treatment)} [1993] Fam 95.

\(^{190}\) \textit{In re T (Adult: Refusal of Treatment)} [1993] Fam 95, 112. The ‘strong presumption in favour of taking all steps which will prolong life’ has been confirmed in by Munby J in \textit{R (Burke) v General Medical Council} [2005] QB 424 at 465; See eg also, \textit{W v M} [2011] EWHC 2443 (Fam) [222] (Baker J); \textit{Sue Rodriguez v Attorney General of Canada and Attorney General of British Columbia} [1993] 3 SCR 519 [10]; \textit{R (Preety) v DPP} [2002] 1 AC 800 [109].


\(^{192}\) See \textit{Mental Capacity Act 2005} (UK) section 26(2)–(3).
centralised, electronic records that will be readily searchable. Whether or not any directions for future care are in existence, and if so their terms, should be as common a question in admissions to health care institutions or any medical practitioner’s surgery, as the identity of the next-of-kin. Ethics education in medical schools should include information about advance directives and their legal underpinnings. Requiring familiarity with advance directives through continuing professional development could also be part of any re-registration or revalidation process for medical practitioners and can be monitored by the Medical Board of Australia. As noted above, this idea has already been proposed in the Final Report of the Victorian Legislative Council’s Inquiry into End of Life Choices as Recommendation 41: ‘That the Victorian Government require doctors and nurses to undertake continuous professional development on advance care planning.’

As the population ages it is more important than ever before that people are not being maintained needlessly, particularly where they have specified otherwise, in situations where they have experiential interests only and have no realistic contact with the outside world. This is distressing to families and other carers. It is also a needless waste of financial and medical resources. According to an estimate by the American Hospitals Association made in an amicus curiae brief in the Cruzan case, 70% of all deaths in the United States appear to be preceded by a decision to withhold or withdraw life-sustaining medical treatment. There is no reason to suspect that similar conditions do not apply in Australia. Thus, there is no cogent reason for failure by health practitioners to abide by properly made and executed advance directives on the ground of deference to the ‘sanctity of life’ or a differing view of patient ‘best interests’ from what is specified in the advance directive.

One further case study remains to be considered. The all-too-frequent problem of medical error and how its aftermath is handled by medical practitioners and health service organisations is the subject of Chapter VI. Failure to properly acknowledge and deal with medical error is a prime example of insufficient observance by some health practitioners of the tenets of patient-centred care.

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194 Cruzan v Director, Missouri Department of Health, 110 S Ct 2841 (1990).
195 Marcia Angell, ‘Euthanasia in the Netherlands - Good News or Bad’ (1996) 335(22) NEJM 1676, 1677.
CHAPTER VI: MEDICAL ERROR AND PATIENT EXPERIENCE

A  INTRODUCTION

Until Ivan Illich’s iconoclastic work, written in the mid-1970s, the frequency of the occurrence of iatrogenic injury, and its costs to patients and practitioners alike, was not widely recognised. The word, *iatrogenic*, is derived from two Greek words, *iatro* meaning physician and *genesis* meaning origin.

Injuries to patients caused by health practitioners, whether in a hospital or any other establishment, are referred to generally and in the literature as adverse events and also as iatrogenic injuries. Near misses are also referred to and are understood as a safety incident that did not reach the patient. Sometimes a blanket term such as medical mishap may be used.

This chapter recounts the incidence of adverse events in medical practice and proposes ways that these can be avoided. Where this is not possible, adoption of the principles of open disclosure can minimise the harmful clinical, psychological and financial consequences of their occurrence. This chapter also suggests possible ways of reducing the resistance by medical practitioners to making an open and honest admission to the patient of the occurrence of an adverse event, honesty with patients being an element of patient-centred care. The originality in this chapter is the focus. Rather than an emphasis on pure safety aspects, this chapter underlines where quality, as exemplified by adherence to patient-centred care principles, has been compromised in both the incidence of adverse events and in the responses to them. This thesis has argued that patient-centred care aligns with professionalism, and professionalism in turn is represented by the terms of the *MBA Code*.

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Medically-caused injury can often be identified as being the result of inadequate management processes rather than the disease process. Injury caused to patients by medical practitioners and the medical system has always occurred, but its magnitude was not realised. What has changed in recent years is a greater acceptance of the idea that the injury must be acknowledged and immediate action taken to minimise any harmful aftermath. Unfortunately however, patient-centred care following a medical mishap stands to be all-too-readily disregarded if the concerns of the injured patient conflict with the interests of a health practitioner or health service organisation.

Section B documents the observation that the incidence of medical injury in Australia is high and compares the situation in several overseas jurisdictions. What is apparent is that the incidence of adverse events is not an isolated problem but occurs in all countries. Makary and Daniel estimate that medical error is the third leading cause of death in the United States, and that it is under-recognised in many other countries, including the United Kingdom and Canada.  

The most recent figures from Australia in *The Quality in Australian Health Care Study* were reported in the *Medical Journal of Australia* in 1995. If comparison is made with other dangerous industries like aviation or engineering where safety is the first priority, the extent of incidence of iatrogenic injury in health care services is unacceptable.

Section C shows that, an injury having occurred, there is a series of responses that must be initiated, as promptly as possible, to minimise the harm caused. The most pressing concern is to deal with the immediate aftermath of the injury. The first response should be to commence necessary treatment to minimise the extent of damage to the patient if possible. But once this has been undertaken, patients or their families have a series of needs that should be addressed. However, it is also important that lessons are learned from the occurrence and that steps are taken to find ways to prevent a similar incident in future. Reporting both adverse events and near misses is essential to the effectiveness of the learning process.

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1 Eric J Thomas et al, ‘Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado’ (2000) 38 Medical Care 261, 263.
Section D describes the principles of open disclosure that are detailed in the Australian Open Disclosure Framework. The framework has been prepared by the Australian Commission on Safety and Quality in Health Care (ACSQHC) following wide and extended consultation with medical and hospital bodies and patient advocacy groups. It presents and elaborates the argument that optimal management of any adverse event lies in prompt inclusion of the patient and, where relevant, the patient’s family in the conversation about appropriate responses. This chapter demonstrates that involvement of the patient, in accordance with the principles outlined in the Australian Open Disclosure Framework,6 is at the heart of patient-centred care.

In light of the ongoing problems created by the incidence of medical error and the sometimes inadequate responses to it, Section D asks whether some of the difficulties might be mitigated if apportionment of blame could be reduced and the threat of litigation eliminated or, at least, minimised. Adoption of no fault compensation for injury would go a long way toward making sure that injured patients were satisfactorily cared for and any blame culture discontinued. Has the time come to institute a national no fault compensation system? This question was explored in more detail in Chapter IV.

The conclusion in Section E acknowledges that the subject of medical error is complex, stemming from many factors, some of which cannot be anticipated. Human beings are not like aeroplanes where there is a relatively predictable response to each operation of controls or weather event. Responses of human beings to treatments are not invariably predictable, as allergies and other reactions may occur. But ‘sentinel’ events caused by neglect of due care in performance, or systems failures should never arise.

Notwithstanding, medical authorities acknowledge that the hazardous nature of much medical treatment inevitably leads to some errors. Given that medical errors cannot be totally eliminated, what is more important is that the response of the relevant medical practitioner or health care institution is immediate and appropriate. What is not acceptable is failure to face and deal with medical errors when they do occur. The Inquiry into Off-protocol Prescribing at St Vincent’s Hospital found that the culture lacked:

• leadership that provided insight, direction and urgency;
• a patient-centred approach;
• analytical rigour, or the necessary questioning scepticism for an accurate characterisation of the issue;
• training for clinical leaders in leadership and in policy and process; and
• demonstration of adherence to values at a time when they were most needed.\(^7\)

The Inquiry went on to conclude:

As a result, the attempts to characterise the issue and follow policy, were unsuccessful: instead of acting in the best interest of the patient, the organisation’s response to the issue was inadequate, drawn out, internalised and defensive.\(^3\)

As this chapter will show, an inadequate response to a medical adverse event suggests a dichotomy between practitioner and patient interests and a discounting of the ethical obligation to make the care of the patient the first priority of the medical professional.

### B MEDICAL ERRORS — TYPES AND INCIDENCE

#### 1 Adverse Events

\(a\) Definition

An adverse event in the medical context includes where a person, following medical treatment whether in a hospital or not, has to spend unplanned time in hospital or is discharged with a serious disability, or who dies as a consequence of a medical procedure,\(^9\) that is, where harm of some degree is caused to the patient. Even a simple error may still cause unacceptable harm.\(^10\) What is imperative is that the occurrence is acknowledged at once so that prompt action may be taken to remedy or, at least, minimise harmful consequences.

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\(^7\) Inquiry under section 122 of the Health Services Act 1997, Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers, Final Report (31 July 2016) [148].

\(^8\) Inquiry under section 122 of the Health Services Act 1997, Off-Protocol Prescribing of Chemotherapy for Head and Neck Cancers, Final Report (31 July 2016) [149]. The issue was the prescribing of identical doses of a chemotherapy drug irrespective of individual characteristics of the patients concerned. The response was the failure to identify or notify the affected patients or notify the public. ‘No medical oncologist was providing input to the hospital’s executive team to inform and prepare the public statements, nor check their accuracy’. [159].


\(^10\) The occurrence of an adverse event is often a traumatic experience for both the patient and the health practitioner concerned. The health practitioner may question whether his or her competence is adequate. Patients may wonder whether they have been the recipients of careless advice or the subject of a negligent procedure.
(b) Sentinel Events

Sentinel events are those severe events that should never under any circumstances occur.\textsuperscript{11} Compulsory reporting of sentinel events was agreed by the Health Ministers in 2004.\textsuperscript{12} The sentinel events agreed to by the Health Ministers for the purposes of reporting were:

- procedures involving the wrong patient or body part;
- suicide of a patient in an inpatient unit;
- retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- intravascular gas embolism resulting in death or neurological damage;
- haemolytic blood transfusion reaction resulting from ABO incompatibility;
- medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- maternal death or serious morbidity associated with labour or delivery;
- infant discharged to the wrong family.\textsuperscript{13}

Sentinel events are those adverse medical events that result in death, permanent harm or severe temporary harm that require intervention to save life. Sentinel events signal a failure in the health care system so must be subjected to strict root cause analysis to determine causes and in order to prevent recurrence.\textsuperscript{14} Loss of a limb or paralysis would be sentinel events though are not specifically mentioned by the Health Ministers. Other adverse events that do not result in these outcomes may be considered to be sentinel in that immediate investigation is required. Similar events occurring in a doctor’s surgery would also be considered sentinel.\textsuperscript{15}

\textsuperscript{11} Australian Commission on Safety and Quality in Health Care, \textit{Windows into Safety and Quality in Health Care} 2009 62: David C Classen et al, 'Global Trigger Tool' Shows that Adverse Events in Hospitals may be Ten Times Greater than Previously Measured' (2011) 30 \textit{Health Affairs} 581.
\textsuperscript{13} Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Health Care, \textit{Sentinel Events in Australian Public Hospitals 2004–05} (July 2007)3–4. Identification of these broad categories did not include supporting documentation and were considered by the Australian Institute of Health and Welfare (“AIHW”) report on \textit{Sentinel Events} as ‘not unambiguous’. Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Health Care, \textit{Sentinel Events in Australian Public Hospitals 2004–05} (July 2007) 1.
\textsuperscript{15} Australian Commission on Safety and Quality in Health Care, \textit{Windows into Safety and Quality in Health Care} 2009 64: Australian Commission on Safety and Quality in Health Care, \textit{Windows into Safety and Quality in Health Care} 2011 5.
(c) Near Misses

A near miss is a patient safety event that did not reach the patient. It is just as important to report near misses as any other sort of patient safety incident. Medical practitioners can be reluctant to report near misses as they may reflect on the competence of the practitioner involved. However, their importance should not be underestimated. Even though a ‘near miss’ did not lead to harm, information about it is valuable in identifying possible future accidents in the health system. The way the near miss occurred in avoiding a full adverse event is as important in modifying practices as an adverse event that caused harm. The process of reporting near misses can also be used as a way of developing communication skills for disclosure of adverse events. However, most physicians are opposed to reporting near misses on the grounds that they are impracticable and diminish patient trust. Some patients do not want to know about them.

However, reporting of near misses is obligatory under the terms of the MBA Code. Yet, in New South Wales, the Open Disclosure Handbook directs that a near miss must be reported to the incident management system but provides that disclosure to the patient is discretionary. It depends on whether it is in the patient’s interest to know of its occurrence, such as where there may be an ongoing safety issue.

Garbutt observes that near misses reported in other hazardous industries have often been used more than actual adverse events because of their more frequent occurrence and because many have similar latent causes to other accidents that may occur.
2 Incidence

Injury caused by medical practitioners is far more prevalent than generally appreciated in the community. One estimate has the injury rate at one in ten of all acute-care hospital admissions.24 According to Runciman and Moller, the risk of dying by simply being a patient in an acute care hospital in Australia is 40 times that of dying in a traffic accident.25 Another survey estimated that of 14,000 admissions into 28 hospitals in New South Wales and South Australia, one in six was associated with an adverse event. Of those, 51% were considered preventable.26 The incidence of deaths from medical adverse events in Australia as reported in the Quality in Australian Health Care Study has been likened, by Richardson and McKie, to a Bali bombing every 3 days,27 or 13 jumbo jet crashes each year.28

In the United States, the Harvard Medical Practice Survey,29 carried out in 1984, reviewed medical records of patients from 51 randomly selected hospitals in the State of New York. By comparing these results with population estimates, results were extrapolated to give an idea of the incidence of medical injury in New York state at that time. Negligence was found to be more frequent in patients where severe adverse events occurred.30 This research is many years old now but recent research in the United States extrapolating national figures from smaller samples estimates that the original research underestimated the incidence of medical errors.31 However, even if there has been a decrease in the intervening years, there still appears to be inadequate awareness in the health care system that one injury is too many.

26 Ross McL. Wilson et al, 'The Quality in Australian Health Care Study' (1995) 163 MJA 458, 458. Wilson et al reported: ‘In 77.1% the disability had resolved within 12 months but in 13.7% the disability was permanent and in 4.9% the patient died.’
31 M A Makary, and Michael Daniel, 'Medical Error-the Third Leading Cause of Death in the US' (2016) BMJ (Online) <http://www.bmj.com/content/353/bmj.i2139>.
In 1992, a survey was carried out in Utah and Colorado, two smaller states than New York, but using similar processes as had been applied in the New York state survey. Two articles published in 2000 followed this survey, one reporting the incidence of iatrogenic injuries and the other investigating whether or not iatrogenic injuries to patients led to litigation against the medical professionals involved.

Comparative figures for iatrogenic injuries in Australia, Utah/Colorado and New York are tabulated in Appendix VIA. The discrepancy in the incidence is notable, a factor of about five to one.

Following questions about the reasons for the disparity in figures between Australia and the United States, further research was undertaken. In the original Quality in Australian Health Care Study, Wilson et al had noted that whilst the Australian study was modelled on the Harvard study with some modifications, the same methods were used. The substantial difference was that a measure of preventability was applied, a less confronting option for health care professionals, rather than the estimate of malpractice and negligence used in the Harvard study.

More formal research was undertaken by Thomas et al to try to identify the different factors that had led to the discrepancy. When the Australian figures were analysed in a similar way to those in Utah/Colorado, the incidence figures changed for Australia to 10.6% and revised the Utah/Colorado figures to 3.2%, still a factor of three to one. A second article attempted to account for the three-fold difference having adjusted for five differences in methodology. Major disabilities and death had similar rates but the rate for minor disability was six times greater in Australia. The researchers suggested that the disparities were consistent with the

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32 Eric J Thomas et al, 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado' (2000) 38 Medical Care 261, 268.
33 Eric J Thomas et al, 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado' (2000) 38 Medical Care 261.
34 David M Studdert et al, 'Negligent Care and Malpractice Claiming Behavior in Utah and Colorado' (2000) 38 Medical Care 250.
differing aims of each study but there were no observable divergences in quality of care.\textsuperscript{38}

This epidemic of adverse events cannot be ignored and there have been attempts to establish processes for dealing with the adverse events and the injuries caused to patients by their occurrence. As Faunce has commented, many injuries are not caused so much by the individual medical practitioner as by system error. He goes on to observe that efforts have been made to introduce quality assurance and incident reports but these have made little impression on the jurisprudence surrounding patient injuries.\textsuperscript{39} Any effort to resolve these difficulties has to take system error into account.\textsuperscript{40} Figures from the Quality in Australian Health Care Study show that 53\% of adverse events are a result of system error, failure to use policy or the absence of policy.\textsuperscript{41} The efforts to prevent recurrence indicated that failure of communication was a factor in 81\% of those matters reported.\textsuperscript{42} Yet, Christakis comments that blaming the system can, on occasion, look like an excuse.\textsuperscript{43}

C MANAGING ADVERSE EVENTS

Makary and Daniel have remarked that:

Human error is inevitable. Although we cannot eliminate human error, we can better measure the problem to design safer systems mitigating its frequency, visibility, and consequences. Strategies to reduce death from medical care should include three steps: making errors more visible when they occur so their effects can be intercepted; having remedies at hand to rescue patients; and making errors less frequent by following principles that take human limitations into account.\textsuperscript{44}

Medical adverse events are an ongoing and important concern for medical regulators and health service providers. The existence of the Open Disclosure

\textsuperscript{40} W B Runciman and J Moller, Iatrogenic Injury in Australia (Australian Patient Safety Foundation, 2000) 17.
\textsuperscript{42} Ibid.
\textsuperscript{43} Nicholas A Christakis, 'Don't Just Blame the System' (2008) 336 BMJ 767.
\textsuperscript{44} M A Makary, and Michael Daniel, 'Medical Error-the Third Leading Cause of Death in the US' (2016) BMJ (Online) <http://www.bmj.com/content/353/bmj.j2139>.
Framework promulgated by ACSQHC,\textsuperscript{45} is supplemented by directions of state health authorities. In New South Wales, the Clinical Excellence Commission supports the advice of the Open Disclosure Framework with its own handbook.\textsuperscript{46} Western Australia’s Department of Health has published a guide to open disclosure\textsuperscript{47} as has Victoria,\textsuperscript{48} and ACT Health has issued an Open Disclosure Policy.\textsuperscript{49}

Similar directions are emphasised by all the policies and guides and these will be analysed below. However, recognition of iatrogenic injuries as an ongoing problem has been slow in the past and is only now being given the detailed attention that was previously lacking. Yet dealing with adverse events is clearly an obligation of medical practitioners as is evidenced by its inclusion in the MBA Code.\textsuperscript{50}

This section commences by documenting the slow path to the realisation that medical errors must not be ignored but must be faced. Procedures must be developed to mitigate harm to both the individual concerned and to those who were answerable (whether to blame or not). The section continues by exploring the responses most important to the injured patient and family and why they are critical to management of adverse events. It then moves on to a discussion of the benefits to both patients and health professionals where effort is put into using the incidence of medical errors and near misses as a learning tool. Minimising recurrence by modification of systems and by finding ways to adapt to human limitations would appear to be the most effective responses.

1 Dealing with Iatrogenic Injuries

In 1987, Sir Frederick Lawton commented that attitudes of courts and the legal profession to medical injuries were gradually changing and reflected what the public was, at that time, expecting of courts and lawyers. In the United Kingdom, until about 1950, litigation was conducted in accordance with the Rules of the

\textsuperscript{45} Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013).
\textsuperscript{47} Government of Western Australia, WA Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia (May 2009 (amended July 2012)).
\textsuperscript{49} ACT Health, Open Disclosure Policy (February 2010).
\textsuperscript{50} Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10] and [6.2.1].
Supreme Court that permitted documents that came into existence for the purpose of litigation to be privileged from production or inspection.

This covered all medical reports obtained for the purposes of actions for personal injuries and alleged acts or omissions in the course of medical treatment. The latter kind of actions were then rare because of the difficulty of proof. In those days finding a doctor who was willing to testify that another doctor had been negligent was difficult.51

Runciman and Moller point out that, to some extent, this attitude still persists in medical negligence litigation. ‘Patients have had, and still have in the private sector, difficulty in obtaining access to their medical records in the event of a dispute.’52 However, the frequency with which iatrogenic injuries occurs is a matter that should be of great concern to the medical establishment. Until relatively recently, little information was available to either health care professionals or the general public. The necessity to track adverse events became apparent in the perception by public authorities that patient safety was under threat from preventable human error or system failure.53 The Quality in Australian Health Care Study was instituted to determine the incidence of adverse events in admissions to Australian hospitals54 because, without this information, it would be difficult for preventive action to be taken.

Runciman and Moller comment that there has in the past been a general reluctance to acknowledge that adverse events have occurred and that they should be properly documented.55 Medical practitioners who are involved in an adverse event have numerous concerns about acknowledging those errors, both to themselves and to their patients. The perception by medical practitioners that they are at risk of litigation, that their reputations will suffer, that their authority will be questioned, that their patients will no longer trust them and that any admission of guilt will dent self-esteem and confidence has led to secrecy and a reluctance to admit any responsibility. Several commentators have remarked that many medical practitioners have attempted to hide their errors, or shift the blame onto some-one else including the patient.56

51 Naylor v Preston Area Health Authority [1987] 2 All ER 353, 365 (Sir Frederick Lawton).
Where adverse events have occurred, other hazardous industries have made a determined effort to find out what has happened and why. For example, the aviation industry has taken the view that a 1% error rate is unacceptable and has worked to modify its procedures accordingly. In medical practice, anaesthetists have made an effort to learn from past errors. Among other activities, anaesthetists have negotiated with manufacturers to engineer safety devices to prevent errors in connection of lines, and to ensure that a minimum proportion of oxygen is always available.

Atul Gawande recounts the story of a surgeon who introduced a checklist of five essential procedures to reduce the incidence of central line infections. Following the dramatic reduction in infections because the check list reduced the number of missed necessary steps in the process, the hospital convinced one of the largest manufacturers of central lines to include necessary drapes and antiseptics with their central line kits.

It is an indictment of the health system if medical practitioners seek to deflect attention from responsibility and to avoid reporting all relevant information. As Healy and Braithwaite observe, any other industry that took the same attitude would become the object of greater public and regulatory attention for attempting to put the interests of the individual practitioner above those of members of the public who entrust themselves to the system in question. No-one doubts that some errors are unavoidable or unexpected, but analysing their occurrence can reveal system errors that can be rectified or minimised. But incidents cannot be analysed unless they are reported, the value in reporting being to provide information so that responses can be prioritised. Prevention of future similar occurrences demands that all adverse events be reported.

Attempts are now being made to rectify this situation. The recognition in paragraph 3.10 of the MBA Code that acknowledgement of medical errors is a...

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60 Judith Healy and John Braithwaite, 'Designing Safer Health Care through Responsive Regulation' (2006) 184(10) Supplement MJA SS6, s 57.
responsibility of medical practitioners has been bolstered by the development of the Australian *Open Disclosure Framework* and its release in 2013 following many years of pilot studies and consultations.\(^63\) Paragraph 3.10 and the *Open Disclosure Framework* will be analysed later in this chapter.

2 What Patients and Their Families Are Seeking

Almost all the literature about patient reactions to medical error has emphasised that patients have several basic requirements. They want

(a) to know what happened and why;
(b) to find out who or what is responsible;
(c) to make sure that what has befallen them will not cause a similar injury to some-one else in the future;\(^64\)
(d) a *sincere* apology;
(e) to know the short- and long-term consequences of the event.\(^65\)

The reason why many patients have turned to litigation is because they have not had satisfactory explanations about what occurred and litigation has been a way of finding out the facts.\(^66\) Patients have reported that their medical practitioners have ignored them and left it to hospital administrators to handle the matter:

No doctor actually spoke to me ... and the office person or floor person or whatever her title, when she seen me [sic] come that day she didn’t even have the decency to look at me and say I’m sorry for your loss, she turned and looked away from me ...\(^67\)

Patients have been provided with evasive answers to questions.\(^68\) They have been stonewalled for years by physicians, lawyers and administrators.\(^69\) Frequently the passive voice has been used as a way of deflecting attention from the responsibility of the medical practitioner involved:\(^70\)

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He was worried, I’m certain, of what was going to happen, what the outcome ... what he was going to say to us, what he could say to us. Everything he did say was very carefully worded.\textsuperscript{71}

The principles of open disclosure that will be examined later in this chapter commence with the focus on these patient-centred objectives. Open disclosure will not achieve its desired result of minimising harm to patients if patient needs and wants are not integral to the process. Just using the data to change defective procedures is only part of the story. Involving the patient in the decisions concerning desired outcomes may reduce resort to negligence litigation.

\textit{(a) What Happened and Why} \\
If a patient has been the subject of an adverse event, the first reaction of the patient is to try and understand the facts, to find out what happened.\textsuperscript{72} Without understanding the reason why this situation has occurred, patients cannot begin to process its ramifications for them and their families:\textsuperscript{73}

[...]and they called us up and they say, the investigation’s complete. Nobody at the hospital made any mistakes. None of their doctors, none of their nurses, none of their janitors, nobody made any mistakes.\textsuperscript{74}

I actually got to ask, and they answered ... because [health service staff] only look at a medical reason. You only look for medical [things]. You don’t look for the actual facts around and what led to it. You only look at what it is when you walked into that room, what you saw, or what you had to treat. You don’t look at okay, what happened before you got to that room ... It’s only through them understanding the full story ... [that] you can only bring about change.\textsuperscript{75}

They seemed to talk above your head somehow. Even though they’re trying to say it simply ... “I feel as though I’m, er, just, er, a subject rather than a person, if you know what I mean ...” “ell [sic], I had to press for it, to get the information I wanted. See, my question was, if I was given this, er, injection, why wasn’t it checked and double checked before it was administered.\textsuperscript{76}

\textsuperscript{72} See eg, Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005) 38, 67.
\textsuperscript{73} Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013) [1.1].
\textsuperscript{74} Christine W Duclos et al, ‘Patient Perspectives of Patient-Provider Communication after Adverse Events’ (2005) 17 International Journal for Quality in Health Care 479, 481.
As several writers have commented, instead of being told what happened, patients and carers have been pushed aside, disbelieved or avoided.\textsuperscript{77}

\textit{(b) Who or What is Responsible}

The next requirement for the patient is to know who was responsible.\textsuperscript{78} Duclos reports the trauma of an adverse event where the harm was caused by someone trusted by the patient:

I’m extremely hurt just because I’m still having complications. I’m going to get cut open again ... Just the fact that he has no idea what I’m going through. And he’s just moved on with his life and never called me. That really hurts. It really bothers me.\textsuperscript{79}

The fear of facing a patient who may be angry and emotional keeps some medical practitioners from facing up to the results of their activities. Though as Wu says, until the medical practitioner does face up, he or she is not going to have the opportunity for the patient to forgive. Being forgiven by an injured patient allows both patient and responsible health practitioner to better deal with the aftermath of an adverse medical event.\textsuperscript{80} More recent research suggests that when an offender makes a sincere effort to make amends, such as by apologising, an injured person is more likely to see the offender as deserving of forgiveness.\textsuperscript{81} The act of forgiving itself can be beneficial to injured persons by enhancing well-being and giving them the feeling of being valued.\textsuperscript{82}

Not being treated seriously by the person who caused the problem can arouse anger and the feeling of wishing to seek revenge.\textsuperscript{83} Where a hospital administrator is substituted for the person responsible, the patient can feel slighted. The patient’s dignity is compromised where it appears that no respect is being paid to the


\textsuperscript{78} Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005) 24.


\textsuperscript{83} Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard Review Report (June 2012) [4.2.1].
feelings of the patient concerned. Slights to one’s dignity are one way for the patient to feel devalued and consider resorting to litigation.

I don’t think he gave me the respect he should have given me, and I wouldn’t give him another chance. He didn’t listen to me.\textsuperscript{84}

(c) System Correction

The patient will also be concerned to make sure that a similar mishap will not occur to any other person.\textsuperscript{85} The patient must be reassured that the experience of the adverse event is taken seriously as a way of learning from the error, and that systems will be modified to take account of the occurrence.\textsuperscript{86} Patients are more likely to forgive if they are satisfied that system changes will prevent a similar fate befalling anyone else.\textsuperscript{87}

At the end of the day, you know, when an unfortunate accident happens like that, that [inappropriate disclosure communication] could be avoided in the future ... It would be good to know that my dad’s death, you know, sort of prompted some changes in that area, you know, and I’m sure that if he was around, he would like to know that as well.\textsuperscript{88}

(d) Apologies

Research suggests that patients are less likely to sue when they have been given a complete explanation of how the adverse event arose, and a full and sincere apology.\textsuperscript{89} Failure to apologise contributes to anger which can lead to litigation.\textsuperscript{90}

That’s what the meeting was supposed to be about, but it was just a big defense mechanism for them. There wasn’t much admission of anything that went wrong ... it was a lot like talking to a politician, it felt like, you know? He would answer questions in a long and roundabout sort of way?\textsuperscript{91}

Er, I mean ... from what I can remember, I was quite sort of upset at the time. They were basically ... the whole thing it seemed like they were covering their tails, basically. They haven’t ... The doctor at the time did apologise but no-one’s really

\textsuperscript{84} Christine W Duclos et al, ‘Patient Perspectives of Patient-Provider Communication after Adverse Events’ (2005) 17 International Journal for Quality in Health Care 479.481.
\textsuperscript{85} Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013) [1.1].
\textsuperscript{86} Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013) [11.1].
\textsuperscript{87} Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005) 111.
\textsuperscript{89} Nina Khouri, Making It Safe to be Sorry' [2012] New Zealand Law Journal 330, 331.
\textsuperscript{90} Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005) 53.
taken responsibility for it. I would like to have an apology ... a sincere apology, that, “yes, we shouldn’t have put you in that position” 92

I just wanted him to take responsibility for it. ‘Look, I’m sorry I did this and I’ll do whatever it takes to make things right’. Just own up to what happened.93

The value of apologies is scrutinised in more detail later in this chapter.

(e) Possible Long-Term Consequences

Lat but not least, the patient needs to know what the short- and long-term consequences will be.94

I was on antibiotics for four weeks and they discontinued it because the antibiotics were affecting my kidneys. And it’s like, well, what else is going to happen to me now? It just seemed like one thing after another after another after another.95

The injury may be a simple matter that can be rectified comparatively easily. However, many adverse events result in long-term consequences that may mean a drastic reduction in the quality of life previously enjoyed. Where a death has occurred, the long-term consequences may include finding ways for a bereaved partner to cope with what has happened and to move on.

3 Learning from Adverse Events

No-one, whether medical practitioner or patient, wants an adverse event to occur. Reporting of adverse events and near misses is an obligation on medical practitioners and health care organisations96 to assist in managing incident resolution. It also throws up those sentinel events that must be subjected to root cause analysis to determine how to modify systems to minimise recurrence.97 Identification of those factors that have caused a sentinel event is necessary for any monitoring system.98

93 Christine W Duclos et al, 'Patient Perspectives of Patient-Provider Communication after Adverse Events' (2005) 17 International Journal for Quality in Health Care 479, 482.
94 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10.3].
96 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [6.2.3].
The National Quality Forum endorsed a list of *Serious Reportable Events in Healthcare* to provide a set of events upon which to base a national reporting system. Whilst this purpose is still being fulfilled, this list is increasingly also being used ‘... with the goal of illuminating such events to facilitate learning and improvement’.\(^9\) Rather than using reporting to apportion blame, all health service organisations should be accountable for the quality of care they are providing, accountability including

1. diligent effort to discover vulnerabilities that could lead to adverse events;
2. focused review and analysis of events that do occur to determine causal or contributing factors;
3. applying what is learned to consciously improve quality;
4. public reporting to enable other organisations to apply lessons learned and take actions to prevent recurrence.\(^10\)

However, reporting is not always an optimum method of obtaining accurate, timely, credible and useful information. Over time, participants can be afflicted with inertia.\(^11\) If the outcome of reporting is a perception that blame will be laid, motivation to report may be minimal. Yet, when reporting of near misses in the air traffic system was disconnected from blame, the rate of reporting increased dramatically.\(^12\) It is also essential that those reporting should see that valid remedial action is taken in response to reports or reporting will be seen as a waste of time.\(^13\)

\(\text{(a) Safety}\)

As reported earlier in this chapter, the incidence of iatrogenic injury in Australia is still unacceptably high. For example, the report by Australian Institute of Health and Welfare, *Admitted Patient Care 2014–015: Australian Hospital Statistics* shows a total of 569 418 separations\(^104\) with an adverse event.\(^105\) Of these, a total of

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\(^12\) Lucian L Leape, 'Error in Medicine' (1994) 272 *JAMA* 1851, 1855.
\(^13\) Australian Commission on Safety and Quality in Health Care, *Windows into Safety and Quality in Health Care 2009 60*.
\(^104\) *Separation* is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). A separation may also be generated by a transfer between hospitals. ‘Separation’ also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care’. Australian Institute of Health and Welfare, *Admitted Patient Care 2014–015: Australian Hospital Statistics* (16 March 2016) 5.
33,496 related specifically to patient falls.\textsuperscript{106} Despite the recognition over many years that adverse events in the medical context occur, patients still expect their intersections with the medical system will not result in injury or death.

(b) \textit{Patient-Centred Care}

The adoption of the principles of patient-centred care has led to a particular focus on those aspects of medical practices that have led to patterns of adverse incidents. Standards 3 to 10 of the \textit{National Safety and Quality Health Service Standards} deal with specific problems that cause injuries to patients. Standards 3 to 10 are as follows:

- Preventing and controlling healthcare associated infections
- Medication safety
- Patient Identification and procedure matching
- Clinical handover
- Blood and Blood products
- Preventing and managing pressure injuries
- Recognising and responding to clinical deterioration in acute health care
- Preventing falls and harm from falls.\textsuperscript{107}

The example of patient falls shows that simple failures to adhere to procedures can result in catastrophic consequences, especially for older people. Yet falls are still occurring regularly in medical settings. Making the patient’s needs, wants and values the essence of patient interactions with the medical system means that patient safety and the quality of health services must be emphasised above all factors. Developing the safety systems to minimise adverse events is a patient-centred activity.

4 Conclusion

Given the necessity to manage adverse events in a way that provides the optimum outcomes for both patients and health professionals involved, it is clear that, despite some objections, the essential information required before any inroads can be made into the high incidence of iatrogenic injuries, is a reliable and robust system of reporting. Failing to face and deal with the event is a recipe for litigation.

\textsuperscript{106} Australian Institute of Health and Welfare, \textit{Admitted Patient Care 2014–015: Australian Hospital Statistics} (16 March 2016) Table 8.9.

\textsuperscript{107} Australian Commission on Safety and Quality in Health Care, \textit{National Safety and Quality Health Service Standards} (September 2012) 3.
D MEDICAL ERRORS AND OPEN DISCLOSURE — AN ETHICAL OBLIGATION FOR MEDICAL PRACTITIONERS?

1 Introduction

The term ‘open disclosure’ is increasingly being used to describe, in summary form, the ‘best’ way to deal with iatrogenic injuries.\(^{108}\) The principles of open disclosure emphasise the necessity for involvement of the patient in all responses to an adverse event, the partnership aspect of patient-centred care. Putting patients first involves subordinating personal interests to patient interests. It also acknowledges those matters that are important to patients who have suffered an adverse event, as detailed in Section C above.

In 2003, the Australian Health Ministers Advisory Group developed the *Open Disclosure Standard* that outlined procedures for dealing with the aftermath of adverse events. This standard was the subject of a review report by ACSQHC that recommended amendments to take account of accumulated experience and changing views of the best way to conduct the process.\(^{109}\)

In 2008, the Health Ministers resolved that open disclosure should be implemented in health care organisations throughout Australia,\(^{110}\) and in December 2013 the *Framework* was formally endorsed by them.\(^{111}\)

The *Framework* specifies the guiding principles for open disclosure as follows:

1 Open and timely communication;
2 Acknowledgement;
3 Apology or expression of regret;
4 Supporting, and meeting the needs and expectations of patients, their families and carers;
5 Supporting, and meeting the needs and expectations of those providing health care;
6 Integrated clinical risk management and systems improvement;
7 Good governance;

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The MBA Code outlines how medical practitioners should deal with the business of providing care and treatment to patients. It acknowledges that risk is inherent in the practice of medicine and advises that medical practitioners should be aware of risks and work to minimise their occurrence. It also advises that medical practice must be conducted safely.

Paragraph 6.2 specifies what good medical practice in relation to risk management involves:

- **6.2.1** Being aware of the importance of the principles of open disclosure and a non-punitive approach to incident management;
- **6.2.2** Participating in systems of quality assurance and improvement;
- **6.2.3** Participating in systems for surveillance and monitoring of adverse events and ‘near misses’, including reporting such events;
- **6.2.4** If you have management responsibilities, making sure that systems are in place for raising concerns about risks to patients;
- **6.2.5** Working in your practice and within systems to reduce error and improve patient safety, and supporting colleagues who raise concerns about patient safety;
- **6.2.6** Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised.

These stipulations are reinforced by the terms of paragraph 3.10 that states that when adverse events occur, the medical practitioner has a responsibility to be open and honest in all communications with the patient, to review what has occurred and to report appropriately. When something goes wrong the medical practitioner should seek advice from colleagues and the medical indemnity insurer. Good medical practice involves:

- **3.10.1** Recognising what has happened;
- **3.10.2** Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice;
- **3.10.3** Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences;
- **3.10.4** Acknowledging any patient distress and providing appropriate support;
- **3.10.5** Complying with any relevant policies, procedures and reporting requirements;
- **3.10.6** Reviewing adverse events and implementing changes to reduce the risk of recurrence;
- **3.10.7** Reporting adverse events to the relevant authority;

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113 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [6.1].
114 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10].

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Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant healthcare complaints commission or medical board).\textsuperscript{115}

However, the 	extit{MBA Code} is silent about any obligation to apologise. Paragraph 3.10 did not take into account the provisions of the 	extit{National Open Disclosure Standard} that had been promulgated in 2003, six years before the publication in 2009 of the first edition of the 	extit{MBA Code}. This silence contrasts with the United Kingdom’s 	extit{Good Medical Practice} that specifies that when things go wrong an apology should be offered.\textsuperscript{116} Notwithstanding, the obligation in paragraph 6.2.1 to be aware of the principles of open disclosure suggests that an apology should be offered.

The obvious conclusion is that failure to be guided by open disclosure principles in contravention of the 	extit{MBA Code} must be seen as an ethical shortcoming, quite apart from the risk of legal and disciplinary action against health practitioners.

2 Patient Experience

The way open disclosure is conducted will have a profound effect on the outcome after a patient has endured an adverse event and will determine whether the patient will make the best recovery. Therefore it is essential that the response to adverse events is practised in accordance with the 	extit{Australian Open Disclosure Framework} commencing with open and honest, good communication to help the patient understand what has happened.\textsuperscript{117} The patient must be encouraged to become involved in the investigation process as well as the development of the plan for ongoing care and counselling. For example, reimbursement of immediate out-of-pocket expenses and arrangements for ongoing care are vital for the patient’s continued well-being.

And it’s almost to the point where … well, if the problem persists for two or three years, how long can it be before I sue the people who were involved to help pay for the problem. I mean, it’s bad enough that I have to physically deal with it, but then to have to financially deal with it is a totally different situation.\textsuperscript{118}

\textsuperscript{115} Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [3.10].

\textsuperscript{116} General Medical Council, \textit{Good Medical Practice} (at 22 April 2013) Clause 55b.

\textsuperscript{117} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) [4.1].

\textsuperscript{118} Christine W Duclos et al., ‘Patient Perspectives of Patient-Provider Communication after Adverse Events’ (2005) \textit{17 International Journal for Quality in Health Care} 479, 482.
3 Implementation

According to Finlay, Stewart and Parker, despite compelling professional obligations and common law developments, Australian doctors have generally avoided open disclosure\(^\text{119}\) even following its endorsement by the Health Ministers. The promulgation of the Australian Open Disclosure Framework and the recognition in Lamb’s editorial in the journal, *Quality and Safety in Health Care*, that owning up to and facing the consequences of an adverse event is an ethical, moral and professional imperative,\(^\text{120}\) both underline the importance of the adoption of open disclosure practices throughout the Australian health system. Having acknowledged open disclosure as ethically mandated, the law should enforce the clear statutory obligations.\(^\text{121}\) Brazier and Cave point out that ethics demands a higher standard from the medical practitioner than what is stipulated by the law.\(^\text{122}\)

All levels of management must be involved in developing open disclosure protocols. However, once the protocols have been developed, the senior person in the medical team together with a senior management person must implement each open disclosure action following an adverse event.\(^\text{123}\) Involving senior personnel makes the patient feel that the occurrence of the adverse event is being taken seriously and that the problem will not be repeated for any other person,\(^\text{124}\) prime needs for injured patients as outlined in Section B.

(a) *Timely Acknowledgement*

The first aspect of open disclosure is the necessity for both complete openness and for communication of the perceived error to be made to the patient and the patient’s family at the earliest opportunity — when it is clear something has gone


\(^{122}\) Margaret Brazier and Emma Cave, *Patients, Medicines and the Law* (Penguin Books, 2007) [3.4].


wrong. The temptation to say nothing is strong, especially if the patient does not appear to be aware of what has occurred. Prompt disclosure of medical error avoids many problems that can occur later. The fact that the information is not complete is no excuse for delaying the communication. Even if all information is not known at the beginning, it can be provided as further meetings occur.

A prime example of delay has been provided in the Interim Report into Off-protocol Prescribing of Chemotherapy for Head and Neck Cancers, the St Vincent’s Hospital revelations. Both paragraphs 29 and 62 found that no affected patients were contacted for open disclosure until after a media report was aired on 18 February 2016. There was no recognition that what was occurring was a serious incident. As the report states in paragraph 42:

[42] There appeared to be no effective executive sponsorship of the incident. There was no sense of urgency about the internal or external reviews that were undertaken. It was assumed that because an early decision (although not clear by whom) was made that there was no further treatment that could be offered and the practice had ceased, there was no urgency to review affected patients. There is no single time point or person who is responsible for the lack of urgency: it appears to have come about from the way the incident was framed – an ‘error’, ‘under-dosing’ or as a ‘protocol variation’ by a senior clinician rather than characterising it as someone unilaterally prescribing ‘off-protocol’ with flat dosing.

(b) Apology

One of the more important requirements for any healing process following an adverse event is a sincere apology. Doctors have been reluctant to apologise on the grounds that an apology may mean an admission of liability. However, unless the injured patient hears at least the words ‘I am sorry’, the patient is unlikely to be convinced that the apology is more than mere window-dressing. Face-to-face meetings between the patient and support person and the medical staff

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involved will be more beneficial than an apology delivered by a member of management or a clinician who has not been involved in the actual adverse event. Research suggests that health care professionals want to apologise and seek forgiveness for any patient harmed while in their care but are constrained by fear of litigation.

Medical practitioners are advised to express regret for the event but to avoid acknowledging fault or making any apology. Doctors must not state that anyone is liable for the event, nor agree that someone should be held liable. This direction exemplifies a diffusion of accountability that is a function of modern social organisation. Harms are separated from responsibility for them. Affected patients may be unable to pin down the responsibility for the occurrence of the adverse event.

Precisely what is meant by a sincere apology? Definitions play around with apology as an expression of regret but do not acknowledge open and honest communication between doctor and patient. As they stand, sincere expressions of regret for patient injury can adopt a defensive position that is incompatible with the comprehensiveness of acknowledging responsibility and expressing remorse. As Berlinger observes, without these two aspects, an apology is hollow and will not serve to provide patients with the comfort and healing that they need.

No apology is going to be acceptable to an injured patient unless it is clear that the person making the apology is accepting responsibility even if that person is not to blame for the occurrence. Recent research shows that implementation of open disclosure might also be improved if apology laws were broadly consistent across jurisdictions.

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134 Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard Review Report (June 2012) 44.
136 Scott Veitch, Law and Irresponsibility (Routledge-Cavendish, 2007) 47.
137 Scott Veitch, Law and Irresponsibility (Routledge-Cavendish, 2007) 43.
139 Nancy Berlinger, After Harm (Johns Hopkins University Press, 2005) 95.
140 Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard Review Report (June 2012) 43.
As Vines points out, an apology is more than mere regret; a real apology does acknowledge responsibility.\textsuperscript{142} Allan argues that legislators developing legislation to encourage apologies in litigation by protecting them from implication of liability, rely on five grounds:

- Moral – the harm in tort law is negligence caused by lapses in concentration or judgment such that most victims and offenders think an apology to be appropriate in the circumstances.
- Intangible loss – money cannot undo the harm caused by intangible injuries like pain and suffering.
- Economic – the questionable argument that tort litigation in Australia is increasing and is not sustainable.
- Efficacy – offenders do not engage directly with their victims because they fear that they may, if apologising, admit liability.\textsuperscript{143}
- Therapeutic jurisprudence – there is evidence that victims obtain physical and mental health advantages from receiving an apology.\textsuperscript{144}

Berliger reports a focus study of physicians’ attitudes towards disclosure finding that physicians choose their words carefully which can have the effect of concealing a mistake rather than admitting it.\textsuperscript{145} Use of the passive voice and technical language serve to shield medical practitioners from facing responsibility for injuries caused to patients. Berliger reports a conversation from a book written by the wife of a man whose hand and forearm had to be amputated after two catheters were put in the hand, blocking circulation:

> [t]he neurosurgeon met me in the hall. He seemed very angry. “There was a mistake,” he said. “The catheter used to measure arterial gases became clogged, and a new catheter was placed on the same hand instead of the other hand. You never put two sticks in one hand. When the catheter became clogged, circulation was blocked through his hand” He then said, “It wasn’t noticed for twenty-four hours,” the passive voice subtly deflecting responsibility from a human agent ...\textsuperscript{146}

Failure to take responsibility derogates from the requirement of truthfulness stated in the \textit{MBA Code},\textsuperscript{147} though it should be noted that the \textit{MBA Code} itself has no reference to giving of an apology in its required responses to medical mishaps.\textsuperscript{148}

\textsuperscript{145} Nancy Berlinger, \textit{After Harm} (Johns Hopkins University Press, 2005) 23.
\textsuperscript{146} Nancy Berlinger, \textit{After Harm} (Johns Hopkins University Press, 2005) 30.
\textsuperscript{147} Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [1.4] & [3.1].
\textsuperscript{148} Its only reference to giving of an apology (‘if appropriate’) is in the context of dealing with complaints, not as part of a response to an adverse event. Medical Board of Australia, \textit{Good Medical Practice: A Code of Conduct for Doctors in Australia} (at March 2014) [3.11.4].
There is also compelling evidence that sincere acknowledgements of responsibility and genuine apologies reduce the resort by patients or their families to litigation.\(^{149}\)

As Lord Woolf explained, most times the patient or family member merely wants a sincere apology and an assurance that the same adverse event will not happen to another patient in the future.\(^{150}\) Non-disclosure of adverse medical events increases the likelihood of resort to litigation when a failure to apologise and accept responsibility leads to a threat to the trusting relationship between medical practitioner and patient.\(^{151}\) Without acknowledgment of the harm caused, restoration of the trust violated by the occurrence cannot occur.\(^{152}\) Parker comments that sincere apologies are in everyone’s interest.\(^{153}\)

Parker reports that examination of the open disclosure policies of the states adopted following the National *Open Disclosure Standard* shows that they are all careful to advise medical practitioners to avoid making any apology imply an admission of error.\(^{154}\) Whilst these policy statements treat apologies as having a sense of expressing sorrow for the patient’s situation, none accepts responsibility.\(^{155}\) To a certain extent, this advice is a response to policies of professional indemnity insurers that require practitioners to desist from acknowledging any responsibility for error.\(^{156}\) There is a fear among medical practitioners and medical indemnity insurers that an apology or expression of regret can be used as an admission of negligence but this appears to be not necessarily the case.\(^{157}\)

This view is supported in a non-medical context by the case of *Dovuro v Wilkins*\(^{158}\) where a company had made several apologies to farmers to whom weed-contaminated seeds had been supplied. As Kirby J said: ‘The various apologies,
statements of regret and promises of improvement do not, as such, establish the claim of negligence against Dovuro.\textsuperscript{159} Similarly, Gummow J stated: ‘The so-called “admissions” of officers of Dovuro ... provide no basis for a finding of negligence in this case.’\textsuperscript{160} Gleeson CJ agreed with Gummow J about the care that should be taken in identifying the precise significance of an admission, especially in a situation where the maker of the statement was seeking to retain the goodwill of the persons to whom the statement is made.\textsuperscript{161} As Vines comments, a statement made by a party as to a legal conclusion does not establish that conclusion as determination of legality is the function of the court.\textsuperscript{162}

In any case, liability for apologies is denied by section 69(2) of the \textit{Civil Liability Act 2002} (NSW). This provision is reflected in varying terminology in the civil liability legislation of the ACT,\textsuperscript{163} Western Australia,\textsuperscript{164} Victoria\textsuperscript{165} and Tasmania.\textsuperscript{166} Queensland has provision for both expressions of regret\textsuperscript{167} and apologies\textsuperscript{168} and provisions confirming that they are not admissible in evidence against the person or any organisation. South Australia has no provision for apology but does mention expressions of regret in the context of non-admission of liability or fault.\textsuperscript{169} Similarly, Northern Territory legislation only applies to expressions of regret.\textsuperscript{170} Whilst the legislation is supposed to be uniform, differences in expression mean that the consequence for litigants varies between jurisdictions.\textsuperscript{171} The differing provisions have been tabulated in Appendix IVA.

According to Khouri, inadmissibility of apology evidence in litigation is of significant benefit to insurers.\textsuperscript{172} Apology laws predated the civil liability legislation that applies in various guises around Australia. However, as Gallagher

\textsuperscript{159} Dovuro Pty Limited v Wilkins (2003) 215 CLR 317, 356 (Kirby J).
\textsuperscript{160} Dovuro Pty Limited v Wilkins (2003) 215 CLR 317, 342 (Gummow J).
\textsuperscript{161} Dovuro Pty Limited v Wilkins (2003) 215 CLR 317, 327 (Gleeson CJ).
\textsuperscript{162} Prue Vines, ’Apologising to Avoid Liability: Cynical Civility or Practical Morality’ (2005) 27 \textit{Sydney Law Review} 483, 496. An article by a medical practitioner in \textit{Australian Doctor} recommended that the medical practitioner apologise when something goes wrong, and also advised that saying sorry is not an admission of guilt. (Jon Fogarty, ’I’m Sorry’ \textit{Australian Doctor} (Online) (12 June 2014) <http://www.australiandoctor.com.au/opinions/log-s-blogs/i-m-sorry>.
\textsuperscript{163} Civil Law (Wrongs) Act 2002 (ACT) s 14(2).
\textsuperscript{164} Civil Liability Act 2002 (WA) s 5AH(2).
\textsuperscript{165} Wrongs Act 1958 (Vic) s 14J(1).
\textsuperscript{166} Civil Liability Act 2002 (Tas) s 7(2).
\textsuperscript{167} Civil Liability Act 2003 (Qld) s 72.
\textsuperscript{168} Civil Liability Act 2003 (Qld) s 72D(2).
\textsuperscript{169} Civil Liability Act 1936 (SA) s 75.
\textsuperscript{170} Personal Injuries (Liability and Damages) Act 2003 (NT) s 13.
\textsuperscript{172} Nina Khouri, ’Making It Safe to be Sorry’ [2012] \textit{New Zealand Law Journal} 330, 331.
et al point out, the predisposition of medical defence insurers to require that the people they insure should not ever apologise can cause more trouble than it is supposed to prevent, by making it more probable that an injured patient will resort to litigation.173

(c) Dealing with Reasonable Expectations of Patients
Open disclosure is also a means of recognising what the reasonable expectations of an injured patient are.174 Letting the patient and the patient’s support person know what has happened and why, together with a fulsome apology does not deal fully with the patient’s needs. Simple things like ex gratia reimbursement of immediate costs is an important indicator that the problem is being taken seriously by management and clinical personnel.175 Reasonable expectations of the patient also include having a care plan put into place at once to try to reverse or, at least, minimise the damage caused by the adverse event and includes offers of counselling.176

(d) Communication
ACSQHC declares that complaints about medical care are, more often than not, the result of poor communication between medical practitioner and patient.177 Therefore, the communication must be made in an empathetic and compassionate atmosphere where the patient feels respected and treated with dignity.178 According to Liang, if the reaction to an adverse event is casual or discourteous, an already injured person may be tempted to complain to management, to report to disciplinary bodies or to attempt to find ways of wreaking revenge on any person who has caused the injury and made it appear as though no-one cares what has happened.179

177 Australian Commission on Safety and Quality in Health Care, Safety and Quality of End-of-life Care in Acute Hospitals: A Background Paper, (August 2013) 3.
Opportunities must also be provided for the patient to ask questions.\textsuperscript{180} Information must be provided in a way that the patient understands and be delivered by the most senior medical practitioner involved.\textsuperscript{181} It is not acceptable to hide behind a more junior practitioner. Phillips-Bute observes that not only is this damaging to the young person concerned, it is one way of ensuring that the patient will be so emotional and angry that litigation is commenced or at least contemplated.\textsuperscript{182} The most senior person involved is also best able to deal with the ramifications of the adverse event and to start to develop a care plan for the future.\textsuperscript{183} Where a patient has nominated a support person, that person must also be present as there may be questions that can be dealt with by the senior medical practitioner. Plans for the future may include counselling and support for the support person as well as the patient.\textsuperscript{184}

\textit{(e) Dignity and Autonomy}

The open disclosure process will not work properly unless it is conducted in full recognition of the dignity, autonomy and personhood of the patient.\textsuperscript{185} An injured plaintiff needs disclosure as an indicator of being accorded corrective justice and as a way of having dignity restored.\textsuperscript{186} The inherent hierarchies of medical practice may militate against the necessity to show compassion and humility for what has occurred. Adoption of open disclosure practices can provide a way to equalise the power imbalance and restore patient dignity.\textsuperscript{187} People can detect insincerity and less than genuine contrition will be more likely to inflame the situation than to allow its resolution.\textsuperscript{188}

\textsuperscript{180} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) 15.

\textsuperscript{181} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) [6.1.1].


\textsuperscript{183} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) 12.


\textsuperscript{186} Australian Commission on Safety and Quality in Health Care, \textit{Open Disclosure Standard Review Report} (June 2012) 27.

\textsuperscript{187} Australian Commission on Safety and Quality in Health Care, \textit{Open Disclosure Standard Review Report} (June 2012) 43.

\textsuperscript{188} Australian Commission on Safety and Quality in Health Care, \textit{Open Disclosure Standard Review Report} (June 2012) 63.
(f) Safety Culture
Dealing with medical adverse events requires a change in culture within the organisation. With the wholehearted adoption of open disclosure by management must come the embrace of a safety culture. This prioritising of safety from the top down makes all members of the staff conscious of the necessity for safety in all their activities. A safety culture must permeate to all levels especially clinical staff.

(g) Endorsement by Learned Colleges
As the Open Disclosure Standard states, professional associations and learned colleges are ideal enablers of principles and practices of open disclosure. The ideal is reflected in inclusion of open disclosure requirements in their official charters, the making of open disclosure a part of clinicians’ responsibilities to their patients, and making open disclosure part of ongoing certification and mandatory continuing professional development obligations of the learned colleges.

The Royal Australian College of General Practitioners was a partner with ACSQHC in development of the Open Disclosure Standard. The Royal Australasian College of Physicians has supported mandating the reporting of adverse drug reactions to the Therapeutic Goods Administration that is responsible for identification of problems with medications. It advises that the value of

190 Judith Healy and John Braithwaite, 'Designing Safer Health Care through Responsive Regulation' (2006) 184(10) Supplement MJA S56, s56.
191 Whilst it is virtually impossible to eliminate adverse events in health care, minimisation of their impact is a necessary part of the management of the risks that occur in each health care organisation.
193 Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard (at July 2003, reprinted 2008) 103; Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013) has been officially endorsed by the following (at 8):
Australian College of Nursing;
Australian and New Zealand College of Anaesthetists;
Royal Australian and New Zealand Colleges of Obstetricians and Gynaecologists;
Royal Australasian College of Physicians;
Royal Australasian College of Surgeons;
Society of Hospital Pharmacists of Australia
and is supported by:
Australasian College of Emergency Medicine;
Royal College of Pathologists of Australia.
reporting lies in the ability to identify previously unknown risks so that necessary urgent action can be taken.\textsuperscript{196}

\textit{(h) Good Governance}\textsuperscript{197}  
As with Standard 1 of the \textit{National Safety and Quality Health Service Standards}, adoption of open disclosure processes requires good governance within the health care organisation.\textsuperscript{198} Good governance will also imbue the open disclosure approach with an ethical aspect that should reinforce all processes put in place to minimise risk and embrace safety. From prompt and transparent communication and timely acknowledgement to immediately dealing with problems, any adverse event can be turned to positive advantage for education.

Key staff within the organisation must be trained in open disclosure processes as their involvement in the resolution of any adverse event will be necessary.\textsuperscript{199} These staff will be responsible for contact with patient and family but also will be pivotal in the development of new safety systems and modification of old ones in light of the experience. The function of these key staff members must also include ongoing monitoring of the implementation of open disclosure process and reviewing their successes and failures with an eye to change where required.\textsuperscript{200}

\textit{(i) Barriers to Implementation of Open Disclosure Principles}  
Studdert, Piper and Iedema maintain that fear of medico-legal consequences and inadequate education and training are leading barriers to achieving optimal outcomes from the adoption of open disclosure processes.\textsuperscript{201} Lamb adds that, in addition, fear of adverse publicity and concern about damage to career and reputation among one’s peers are potent barriers to disclosure of adverse events.\textsuperscript{202} Studdert and Richardson observe that embarrassment at acknowledging error, and uncertainty as to how much information should be disclosed point to the disparity

\textsuperscript{196} Royal Australasian College of Physicians, \textit{Budget Submission: Adverse Drug Event Reporting.}  
\textsuperscript{197} Good governance is Standard 1 in the \textit{Australian Safety and Quality Health Service Standards.}  
\textsuperscript{198} Jeff Richardson and John McKie, \textit{Reducing the Incidence of Adverse Events in Australian Hospitals: An Expert Panel Evaluation of Some Proposals} (Centre for Health Economics Monash University, 2007) 40.  
\textsuperscript{199} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) 15.  
\textsuperscript{200} Australian Commission on Safety and Quality in Health Care, \textit{Australian Open Disclosure Framework} (2013) 36.  
between ethical obligations to report and poor uptake in practice. Open disclosure is patient-centred and, according to Brazier and Cave, it is necessary to put the patient first even if it conflicts with the personal interests of the medical practitioner.

Garbutt et al found that accepted barriers to reporting such as insufficient time, fear of punishment, and fear of malpractice litigation did not appear to affect self-reported reporting behaviours of paediatricians in USA. They were more likely to report when they saw evidence of system improvements. But the culture of medicine itself including the expectation that medical practice must be free of errors, tends to put blame on the individual who does not perform perfectly. When these paediatricians felt to blame they were more likely to institute informal responses like discussion with colleagues than to report, sometimes appearing to think that reporting is unnecessary.

(j) Non-Threatening Process
In order to minimise possible emotional harm to good and competent staff, the process must be conducted in an atmosphere of support. ACSQHC reports that, apart from the implications for any person involved in the adverse event, the prospect of a blame free process may encourage the reporting of incidents and near misses. But even a ‘no blame’ culture should incorporate a degree of personal accountability. In rare cases there will be criminal behaviour or reckless and negligent conduct. But patient harm is usually unintentional rather than the result of individual malevolence. Making sure that the clinician implicated is supported by the system is a helpful strategy because the clinician’s self-belief will

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be dented. 210 Many give up practice rather than face this feeling again, doubting their own competence. 211

(k) Legal and Insurance Implications

The aftermath of an adverse event includes not simply the immediate clinical requirements, but there are also legal and insurance implications. 212 Insurers are always insistent that any possible situation that has led to a real or suspected adverse event and that might have ramifications for the insurer must be notified at the earliest opportunity. 213 On the other hand, Lamb warns that care must be taken to ensure that the process of timely notification to the insurer does not detract from the more important obligation of timely and open communication to the patient. 214 Also, notification to the insurer must not take the place of notification to relevant regulatory authorities, but be concurrent with it. 215

There are also legal implications to be handled. If the patient has died then the coroner may have to be notified. There are also possible privileges for information obtained during the investigation process, information that cannot be divulged because of legal professional privilege. Documents that come into being for the dominant purpose of legal advice may be subject to this privilege. 216

4 Duty to Disclose

Medical practitioners have an ethical obligation to disclose any medical mishap. 217 Failure to disclose an adverse event is the primary barrier to implementation of

213 Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard (July 2003, reprinted 2008) 15. This gives the insurer the chance to face and deal with the immediate consequences. Early notification provides the opportunity to negotiate with potential claimants possibly reducing the resort to litigation. Timely and sensitive handling of incidents should lead to a satisfactory resolution for all involved.
215 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10.5].
open disclosure processes. There may be relatively minor implications of an error218 and occasions where the medical practitioner will consider that it is not necessary to report, either to the patient or to the health care institution.219 The patient might not even have noticed. But failure to report or disclose leads to several outcomes. Firstly, the data available will be deficient as the figures for incidence of adverse events will be skewed and look as though the problem is smaller than it is in reality. Secondly, if there is silence and the patient does become aware of a problem, then there will be a devastating blow to the trust of the patient, not only in the clinician concerned but in the whole medical system.220 Any medical practitioner who fails to report an adverse event is being dishonest.221 Dishonesty undermines the trusting association that is the hallmark of the good doctor-patient relationship.222

There will also be occasions where the patient is the one to report that something is not quite ‘right’. The open disclosure system adopted in a health care organisation must be able to cope with initiation of open disclosure processes by the patient rather than a clinician.

The duty of the medical practitioner to disclose an adverse event both to the patient and to appropriate authorities arises in several ways. It is a code obligation223 that is bolstered by the statutory imprimatur given to the code.224 Wu claims that any code requirement is supplemented by a more recently recognised ethical obligation upon the medical practitioner.225 As exploration of the tenets of open disclosure reveals, disclosure of medical errors is the ‘right thing to do’.226 Several

223 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10.3].
224 National Law s 41.
commentators declare that the ethical obligation to disclose a medical error is also an acknowledgement of the patient’s autonomy.227

Faunce and Bolsin argue that following an adverse event, a patient is in a situation of heightened vulnerability. Therefore, there is a case for attaching a fiduciary duty to the obligation to report adverse events.228 The legal obligation to advise a patient, prior to any procedure, of all material risks associated with that procedure229 should now extend to a fiduciary obligation to disclose any adverse events as soon as possible.230

There is now judicial recognition of the duty of the medical practitioner to disclose any adverse event as soon as possible. The case of Wighton v Arnot231 illustrates the obligation for prompt disclosure. A surgeon considered it possible that the patient had sustained nerve damage during his surgery on an abscess on the patient’s neck. However, nothing was said and three years had elapsed before it was confirmed that nerve damage had been sustained. By then it was too late for remedial action to be taken. The medical practitioner was not found negligent in the performance of the surgery and the dividing of the accessory nerve in the process. What was negligent was the failure to inform the plaintiff.232 His resort to the principle of therapeutic privilege as the reason for the failure to inform was not accepted by the court.233

In Tasmania, Dr David Edis was reprimanded and suspended for one month, not for the spinal surgery carried out on the wrong level, but for failure to disclose it to the patient.234

229 Rogers v Whitaker (1992) 175 CLR 479.
232 Wighton v Arnot [2005] NSWSC 637, [38] (Studdert J).
234 Tasmanian Board of the Medical Board of Australia v Dr David Edis [2014] TASHPT 1. A surgeon called Malone who operated on the wrong level then rewrote the record and misinformed the patient’s GP has been suspended for 12 months and ordered to pay $107,000 MBA costs. Staff Writer, ‘Surgeon Botches Spinal Surgery Then Misleads GP and Patient’, Medical Observer (Online) (28 September 2016) <http://www.medicalobserver.com.au/professional-news/surgeon-botches-spinal-surgery-then-misleads-gp-and-patient>.
In England, in the case of *Naylor v Preston Area Health Authority*, Sir John Donaldson MR stated that in professional negligence cases, particularly medical negligence cases, there is ‘... a duty of candour resting on the professional man.’

As Madden and Cockburn conclude, in their opinion,

[i]t is difficult to argue against the recognition in Australia of a broad ethical obligation on the part of a medical practitioner to promptly disclose, certainly in a clear case, the fact of an adverse event and the possibility of any negligent aspect to the treatment.

5 Conclusion

It is clear that the former reflex of medical practitioners to ‘retreat behind a sullen veil of secrecy’ when an adverse event has occurred is no longer acceptable. Not only is the outcome for the patient of a failure to disclose potentially a disaster for the patient, it also has ongoing implications for the medical practitioner. Any medical practitioner who fails to disclose what has happened, in breach of his or her ethical obligations, is at risk of legal and disciplinary consequences. But in addition, the medical practitioner has to live with the fact of the adverse event and the accompanying self-recriminations of substandard professional performance both from the fact of the occurrence of the adverse event and from the failure to disclose it. As the *Open Disclosure Standard Review Report* declares,

Openly discussing adverse events with patients ... and as a result enabling and witnessing their closure and forgiveness, can assist healthcare professionals achieve their own closure and ameliorate feelings of shame or guilt.

Failure to disclose undermines the medical profession’s declaration of its trustworthiness. Public perceptions of medical practitioners as untrustworthy have been present in publicity concerning medical scandals.

However, most practitioners would prefer that they never have to face the prospect of invoking open disclosure following an adverse incident. One way of minimising

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235 Naylor v Preston Area Health Authority [1987] 2 All ER 353.
236 Naylor v Preston Area Health Authority [1987] 2 All ER 353, 360 (Sir John Donaldson MR).
239 *Tasmanian Board of the Medical Board of Australia v Dr David Edis* [2014] TASHPT 1.
241 Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014) [3.10].
the risks that medical practitioners face every day would be greater adoption of checklists, and it is to a consideration of their benefits to which this chapter now turns.

E HOW WIDER USE OF CHECKLISTS CAN ENHANCE SAFETY

1 Introduction

Donabedian describes quality assurance as ‘... all actions taken to establish, protect, promote, and improve the quality of health care’. In his view, the key object of quality assurance should be the performance of medical practitioners when they are caring for patients. The actions that are required to ‘establish and protect’ lie, firstly, in determining protocols to achieve quality to specified standards of excellence. The second part of the process is the actions to ‘promote and improve’, namely to ensure that the protocols are consistently applied. As Donabedian states: ‘... it is ... necessary to have a formal predictable monitoring activity ... uniformly implemented ... ’ That is where checklists can assist. Showing that each factor has been considered and achieved is ideally demonstrated by the ‘tick box’ behaviour associated with checklists.

American Surgeon, Atul Gawande has been an enthusiastic promoter of checklists as a way of reducing avoidable errors in medical practice. Checklists are designed to eliminate those simple steps that can easily be forgotten but which may have catastrophic consequences if not implemented. Checklists can operate in any context where strict compliance with protocols is essential for quality, safety and operational issues. As discussed in Chapter III, the requirement for all health care institutions to be accredited to the National Safety and Quality Health Service Standards introduces to all aspects of health service organisations the necessity for checklists.

243 Avedis Donabedian, An Introduction to Quality Assurance in Health Care (Oxford University Press, 2003) xxiii. He continues by remarking that strictly speaking one cannot assure or guarantee quality and suggests that continuous improvement may be a better term. (at xxiv).
244 Avedis Donabedian, An Introduction to Quality Assurance in Health Care (Oxford University Press, 2003) xxv.
245 Research has shown that adherence to recommendations of practice guidelines showed significant improvement in patient outcome. Jeremy Grimshaw et al, ‘Developing and Implementing Clinical Practice Guidelines’ (1995) 4 Quality in Health Care 55, 60.
248 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012).
The centrality of checklists in achieving safe and quality practice lies in Standard 1 of the ten standards in the National Safety and Quality Health Service Standards that requires “[A]n organisation-wide management system ... for the development, implementation and regular review of policies, procedures and/or protocols.”

For example, Standard 6.1, ‘Clinical Handover’ provides that this criterion will be achieved by:

- Developing and implementing an organisational system for structured clinical handover that is relevant to the healthcare setting and specialties, including:
  - documented policy, procedures and/or protocols
  - agreed tools and guides.

As the literature attests, errors are not limited to institutional settings and the adoption of checklists by individual practitioners could be a simple but effective way for medical practitioners to standardise their processes and provide safe, quality patient-centred care. Consequently, this section will argue that a simple, yet effective method for promoting quality and safety in medical practice is the wider adoption of checklists.

This section commences by examining evidence for the efficacy of checklists in assuring safe, quality medical practice. That review is followed by considering some ways that checklists can be implemented in practice. The following part will deal with barriers to wider adoption of checklists by medical professionals. Finally, the section concludes that checklists are so important to the promotion of safe and quality practice that they should not be considered as trivial tools but that medical schools should be educating their students in the benefits of their regular use.

2 How Checklists Can Promote Safety and Quality

In 2006, Gawande was asked by the World Health Organisation (WHO) to lead the development of a surgical safety checklist. WHO was concerned about the dramatic increase in surgical procedures world-wide and had perceived that much

249 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) 16. The ten standards require 256 actions, each of which requires the signing off of the equivalent of checklists to prove compliance with each protocol.

250 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012) 46.

of it was unsafe. Gawande looked at the figures and found that the number of surgical procedures throughout the world had overtaken childbirth but the death rate was many times higher, leaving millions of people throughout the world either dead or disabled.

Gawande and his group eventually developed a checklist involving 19 items, and divided it to be used in three stages, the Sign in (before administration of anaesthesia), the Time out (before skin excision) and the Sign out (before the patient leaves the operating theatre). The WHO checklist was trialled in eight hospitals around the world, including high-, middle- and low-income countries. It was found that "... a checklist based program was associated with a significant decline in the rate of complications and death from surgery in a diverse group of institutions around the world."

Checklists have been an essential tool in the achievement of the safety record of the aviation industry. They are also used in building projects and other industries where safety is critical as it should be in medical practice. There is now substantial evidence that introduction of surgical safety checklists has reduced mortality and morbidity in surgery patients. But checklists can extend to more facets of medical practice than surgery.

Atul Gawande maintains that there are three sorts of problems in the world — simple, complicated and complex. Medical practice creates problems of great complexity. Among the simplest and most effective methods of minimising errors in medical practice is to adopt checklists as a way of supplementing technical knowledge and judgement. As he points out, in complex environments there are

two possible human failings. The first is the fallibility of human memory, especially with regard to routine matters when more complex events are unfolding. The second is that some simple steps can, in some circumstances, be omitted.\textsuperscript{260} Likewise, Winters et al observe that influential research has shown that our minds can only retrieve up to seven pieces of information and when we are tired or stressed that can drop to three.\textsuperscript{261} Checklists can catch the mental flaws to which we are all subject, namely deficiencies in memory, attention and thoroughness.\textsuperscript{262}

In addition to catching omissions due to memory lapses, checklists also have other advantages. A widely-recognised advantage\textsuperscript{263} is the improvement in communication between team members that leads to clear demarcation of the tasks and responsibilities of each person in the team. Gillespie and Marshall state that any safety checklist should intend to ‘... improve work processes through better team communications’.\textsuperscript{264} Good communication is imperative because, as Winters et al observe: ‘... miscommunication is common and a major contributor to medical error’.\textsuperscript{265} Similarly, Pitcher et al note that: [m]iscommunication is a major source of patient dissatisfaction ... and a major contributor to clinical error’.\textsuperscript{266} Research has also shown that checklists can flatten the hierarchy\textsuperscript{267} that is often a feature of medical teams\textsuperscript{268} and empowers junior practitioners and nurses to remind

\textsuperscript{266} Meron Pitcher et al, 'Implementation and Evaluation of a Checklist to Improve Patient Care on Surgical Ward Rounds' (2016) 86 \textit{ANZ Journal of Surgery} 356, 358.
more senior practitioners to adhere to relevant safety procedures. Checklists can also act as an *aide memoire* so that important matters are not forgotten. Their adoption also goes with the internalising of a safety culture for medical procedures.

A qualitative study carried out to check experience after two years with the *WHO Surgical Safety Checklist* concluded that, despite evidence that wrong-site surgeries were still occurring:

All professions recognise the checklist as an element that enhances safety in the OR [operating room], and increasingly so as it has become an integral part of the daily routines. However, challenges that need to be addressed include making the Sign-in part a team effort, making room for pause in performance during the Time-out and Sign-out and cross-checking in order to avoid automated use of the checklist.

Verdaasonk et al reviewed the literature and suggested that introduction of a surgical safety checklist should provide:

- a defense [*sic*] strategy to prevent human errors
- a memory aid to enhance task performance
- standardization of the tasks to facilitate team coordination
- a means to create and maintain a safety culture in the operating room
- support [of] quality control by hospital management, government, and inspectors.

However, checklists need not be restricted to surgery. Winters et al comment that checklists can be ‘... applied to the whole spectrum of the care process’. The function of a medical practitioner can be divided into diagnosis, treatment and monitoring, each of which can be further divided into decision (whether and what to do), execution (carrying the process out) and interpretation (what is the result and what does it mean). Errors can occur anywhere on this spectrum and

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checklists can be introduced to standardise processes and reduce errors.\textsuperscript{275} Anaesthetists have long been using checklists to check that their equipment is operating satisfactorily.\textsuperscript{276}

3 Ways of Implementing Checklists in Practice

What becomes apparent in the relevant literature is that satisfactory adoption of the use of checklists is not dependent on their implementation being mandated by management. As elaborated below, acceptance of the benefits of checklist use has many facets including, education, commitment by senior medical practitioners and local modification of checklists to adapt to prevailing practices. As the discussion of electronic record keeping in Chapter III has shown, computer programs can become a kind of checklist or aide memoire that can see medical practitioners having to advert to particular important matters in making a detailed record of patient contacts. Reed et al also tested a novel tool, an audio system that reminded members of the medical team when various procedures had to be performed.\textsuperscript{277}

An important and evidence-based source of information about treatment protocols is issued as guidelines by the Medical Board of Australia and the learned specialty colleges. Guidelines to best practice in a wide variety of circumstances are important benchmarks by which to measure professional behaviour. Some of these guidelines could be issued in the form of checklists. As Chapter III has shown, courts and tribunals refer to codes and guidelines as the touchstone for good medical practice, in other words, for professionalism.\textsuperscript{278} In the United States, adherence to guidelines can be used as ‘safe harbors [sic]’ to protect medical practitioners from malpractice claims. As Mello, Studdert and Kachalia comment:

\begin{quote}
[Physicians who adhere to a preapproved clinical practice guideline should be able to use compliance as a strong, if not impenetrable, shield against malpractice claims. Safe harbors continue to attract attention because they offer a potential two-for-one
\end{quote}


\textsuperscript{278} See eg, Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44; Dr A v Health District (No 2) [2014] NSWIRComm 50; Medical Board of Australia v Kanapathipillai [2016] ACAT 16; Medical Board of Australia and Veetill [2015] WASAT 124; Airo v Medical Board of Australia [2015] QCAT 482; Crickitt v Medical Council of NSW (No 2) [2015] NSWCATOD 115; Medical Board of Australia v Mbo [2015] ACAT 69.
policy benefit: they address physicians’ concerns over nonmeritorious lawsuits, and by providing an incentive to follow evidence-based guidelines, they may address current gaps in guideline adherence and improve healthcare quality.\textsuperscript{279} By issuing each guideline in the form of a checklist, not only will it be easy for the medical practitioner to adhere to all the requirements of the guideline, but to also prove that he or she has done so. As Mello and her colleagues claim, healthcare quality also would be enhanced.

The importance of education and training of all participants has been emphasised by several researchers.\textsuperscript{280} Vats et al pointed out that successful implementation of a checklist was dependent on training.\textsuperscript{281} Pitcher et al conclude that the use of a checklist not only improves consideration of care, but that cannot be confirmed without the documentation a checklist provides and that; [i]integral to this process is education and reinforcement by all team members.\textsuperscript{282} O’Connor et al observed that training raised the frequency of implementation of checklists dramatically.\textsuperscript{283} Similarly, Hannam et al noted that a model of what is necessary to establish good checklist practice included comprehensive education.\textsuperscript{284} Both Hannam and O’Connor and their colleagues also commented that satisfactory implementation of checklist use was highly dependent on ‘... engagement of relevant leadership “champions”’\textsuperscript{285} or ‘[d]emonstrated support ... from senior personnel’.\textsuperscript{286} Similarly, O’Connor et al proposed a regulatory pyramid that required the engagement of opinion leaders.\textsuperscript{287}

Several researchers commented on the greater acceptance of checklists when they were modified to deal with local conditions or practices. Gillespie and Marshall stated that tailoring should not only deal with local context but should also ‘...address barriers’.\textsuperscript{288} Winters et al emphasised the need to incorporated local data, and local beliefs and experience into the process for developing a checklist for any clinical purpose.\textsuperscript{289} Vats et al commented that successful implementation of a checklist required support for essential local adaptations.\textsuperscript{290} Hannam et al suggested that: ‘Optimisation of checklist design to suit local circumstances may also be important and provides an opportunity to involve checklist users with its development’.\textsuperscript{291}

The importance of local adaptations has been recognised by WHO. The Royal Australasian College of Surgeons (RACS) has prepared and promulgated a \textit{Surgical Safety Checklist} and refers its members to the \textit{Implementation Manual} of the World Health Organisation.\textsuperscript{292} The \textit{RACS Surgical Safety Checklist} has been adapted from the \textit{WHO Surgical Safety Checklist}. The \textit{Implementation Manual} clearly states that: ‘[t]he Checklist is not a regulatory device or a component of official policy: it is intended as a tool for use by clinicians interested in improving the safety of their operation and reducing unnecessary surgical deaths and complications.’\textsuperscript{293} The \textit{Implementation Manual} also states that: ‘[t]he checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged’,\textsuperscript{294} a direction echoed in the \textit{RACS Surgical Safety Checklist}.

4 \hspace{0.5em} \textbf{Barriers to Wider Adoption of Checklists}

As this part details, some of the barriers to wider adoption of checklists in medical practice include disengagement by medical practitioners, that their use takes up too much time in an already busy work schedule, that the steep hierarchy in medical

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practice means that nurses are discouraged from taking charge of the process, engagement by senior practitioners is necessary and that use of checklists is merely a ‘tick box’ exercise. In addition, some parts of the WHO model were not followed because no-one was taking relevant responsibility.

A potent barrier is disengagement by some medical practitioners who appear to feel that something so simple as a checklist is tantamount to insult as they do not need to be reminded of basic procedures. Gawande reports that when checklists were first proposed in the United States, uptake was slow. ‘Some physicians were offended by the notion that they needed checklists’.

‘Charts and checklists, that’s nursing stuff — boring stuff. They are nothing that we doctors, with our extra years of training and specialization, would ever need or use’. Introduction of checklists by hospital safety officers are regarded by some physicians ‘... as an irritant, as interference on our terrain. This is my patient. This is my operating room. And the way I carry out an operation is my business and my responsibility. Who do these people think they are, telling me what to do?’

Similarly, Winters et al have commented that physicians have resisted using checklists on the basis that relying on a checklist is an insult to their intelligence and they doubt whether checking boxes will prevent medical mistakes. They ‘ ... believe they know their job ... ’ and that they do not need prompts.

Haugen et al report that surgeons are the most reluctant to use a checklist. Similarly, Vats et al noted that some consultant surgeons were not very enthusiastic.

Another criticism is that completing a checklist takes up too much time. Reed et al described results from a French study where staff in half the centres surveyed reported that the checklist took too long to complete, they were already under heavy work pressures and they could not see any benefit from the process. However, as Pitcher et al observed: ‘... once the use of the checklist became routine, extra time was minimal’. Possible extra time might be well-spent when considered against reduction in calls regarding what orders, management or

discharge plans were in place.\textsuperscript{302} This observation points up how inconsistent delivery of relevant services may lead to omission of necessary items.\textsuperscript{303}

When Vats et al carried out their pilot survey concerning the practical challenges of introducing the WHO checklist, they noted that the ‘steep hierarchy’ in most operating theatres was a barrier to nurses being in charge of completing a checklist, and that implementation was much more carefully attended to when surgeons or anaesthetists were receptive to their use.\textsuperscript{304} Similarly, Pitcher et al pointed out that their survey showed that encouragement by consultants and registrars was important in the adoption of checklists to facilitate the handover process.\textsuperscript{305}

Another observation by Reed et al concerning a French study, was that one-quarter of the centres studied stated that items were ticked off when they had not been checked, because of time pressures and also to satisfy auditors that the checklists were being used.\textsuperscript{306} Vats et al also reported that some teams saw use of the surgical safety checklist as merely a tick box exercise.\textsuperscript{307} Haugen et al counsel that practitioners must engage with the checklist process and avoid automated use of checklists.\textsuperscript{308}

Reed et al found that, in many of the cases they studied, adopting the sign out aspect of the WHO checklist was not occurring. It appeared that nobody was taking responsibility for it, and that members of the team were either disappearing or becoming engaged in other activities.\textsuperscript{309} Both Vats et al\textsuperscript{310} and Haugen et al emphasised the importance of Time Out and Sign Out aspects of the WHO checklist both as a way of completing the checklist process and as a way of cross-
checking with all members of the team.\textsuperscript{311} Without some-one taking responsibility, the omission of the step could lead to failure to notice that some important step had not been carried out.

Hannam et al noted in passing that it was essential to maintain commitment, or the attention needed for appropriate use of checklists may well diminish over time.\textsuperscript{312}

5 Conclusion

The safety benefits of the use of checklists have been widely reported.\textsuperscript{313} Hannam et al commented that their investigation of previous studies provided data supporting the contention that compliance with the surgical safety checklist impacts potential safety benefits.\textsuperscript{314} Haugen et al’s study confirmed that use of the surgical safety checklist could optimise safety and improve the safety culture.\textsuperscript{315}

Safety in the practice of medicine is not limited to surgery, but embraces all contacts between patient and health practitioner. As the above account shows, use of checklists can be adapted to local conditions and to varying aspects of health care. Their use in all health care organisations is mandated by the \textit{National Safety and Quality Health Service Standards} but it is clear that their adoption can extend to individual practitioners for all matters including diagnosis, provision of advice and implementation of treatment protocols. Safe medicine shows the concern for the patient required by the elements of patient-centred care.

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CONCLUSIONS

The legal and ethical duty of medical practitioners is to make the care of patients their first priority. These obligations are coupled with the more recent emphasis on the concept of patient-centred care in all aspects of medical practice as a way to enhance quality medical practice. In addition, the importance of patient-centred care in promoting the safety of patients has been demonstrated. Attention to patient safety is imperative if the disturbingly high incidence of iatrogenic injury in the Australian health care system is to be pared back. An essential safety culture has sometimes been missing in day to day clinical activities. Whilst by no means are medical practitioners implicated in all adverse events, the most serious problems are directly or indirectly related to the activities of medical practitioners. Failure to deal openly with injured patients is a prime example of the self-interest/altruism dichotomy inherent in the gap between the requirement for patient-centred care and the reality of patient experience.

Risk management is essential in medical practice. Medical practice is inherently hazardous so systems must be developed to make sure that risks do not eventuate, but if they do, that their seriousness is minimised. The first thing to do is to recognise where the riskiest aspects of medical practice lie. However, it is not possible to design systems without data collection. The best way to collect necessary data is to have adverse events and near misses reported. This must occur every time an adverse event is identified or the figures will be skewed. Near misses must be reported for the same reason. Information from near misses can be a potent learning tool.

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317 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [6].
319 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [6].
322 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [6.2.3].
It is never possible to have totally risk-free practice but dangers can be minimised. Medical practice can learn from other industries like engineering 325 or aviation 326 that operate within a safety culture that dominates all their activities. Aviation and engineering are dealing with safety. Despite the intimacy of the doctor/patient relationship, doctors must adopt a safety culture and checklists are essential tools to make sure nothing is missed. In Chapter III, Healy observed that high-risk industries assume both human fallibility and system fallibility. Checklists are designed to minimise human and system fallibility that are directly applicable to medical practice.

Checklists are an integral part of safety systems. Adverse events of any kind (including near misses) are analysed by those dangerous industries and the best ways of preventing recurrence are then designed. As adverse events continue to occur, modifications can be made to the safety plan and relevant checklists. It is essential that everyone involved is conscious of the culture of safety. Patients are entitled to safe health care. 327

Adopting the principles of open disclosure is a legal and ethical imperative for medical practitioners. Medical practitioners are not always responsible for adverse events that occur, but the way the aftermath is handled is an ethical duty. As the cases of Wighton v Arnot, 328 Dr David Edis 329 and Dr Malone 330 show, failure to report and adopt open disclosure principles can be the subject of disciplinary proceedings under the National Law where examples of deficient practices can influence compliance by medical practitioners with their open disclosure obligations. Disciplinary bodies should take a stringent stance about reporting failures.

One way of making sure that reports are made when the circumstances require is to introduce regulatory techniques such as making open disclosure part of contracts for employment of clinical staff. A further option is enhancing education about open disclosure in medical schools, that could be achieved by the Medical Board of

327 Tasmanian Board of the Medical Board of Australia v Dr David Edis [2014] TASHPT 1.
Australia through its accreditation processes for medical schools, and health service providers. If the proposed revalidation system for medical practitioners is adopted in Australia, one module in the necessary appraisals could be a requirement to demonstrate familiarity with, and adoption of, the principles and practices of open disclosure.

However, as is clear from the discussion in this chapter, separating the event from blame is a way of enhancing compliance with open disclosure principles such as the requirement to report. Emphasising the safety aspects inherent in the requirement to report over any allocation of blame has been shown by evidence of improved reporting from airline pilots. Therefore, it is worth investigating how blame can be decoupled from assigning responsibility for an adverse event. Thus, it is pertinent to ask whether the time has come for the adoption of a scheme of ‘no fault’ compensation for all injuries, including those incurred through medical error. This possibility was canvassed in Chapter IV.

CHAPTER VII: LESSONS FOR A PATIENT-CENTRED FUTURE FOR MEDICAL PRACTICE AND CONCLUSION

This thesis set out to examine whether the law can enforce quality patient-centred care in Australia. It argued that there is a gap between the rhetoric of patient-centred care and the reality of patient experience and suggested that this gap could be minimised if there were a closer adherence to the ideals and tenets of medical professionalism. It also argued that observance of the principles of medical professionalism leads to quality patient-centred medical practice. Good medical practice is patient-centred.¹ Good medical practice epitomises medical professionalism. The Medical Board of Australia’s, Good Medical Practice: A Code of Conduct for Doctors in Australia (the MBA Code) sets out principles and standards which must be observed by all medical practitioners and observes that ‘[p]rofessionalism embodies all the qualities described here, and includes self-awareness and self-reflection’.²

Part A of this chapter reviews the main arguments of each preceding chapter and looks at changes that could be achieved through hard law and soft law approaches that would bring about a patient-centred approach.

Part B then proceeds to reiterate the significance of this research and its contribution to the literature whilst Part C makes some suggestions for future research where patient-centred care may provide new insights. Part D is an epilogue.

A CHAPTER SUMMARY

Chapter I argued that the conceptual basis for patient-centred care lies in its affinity with medical professionalism. It also analysed three important concepts which

¹ Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
² Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [1.4].
arose frequently throughout the discussion in this thesis, duty, quality and patient-centred care.

Given the importance of medical professionalism, Chapter II commenced by examining what is encompassed in the idea of medical professionalism. Charters of medical professionalism and codes of ethics have urged adherence to professional norms but medical practice still exhibits examples of dismissive behaviour towards patients, humiliation of students and bullying of colleagues all of which depreciate professional ideals. Multiple factors that divert attention from the patient are at work in day-to-day medical practice; some of these have been learned or absorbed during the training process and reinforced during ongoing medical experience.

Chapter II explained that the values of integrity, truthfulness, dependability and compassion are promoted by medical practitioner bodies and their codes as being as important as technical competence.\(^3\) The chapter proposed that one way to internalise the ideals expressed in medical codes and charters could be a greater emphasis on the teaching of medical ethics. It also argued that the Giving Voice to Values method has been shown to be an effective way of instilling ethical values.

While provisions in the codes permit medical practitioners to decline to perform legally-available medical procedures based upon a conscientious objection, those provisions can conflict with other provisions promoting the primacy of the patient. As Dickens observes, the resort to conscientious objection to deprive some patients of necessary medical care is tantamount to elevating a protection for medical practitioners to the status of an assault on the rights of some patients.\(^4\) This is especially so where the government has bestowed on doctors a practical and legal monopoly. Currently missing in Australia is any obligation to refer the patient (and the patient’s records) to another practitioner who would be prepared to perform the procedure refused. The MBA Code should be amended to make referral to another practitioner a code responsibility, as it is for United Kingdom medical practitioners. The Medical Board of Australia (MBA) should also make it

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a requirement for medical practitioners to put up a notice in their waiting rooms advising patients about procedures that will not be undertaken on conscientious grounds.

Chapter III explored the regulatory regime for medical practitioners in Australia. The provisions of the Australia-wide Health Practitioner Regulation National Law (the National Law) are augmented by a raft of soft law policies embodied in codes, guidelines, charters, standards, frameworks and directions that have the purpose of influencing the behaviour of those being regulated in order to achieve government regulatory goals. As was evident in Chapter III, use of soft law instruments provides flexibility to, and speed of response by, regulators faced with changing events in complex regulatory environments like the health care system.

The principles of Responsive Regulation\textsuperscript{5} promote regulatory goals through persuasion backed by sanctions. Courts and tribunals are authorised by section 41 of the National Law to refer to codes and guidelines as evidence of what, in any circumstance, constitutes professional behaviour, including whether negligent care has been exhibited. The success of national regulatory legislation for health practitioners suggests that there are other areas of the law controlling the behaviour of medical practitioners which might be enhanced by national legislation.

Chapter III showed that two recurring problems found in disciplinary cases dealt with by tribunals were inadequate record keeping and deficient clinical knowledge. Chapter III contended that more detail is required in medical records to protect both practitioner and patient. Detailed patient records are also necessary to support professional colleagues who must assume management of a patient. Chapter III also advocated a need for the MBA to mandate computerised record keeping to prompt practitioners about matters that should be recorded. It particularly recommended that a paragraph similar to Clause 1(f) of the New South Wales regulations be incorporated into the MBA Code. Clause 1(f) compels medical practitioners to record the outcome of any treatment regimen. Computerised medical records would also be a basis for the proposed centralised system of medical records. Furthermore, Chapter III argued strongly in favour of the introduction in Australia of a system of revalidation of medical practitioners as is in existence in the United Kingdom. Revalidation, even if strongly linked to

\textsuperscript{5} Ian Ayres and John Braithwaite, \textit{Responsive Regulation} (Oxford University Press, 1992).
continuing professional development obligations, is the best way to make sure that each medical practitioner on the roll is up-to-date and fit to practise.

Chapter IV explored some cases where the law appears to have been complicit in the subjugation of the interests of patients to practitioner concerns. Firstly, the medical profession has long insisted that any proposed treatment protocol should be based on the judgement of a ‘responsible body of medical opinion’ in accordance with the Bolam case. Yet, every patient will have a number of non-medical matters to take into consideration, matters that will influence whether he or she will proceed with a recommended treatment. Chapter IV argued that paternalistic attitudes and decisions invoked by medical practitioners without necessarily regarding patient wishes are no longer acceptable.

Chapter IV then scrutinised the requirement that medical practitioners obtain the consent of their patients before the commencement of any treatment. It noted that consent is not just a formality to be observed as a way of shielding the practitioner from litigation. Proper consent involves providing the patient with sufficient relevant information so the patient can make an informed choice about available options, including the option not to accept medical treatment at all. Courts have, on occasion, assisted some medical practitioners to override patient choice, by doubting the mental capacity of a patient who has elected a course of action not recommended by the medical practitioner. This has occurred despite careful judicial formulation of detailed tests to determine mental capacity. Such tests ignore Lord Donaldson’s pronouncement in In re T. (Adult: Refusal of Treatment) that the decision of a patient should be respected whether it appears rational or not. This section concluded that consent is so fundamental to patient-centred medical practice that it should always be honoured even if the outcome from withholding of consent is the death of the patient.

Chapter IV also contended that civil liability legislation throughout Australia, passed in the wake of the Ipp Inquiry, has made it much more difficult for patients with valid claims for medically-caused injury to be properly compensated. As a result, injured patients, who cannot obtain compensation through the tort system, must rely on the social welfare safety net. However, the ‘reforms’ have achieved a

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5 See Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, 587 (McNair J).
6 In re T. (Adult: Refusal of Treatment) [1993] Fam 95, 115.
stabilisation of premiums for medical practitioners in accordance with the Ipp terms of reference. Incidentally, according to Faunce, the ‘reforms’ have also guaranteed good profits to medical indemnity insurers.9

Chapter IV noted that the Ipp Panel had recommended that proposed civil liability legislation should be harmonised between jurisdictions10 even if it is not identical. The current matrix of differing legislation discriminates between patients, depending on the State in which the injury occurs and and the circumstances of it, resulting in complications for solicitors who are advising injured clients. In addition, insurance companies have difficulties in setting insurance premiums.

Chapter IV recommended that harmonisation of legislation should still be undertaken.

Chapter IV also made a case for a National Injuries Insurance Scheme of ‘no fault’ compensation to be introduced in Australia. Severing the link between compensation and the tort system would mean that fulfilling the needs of all injured patients’ would be the prime focus.11 ‘No fault’ compensation could achieve several goals all of which align with patient-centred care principles, in that it would:

• encourage the reporting of of medical mishaps, particularly where injury is caused to the patient;
• foster a climate of quality improvement;
• facilitate the disciplining of incompetent or dangerous medical practitioners;
• reinforce the candour and probity of the doctor-patient relationship;
• expedite the compensation of injured patients in a manner which is fair and sustainable.12

Chapter V explored how observance of instructions given in advance directives can be undermined by medical and legislative obstacles. The Australian Health Ministers’ Advisory Council has promoted mechanisms to permit competent

11 However, the proposed National Injury Insurance Scheme has been quietly put aside. Antony Scholefield, ‘Ministers Dump No-Fault Insurance Scheme’ Australian Doctor (Online) (16 June 2017) <https://www.australiandocotor.com.au/news/latest-news/ministers-dump-no-fault-insurance-scheme>, COAG Communiqué, 9 June 2017: ‘Leaders agreed with Treasurers advice not to proceed with a medical treatment stream of the National Injury Insurance Scheme (NIIS) at this time. Leaders asked Treasurers to review the cost implications of this decision in the context of the Productivity Commission Review of NDIS Costs. Leaders also asked Treasurers, in consultation with the Disability Reform Council, for advice on a general accident stream of the NHS for the first COAG of 2018.’
individuals to give directions about health and social care preferences in anticipation of being unable to do so in the future. Parliaments in Australia and the United Kingdom have legislated relevant procedures. The mere fact of thinking about future contingencies improves communication both with family members and with health practitioners. However, some legislation circumscribes strict observance of the terms of an advance directive by health practitioners whilst courts have not always upheld their provisions. The fact that the patient might die if doctors follow directions in an advance directive has sometimes raised a question as to whether that patient had legal capacity at the time the advance directive was made.

Chapter V recommended that the law governing preparation, interpretation and implementation of advance directives should be at least be harmonised if not made identical throughout all the Australian jurisdictions. Similar legislative requirements would enhance their adoption nationwide and prevent misunderstandings, especially by health practitioners, as to what is permitted in one or other jurisdiction. Education of undergraduates in medical schools and graduate medical practitioners would also assist. Making sure that the law surrounding advance directives was part of continuing professional development obligations is one way of ensuring better understanding. The Victorian Legal and Social Issue Committee recommended a government-funded public awareness campaign including for advance directives. The Australian Health Ministers’ Advisory Council recommended that government policies should require health, mental and aged care facilities have clear procedures for recording the existence of advance care planning documents. This chapter proposed that it should be compulsory for every person being admitted to any health care environment, not just aged care facilities, to have an advance directive or enduring power of attorney. The existence and terms of one of these instruments could also be part of the proposed national system of electronic records.

13 See eg, Australian Medical Association, The Role of the Medical Practitioner in Advance Care Planning - 2006 [1.1], [3.4]; Australian Health Ministers’ Advisory Council, A National Framework for Advance Care Directives (at September 2011) 4, 25. In its issue of 27 April 2017, The Economist argues for more conversations about people’s wishes as death approaches, as a way to make the dying process less traumatic for most patients.
15 Australian Health Ministers’ Advisory Council, A National Framework for Advance Care Directives (at September 2011) [5.3].
Chapter VI examined the problem of how health care practitioners respond to the high incidence of medically caused (iatrogenic) injury in Australia. Despite the legal and ethical duty to make the care of the patient the medical practitioner’s first priority and to practise patient-centred medicine, these obligations can be brushed aside when an adverse medical event occurs, raising the conflict between practitioner and patient interests. Adopting the principles of open disclosure is a legal and ethical imperative for medical practitioners. As the cases of Wighton v Arnot, Dr David Edis and now Dr Malone show, failure to report and adopt open disclosure principles can be the subject of disciplinary proceedings under the National Law.

Adverse medical events should be better managed than they are at present. Despite the obligation in the MBA Code to implement open disclosure procedures at once, there is recent evidence that open disclosure is not always being promptly initiated. Students in medical schools need better education concerning open disclosure obligations. Practitioners also need continuing professional development reinforcing the duty of open disclosure. Employed health practitioners should be contractually bound to implement open disclosure protocols for any medical mishap. Emphasis on open disclosure education should also stress that reporting of all adverse events and near misses is imperative. Failure to report should be should be dealt with by disciplinary tribunals as serious professional misconduct.

Further, the MBA Code should also require medical practitioners to issue an apology. Harmonising state and territory legislation to confirm that an apology does not imply fault would encourage such a change to be made.

Last but certainly not least, wider adoption of checklists for even straightforward medical procedures would, as the research has shown, produce a dramatic reduction in iatrogenic injuries. All health service organisations must now be

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17 Tasmanian Board of the Medical Board of Australia v Dr David Edis [2014] TASHPT 1.
19 Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (at March 2014) [3.10.5], [6.2.1].
accredited to the *National Safety and Quality Health Service Standards*.\(^2\) The protocols for accreditation require 256 actions under 10 standards. Because of the variety of health service delivery models, flexibility is permitted.\(^2\) However, the regulators can require that the key criteria for each of the actions should be in the form of a checklist. For example, compliance with Standard 3, Preventing and Controlling Healthcare Associated Infections requires the development and regular monitoring of ‘policies, procedures and/or protocols’.\(^3\) Demonstrating compliance with the relevant protocols is simpler using a checklist.\(^4\) The ACSQHC paper on Patient-Centred Care provided checklists for organisations to assess their ‘readiness to implement patient-centred care’.\(^5\) Likewise, clinical protocols issued by the learned colleges should be in the form of checklists.

### B SIGNIFICANCE AND CONTRIBUTION

This thesis concludes that the law (both soft and hard) has a role to play in enforcing quality in patient centred care. That role does not have to be disruptive or revolutionary; however, nor does this thesis display an intention to disrupt or revolutionise medical practice. Rather, one of its key points is that a number of small changes, easily made and properly coordinated, can prioritise the ongoing obligation of medical practitioners to practise in a patient-centred manner. Indeed, the originality of the recommendations made in this thesis lies in recognising the power to be wrought by changes that are both achievable and cumulative. The achievability of these proposed changes is underscored by the fact that the majority of them can be made by regulatory bodies without legislative intervention. When implemented in a coordinated fashion (as opposed to piecemeal adoption) their cumulative power could be significant.

Other recommendations could only be implemented by legislative change, by changes to the hard law. This is, of course, an inherently more difficult mechanism

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\(^3\) Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2012) 4.

\(^4\) Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (September 2012) 28.

\(^5\) In similar vein, Australian Commission on Safety and Quality in Health Care, *Australian Safety and Quality Framework for Health Care* (at December 2010) ‘sets out a vision for ... high quality care ... and sets out the actions needed to achieve this vision’. Each of the actions is amenable to a checklist format.

\(^6\) Australian Commission on Safety and Quality in Health Care, *Patient-Centred Care (2011)* 5.
for change. Commonwealth legislation would be required for introduction of ‘no fault’ injury compensation. Also, states and territories would have to meet in a COAG type environment before it would be possible to adopt ‘mirror’ legislation, let alone harmonise differing legislative schemes.

There were many elements in issue but this thesis identified insufficient reflection upon and adherence to medical ethical values as a major element to be addressed. One of the most powerful reasons for this failure to internalise medical ethics lies in the way medical students learn about the non-technical aspects of medical professionalism. ‘The hidden curriculum of unscripted influences’ absorbed by osmosis during training to become a doctor, has been identified by numerous writers as equally influential as formal education.

This thesis also showed how the law has been co-opted by medical practitioner lobbies to promote their interests by diverting attention from sub-standard clinical practices. Failures by medical practitioners, supported by the law, to put the patient’s ‘needs and preferences’ front and centre illustrates the dichotomy recognised by Jonsen as the ‘profound moral paradox’ pervading medicine, ‘the incessant conflict between two basic principles of morality: self-interest and altruism’. This particular dichotomy is on display throughout this thesis in varying contexts.

29 Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011) 7.
31 See eg,

- assertion of a conscientious objection against undertaking some legal procedures (see Chapter II);
- disciplinary proceedings brought after mandatory notifications (see Chapter III);
- the deference shown to medical practitioners by the law where proper compensation for injuries caused to patients by medical misadventure is strictly confined by civil liability legislation in force throughout Australia (see Chapter IV);
- the conflict between self-determination of the patient and paternalistic judgments exemplified by failure to honour advance directives (see Chapter V); and
- the failure to observe the requirements of open disclosure after an adverse medical incident (see Chapter VI).
C  FUTURE RESEARCH DIRECTIONS

Having identified a substantial number of elements of medical practice which detract from the ethical obligation to practise patient-centred care, this thesis has also identified some areas for future research which arise out of the findings in this thesis.

1  Immediate Problems for Research

As adoption of patient-centred care principles has been shown to promote higher quality and safer clinical practice, it is important that more work goes into the development of and articulation of the theory of patient-centred care. As has been observed, patient-centred care is good medical practice which, in turn, relates back to the values which underpin medical professionalism.

Related to this suggestion for further investigation is how regulation of medical professionals can be enhanced. Codes of practice should be developed by detailing further what professionalism in the 21st Century embraces. To that end, many of the shortcomings identified in this thesis could be minimised by redrafting some of the provisions of the MBA Code to clarify the doctor’s obligations to his or her patients. An example of this recasting of provisions of the MBA Code is suggestions concerning the conscientious objection provisions as outlined in Chapter II. As they stand, there is a conflict with the overriding duty to patient primacy.

It is now over 20 years since the publication of ‘The Quality in Australian Health Care Study’. Obviously, the actual study was undertaken even earlier than the publication date. It is imperative that another similar study be instituted to determine whether the initiatives adopted in response to the disturbing incidence of iatrogenic injury have been successful in reducing the numbers. Another aspect of any survey would be to detail those areas where the most injuries occur so that more effort can be applied to reducing their occurrence.

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Related to this question is investigating whether the Surgical Safety Checklist is being adopted in Australia. It is not mandated by the Royal Australasian College of Surgeons, but is left to be adapted to local conditions. Adoption of checklists, whether locally modified or not, is imperative for safer medical practice. How and whether procedures for such things as reducing medication errors, management of patient falls, documentation of handover systems and minimising cross-infection are being implemented, are all subjects amenable to further research. Research should also investigate how improvements in these procedures can be accurately measured.

2 Further Case Studies

This thesis also examined two case studies, the compliance by medical practitioners with advance care directives, and the problems created by medical mishaps. The latter case study has suggested the institution of further research into incidence of medical injuries as proposed above. However, two further subjects for case studies arise out of matters canvassed in the chapter concerning advance directives. There is room for more detailed analysis of the way mental capacity is determined and its ramifications for the patients concerned. There is also need for more comprehensive investigation into end-of-life choices related to withholding and withdrawing of life-sustaining medical treatment.

3 Wider Research

Related to end-of-life decisions arising out of withholding and withdrawing medical treatment are the more vexed questions of legalising euthanasia or physician-assisted dying. Subjecting those questions to analysis using patient-centred care principles may well provide some new insights into what is at stake and how legislation should be framed. Such an investigation could include examining the human rights implications of denying access to these procedures, how to determine when persons under 18 years of age have sufficient understanding of any decision to choose to die and how much a decision to ask for assistance to die is a true indication of mental incapacity.

Likewise, examining other contentious issues through the lens of patient-centred care may illuminate the issues and detach them from the influences exerted on lawmakers by religious inclinations. Some of these issues include questions of
reproductive rights for disabled citizens, how to deal with catastrophically-injured neonates, conditions for access to late-term abortions, separation of conjoined twins and assisted decision-making for persons who are mentally limited to give them the maximum possible autonomy.

D EPILOGUE

Attentiveness to the patient emphasises the patient’s dignity and autonomy. Showing people that they are valued and that someone cares about what happens to them leads patients and their carers to report positively about their experiences within the health system. The King’s Fund report remarked upon the patient representative who ‘... aspired to seeing doctors more aware of the communication and information needs of their patients, so that the service provided is based on the patient “as a whole person”’. The optimistic conclusion is that all is not lost. Medical practitioners are necessarily very intelligent. Their elevated status in society need not blind them to what matters to the ordinary people upon whom their livelihood depends. The Royal College of Physicians reported an idealistic trainee who said: ‘Medical practice requires neither humility nor altruism. Good medical practice, however, requires both.’

This thesis has shown that medical regulators and parliaments have the power to regulate for and enhance the quality inherent in the obligation to practise patient-centred care.

33 See eg, Ben White, Fiona McDonald and Lindy Willmott, Health Law in Australia (Lawbook Co., 2nd ed, 2014) 104.
37 Vijaya Nath, Becky Seale and Mandip Kaur, Medical Revalidation (The King’s Fund, March 2014) 24.
To repeat Sir Donald Irvine’s observation: ‘The obvious question is why a profession with so many conscientious people could act so defensively. How does this behaviour fit with a profession committed to putting patients first?’

A ARTICLES/BOOKS/REPORTS


ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine, 'Medical Professionalism in the New Millennium: A Physician Perspective' (2002) 136 *Annals of Internal Medicine* 243

ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine, 'Medical Professionalism in the New Millennium: A Physician Perspective' (2002) 359 *Lancet* 520


Abu, Ozotu Rosemary, Sanni O Abu and Gerard Flaherty, 'Clinical Medical Students' Experiences of Unprofessional Behaviour and How These Should Inform Approaches to Teaching of Professionalism' (2016) 5(2) *MedEdPublish* 12


Administrative Review Council, *Administrative Accountability in Business Areas Subject to Complex and Specific Regulation* (November 2008)

Adorno, Roberto, 'What is the Role of 'Human Nature' and 'Human Dignity' in our Biotechnological Age?' (2011) 3 *Amsterdam Law Forum* 52


Allan, Alfred and Brett Munro, *Open Disclosure: A Review of the Literature* (Edith Cowan University, 2008)


Angell, Marcia, 'Euthanasia in the Netherlands - Good News or Bad' (1996) 335(22) *NEJM* 1676


Aronson, Mark and Matthew Groves, Judicial Review of Administrative Action (Lawbook Co, 2013)

Ashby, Michael A and Danuta Mendelson, 'Gardner; re BWV: Victorian Supreme Court Makes Landmark Australian Ruling on Tube Feeding' (2004) 181 MJA 442

Ashby, Michael A, Robert N Thornton and Robyn L Thomas, 'Advance Care Planning: Lessons from a Study of Tasmanian Enduring Guardianship Forms' (2013) 198 MJA 188


Atiyah, P S, Accidents, Compensation and the Law (Weidenfeld and Nicolson, 1970)


Audet, Anne-Marie, Karen Davis and Stephen C Schoenbaum, 'Adoption of Patient-Centred Care Practices by Physicians' (2006) 166 Archives of Internal Medicine 754


Australian Health Practitioner Regulation Agency, Annual Report 2015/16 (November 2016)

Ayres, Ian and John Braithwaite, Responsive Regulation (Oxford University Press, 1992)

Badcott, David and Carlo Leget, 'In Pursuit of Human Dignity' (2013) 16 Medicine Health Care and Philosophy 933
Baier, Annette, 'Trust and Antitrust' (1986) 96 Ethics 231


Barondess, Jeremiah A, 'Medicine and Professionalism' (2003) 163 Archives of Internal Medicine 145

Beauchamp, Tom L, 'The Failure of Theories of Personhood' (1999) 9 Kennedy Institute of Ethics Journal 309

Beauchamp, Tom L and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 5th ed, 2001)

Beauchamp, Tom L and James F Childress, Principles of Biomedical Ethics (Oxford University Press, 7th ed, 2013)

Berlant, Jeffrey Lionel, Profession and Monopoly (University of California Press, 1975)

Berlinger, Nancy, After Harm (Johns Hopkins University Press, 2005)

Berlinger, Nancy, 'Conscience Clauses, Health Care Providers and Parents' in Mary Crowley (ed), From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns (The Hastings Center, 2008) 35

Berwick, Donald M, Escape Fire (The Commonwealth Fund, 1999)


Bismark, Marie M et al, 'Mandatory Reports of Concerns about the Health, Performance and Conduct of Health Practitioners' (2014) MJA 399

Bismark, M M et al, 'Relationship between Complaints and Quality of Care in New Zealand: a Descriptive Analysis of Complainants and Non-Complainants Following Adverse Events ' (2006) 15 Quality and Safety in Health Care 17

Bismark, Marie M et al, 'Reporting of Health Practitioners by their Treating Practitioner under Australia's National Mandatory Reporting Law' (2016) 204(1) MJA 24.e1


Bolsin, Stephen N C et al, 'Whistleblowing and Patient Safety: the Patient's or the Profession's Interests at Stake?' (2011) 104 Journal of the Royal Society of Medicine 278


Boyd, K M, 'Mrs Pretty and Ms B' (2002) 28 Journal of Medical Ethics 211


Braithwaite, John, 'Regulating Nursing Homes: The Challenge of Regulating Care for Older People in Australia' (2001) 323 BMJ 443

Braithwaite, John, 'The Essence of Responsive Regulation' (2011) (44) University of British Columbia Law Review 475


Braithwaite, John, Judith Healy and Kathryn Dwan, The Governance of Health Safety and Quality (Discussion Paper, Australian Commission on Safety and Quality in Health Care, 2005)

Brazier, Margaret, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 Legal Studies 169


Brazier, Margaret and Emma Cave, Patients, Medicines and the Law (Penguin Books, 2007)

Breen, Kerry J, 'Revalidation — What is the Problem and What are the Possible Solutions?' (2014) 200 MJA 153


Brock, Dan W, 'Decisionmaking Competence and Risk' (1991) 5 Bioethics 105


Buchanan, Allen and Dan W Brock, 'Deciding for Others' (1986) 64, Suppl. 2 The Milbank Quarterly 17


Buxton, Richard,'R. (on the Application of Purdy) v DPP: Complicity in Suicide Abroad' (2010) 126 Law Quarterly Review 1

'Canada's Upcoming Assisted Death Law Puts Christian Doctors Under "Great Pressure"' The Huffington Post Canada (Online) (3 February 2016) <http://www.huffingtonpost.ca/2016/02/03/christian>

Cane, Peter, 'Reforming Tort Law in Australia: A Personal Perspective' (2003) 27 Melbourne University Law Review 649


Cantor, Norman L, Advance Directives and the Pursuit of Death with Dignity (Indiana University Press, 1993)

Capron, Alexander Morgan, 'Advance Directives' in Helga Kuhse and Peter Singer (eds), A Companion to Bioethics (Blackwell Publishers, 1998) 261


Charo, R Alta, 'The Celestial Fire of Conscience - Refusing to Deliver Medical Care' (2005) 352 NEJM 2471


Christakis, Nicholas A, 'Don't Just Blame the System' (2008) 336 BMJ 767


Classen, David C et al, 'Global Trigger Tool' Shows that Adverse Events in Hospitals may be Ten Times Greater than Previously Measured' (2011) 30 Health Affairs 581

Cleveland Clinic, Creating a Patient-Centred Health System


Cockburn, Tina and Bill Madden, 'Proof of Causation in Informed Consent Cases: Establishing What the Plaintiff Would Have Done' (2010) 18 Journal of Law and Medicine 320

Collaboration for the Advancement of Medical Education and Assessment, The Evidence and Options for Medical Revalidation in the Australian Context (Final Report, 10 July 2015)

Comment, 'Brightwater Care Group (inc) v Rossiter: Declaratory Relief and the Criminal Law' (2010) 34 Criminal Law Journal 128

Commonwealth Interdepartmental Committee on Quasi-regulation, Grey Letter Law, Report (December 1997)


Cook, Catriona et al, Laying Down the Law (LexisNexis Butterworths, 7th ed, 2009)


Coulehan, Jack, 'Teaching Professionalism: Engaging the Mind but not the Heart' (2005) 80 Academic Medicine 892

Coulehan, Jack and Peter C Williams, 'Vanquishing Virtue: The Impact of Medical Education' (2001) 76 Academic Medicine 598

Coulter, Angela, The Autonomous Patient (The Nuffield Trust, 2002)


Davies, Geoffrey, Queensland Public Hospitals Commission of Inquiry (Report (20 November 2005))


Davis, P et al, 'Preventable In-Hospital Medical Injury under the "No Fault" System in New Zealand' (2003) 12 Quality and Safety in Health Care 251

de Marneffe, Peter, 'Self-Sovereignty and Paternalism' in Christian Coons and Michael Weber (eds), Paternalism (Cambridge University Press, 2013) 56

Department of the The Attorney-General and Justice, Advance Personal Planning Bill 2013, Issues Paper (June 2013)

Dershowitz, Alan, Rights from Wrongs (Perseus, 2004)


Devlin, Patrick, Easing the Passing (Bodley Head, 1985)

Devlin, Patrick, The Enforcement of Morals (Oxford University Press, 1965)


Donabedian, Avedis, 'Evaluating the Quality of Medical Care' (2005) 83 The Millbank Quarterly 691


Dresser, Rebecca, 'Human Dignity and the Seriously Ill Patient' in President's Council on Bioethics (ed), *Human Dignity and Bioethics* (President's Council on Bioethics, 2008) 505


Dublin, Louis Israel and Bessie Bunzel, *To Be or Not To Be* (Smith and Haas, 1938)

Duclos, Christine W et al, 'Patient Perspectives of Patient-Provider Communication after Adverse Events' (2005) 17 *International Journal for Quality in Health Care* 479

Dunbar, James A et al, 'In the Wake of Hospital Inquiries: Impact on Staff and Safety' (2007) 186 *MJA* 80


Dworkin, Gerald, 'Paternalism' (1972) 56 *Monist* 64

Dworkin, Ronald, 'Autonomy and the Demented Self' (1986) 64, Suppl. 2 *The Milbank Quarterly* 4


Emanuel, Ezekiel J and Linda L Emanuel, 'Four Models of the Physician-Patient Relationship' (1992) 267 JAMA 2221


Entwistle, Vikki A, 'Hurtful Comments are Harmful Comments: Respectful Communication is not just an Optional Extra in Healthcare' (2008) 11 Health Expectations 319

Expert Advisory Group on Discrimination, Bullying and Sexual Harassment, Report to RACS (8 September 2015)


Faunce, Thomas A, 'Withdrawing Treatment at the Direct or Indirect Request of Patients or in their Best Interests: HNEAHS v A; Brightwater CG v Rossiter; and Australian Capital Territory v JT' (2009) 17 Journal of Law and Medicine 349

Faunce, Thomas, Who Owns Our Health? (UNSW Press, 2007)


Feinberg, Joel, 'Legal Paternalism' (1971) 1 Canadian Journal of Philosophy 105


Finn, Paul, 'Statutes and the Common Law' (1992) 22 Western Australian Law Review 7


Francis, Robert, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2: Analysis of Evidence and Lessons Learned (Part 2) (6 February 2013)


Freckelton, Ian, 'Disciplinary Investigations and Hearings: A Therapeutic Jurisprudence Perspective' in Greg Reinhardt and Andrew Cannon (eds), Transforming Legal Processes in Court and Beyond (Australian Institute of Judicial Administration, 2006) 139

Freckelton, Ian, 'Disciplinary Notations on the Australian Register of Medical Practitioners' (2012) 196 MJA 612


Freckelton, Ian and David Ranson, Death Investigation and the Coroner's Inquest (Oxford University Press, 2006)

Freckelton, Ian R and Kerry Anne Petersen, Disputes and Dilemmas in Health Law (Federation Press, 2006)

Freidson, Eliot, 'How Dominant Are the Professions?' in Frederic W Hafferty and John B McKinlay (eds), The Changing Medical Profession (Oxford University Press, 1993) 54


Freidson, Eliot, Profession of Medicine (Dodd, Mead and Company, 1970)

Frenk, Julio and Luis Durán-Arenas, 'The Medical Profession and the State' in Frederic W Hafferty and John B McKinlay (eds), The Changing Medical Profession (Oxford University Press, 1993) 25

Gaba, David M, 'Anaesthesiology as a Model for Patient Safety in Health Care' (2000) 320 BMJ 785

Gallagher, Thomas H et al, 'Choosing Your Words Carefully How Physicians Would Disclose Harmful Medical Errors to Patients' (2006) 166 Archives of Internal Medicine 1585


Gallagher, Thomas H, David Studdert and Wendy Levinson, 'Disclosing Harmful Medical Errors to Patients' (2007) 356 NEJM 2713


Garbutt, Jane et al, 'Reporting and Disclosing Medical Errors Pediatricians' Attitudes and Behaviors' (2007) 161 Archives of Pediatric and Adolescent Medicine 179

Gawande, Atul, Being Mortal (Profile Books, 2014)

Gawande, Atul, Complications (Metropolitan Books, 2002)

Gawande, Atul, 'The Bell Curve' The New Yorker (New York) 6 December 2004


Gentile, Mary C, Giving Voice to Values (Yale University Press, 2010)

Gentile, Mary C, 'Values-Driven Leadership Development: Where We Have Been and Where We Could Go' (2012) 9 Organization Management Journal 188

Getzendanner, Susan, 'Permanent Injunction Order against AMA' (1988) 259 JAMA 81

Gillon, Raanan, 'Autonomy and the Principle of Respect for Autonomy' (1985) 290 *BMJ* 1806

Gillon, Raanan, 'Medical Ethics: Four Principles Plus Attention to Scope' (1994) 309 *BMJ* 184

Gillon, Ranaan, 'Why I Wrote my Advance Decision to Refuse Life-Prolonging Treatment: and Why the Law on Sanctity of Life Remains Problematic' (2016) 42 *Journal of Medical Ethics* 376


Goiran, Nick et al, 'Mandatory Reporting of Health Professionals: The Case for a Western Australian Style Exemption for all Australian Practitioners' (2014) 22 *Journal of Law and Medicine* 209

Goldie, John, 'Review of Ethics Curricula in Undergraduate Medical Education' (2000) 34 *Medical Education* 108

Goodman, John C, Pamela Villareal and Biff Jones, 'The Social Cost of Adverse Medical Events, and What We Can Do about It' (2011) 30 *Health Affairs* 590


Guttmacher Institute, *Refusing to Provide Health Services* (Guttmacher Institute, 2016)


Haidet, Paul et al, 'Characterizing the Patient-Centeredness of Hidden Curricula in Medical Schools: Development and Validation of a New Measure' (2005) 80 *Academic Medicine* 44


Haugen, Arvid Steinar et al, 'It's a State of Mind': a Qualitative Study after Two Years' Experience with the World Health Organization's Surgical Safety Checklist' (2015) 17 *Cognition, Technology and Work* 55


Healthcare Commission, *Investigation into Mid Staffordshire NHS Foundation Trust* (March 2009)


Healy, Judith and John Braithwaite, 'Designing Safer Health Care through Responsive Regulation' (2006) 184(10) Supplement *MJA* S56


Hindle, Don et al, *Patient Safety A Review for the Clinical Excellence Commission* (Centre for Clinical Governance Research, Faculty of Medicine, University of NSW, 2006)


Hoffman, Tessa, 'Rural GP Should not be Blamed for Woman's Death: Coroner ' *Australian Doctor* (Online) (22 April 2016)
Hogg, Christine, *Patient-Centred Care - Tomorrow's Doctors* (23 March 2004) Education Committee Discussion Document Number 0.2 General Medical Council

Holm, Søren and Andrew Edgar, 'Best Interest: A Philosophical Critique' (2008) 16 Health Care Analysis 197

Honneth, Axel, 'Integrity and Disrespect' (1992) 20 Political Theory 187

Honoré, Tony, 'Medical Non-disclosure, Causation and Risk: *Chappel v Hart* (1999) 7 Torts Law Journal 1

Hörnle, Tatjana, 'Criminalizing Behaviour to Protect Human Dignity' (2012) 6 Criminal Law and Philosophy 307


Hughes, Clifford F and Patricia Mackay, 'Sea Change: Public Reporting and the Safety and Quality of the Australian Health Care System' (2006) 184(10) Supplement MJA S44


Iedema, Rick et al, 'Patients' and Family Members' Views on How Clinicians Enact and How They Should Enact Incident Disclosure: The "100 Patient Stories" Qualitative Study' (2011) 343 BMJ d4423 doi: 10.1136/bmj.d4423


Illich, Ivan, *Limits to Medicine* (McClelland and Stewart, 1976)


Inquiry under Section 122 of the Health Services Act 1997, Prescribing of Chemotherapy (Report on Patients Treated at Western NSW Health District, 16 September 2016)

Institute of Medicine, To Err is Human (National Academy Press, 2000)

Institute of Medicine, Crossing the Quality Chasm (National Academy Press, 2001)

Institute of Medicine, 'Crossing the Quality Chasm: A New Health System for the 21st Century' (Report Brief March 2001)


Irvine, Donald H, 'Everyone Is Entitled to a Good Doctor' (2007) 186 MJA 256

Irvine, Donald, The Doctors' Tale (Radcliffe Medical Press, 2003)


Irvine, Lord, 'The Patient, the Doctor, their Lawyers and the Judge: Rights and Duties' (1999) 7 Medical Law Review 255

Ivory, Kimberley and Karen Scott, 'Let's Stop the Bullying of Trainee Doctors — for Patients' Sake' X The Conversation (Online) (26 May 2015) https://theconversation.com/lets


Johnston, Carolyn and Peter Houghton, 'Medical Students' Perceptions of their Ethics Teaching' (2007) 33 Journal of Medical Ethics 418
Jolly, Rhonda, ‘Personally Controlled Electronic Health Records Bill 2011’, Bills Digest No 100, Parliamentary Library, 7 February 2012

Jones, Michael A, 'Informed Consent and Other Fairy Stories' (1999) 7 Medical Law Review 103


Jonsen, Albert R, A Short History of Medical Ethics (Oxford University Press, 2000)


Jorm, Christine M et al, 'Should Patient Safety be more Patient-Centred?' (2009) 33 Australian Health Review 390

Kahneman, Daniel, Thinking, Fast and Slow (Farrar, Strauss and Giroux, 2011)

Kapp, Marshall B and Bernard Lo, 'Legal Perceptions and Medical Decision Making' (1986) 64, Suppl.2 The Milbank Quarterly 163

Kardamanidis, Katrina et al, 'Hospital Costs of Older People in New South Wales in the Last Year of Life' (2007) 187 MJA 383


Kass, Leon R, '"I Will Give No Deadly Drug": Why Doctors Must Not Kill' in Kathleen Foley and Herbert Hendin (eds), The Case against Assisted Suicide (Johns Hopkins University Press, 2002) 17

Kassebaum, Donald G and Ellen R Cutler, 'On the Culture of Student Abuse in Medical School' (1998) 73 Academic Medicine 1149


Kelly, Jamie, 'Libertarian Paternalism, Utilitarianism, and Justice' in Christian Coons and Michael Weber (eds), Paternalism (Cambridge University Press, 2013) 216


Kennedy, Ian, The Unmasking of Medicine (George Allen and Unwin, 1981)

Kennedy, Ian, Treat Me Right (Clarendon Press, 1988)

Kennedy, Ian and Andrew Grubb, Medical Law (Butterworths, 3rd ed, 2000)
Kenny, Justice Susan, 'Interveners and Amici Curiae in the High Court' (1998) 20 Adelaide Law Review 159


Kerridge, Ian H and Kenneth R Mitchell, 'Missing the Point: Rogers v Whitaker and the Ethical Ideal of Informed and Shared Decision-making' (1994) 1 Journal of Law and Medicine 239

Kerridge, Ian et al, 'Moral Frameworks in Health Care: An Introduction to Ethics' in Ian R Freckleton and Kerry Anne Petersen (eds), Disputes and Dilemmas in Health Law (Federation Press, 2006) 19

Kerridge, Ian, Michael Lowe and Cameron Stewart, Ethics and Law for the Health Professions (Federation Press, 3rd ed, 2009)

Keyes, John Mark, Executive Legislation (LexisNexis, 2010)


Kitchen, Clare, 'You're Taking Out the Wrong Kidney, Surgeon was Told' Daily Mail (Online) (27 July 2014) <http://www.dailymail.co.uk/health/article-123005/You're-taking-wrong-kidney-surgeon-told.html>

Kolnai, Aurel, 'Dignity' (1976) 51 Philosophy 251


Kraman, Steve S and Ginny Hamm, 'Risk Management: Extreme Honesty May Be the Best Policy' (1999) 131 Annals of Internal Medicine 963


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<http://revofneg.treasury.gov.au/content/reports.asp>


Leape, Lucian L, 'Error in Medicine' (1994) 272 JAMA 1851

Leape, Lucian L, 'Reporting of Adverse Events' (2002) 347 NEJM 1633

Leape, Lucian L and Donald M Berwick, 'Five Years After To Err is Human What Have We Learned' (2005) 293 JAMA 2384

Legal and Social Issues Committee, Parliament of Victoria Legislative Council, 
Inquiry into End of Life Choices (Final Report, June 2016)


Levi, Benjamin, 'Advance Directives' (Lecture Delivered at the Queensland University of Technology, Brisbane, 12 April 2012)


LexisNexis, Halsbury's Laws of Australia


Little, Paul et al, 'Observational Study of Effect of Patient Centredness and Positive Approach on Outcomes of General Practice Consultations' (2001) 323 BMJ 908

Little, Paul et al, 'Preferences of Patients for Patient Centred Approach to Consultation in Primary Care: Observational Study' (2001) 322 BMJ 1

Locke, John, An Essay Concerning Human Understanding (George Routledge and Sons, Lubbock 1897 ed, first published 1689)


Luntz, Harold, 'Mrs. Whitaker's Gothic Cathedral' (1996) 4 Torts Law Journal 1


Luntz, Harold et al, Torts Cases and Commentary (Lexis Nexis Butterworths, 7th ed, 2013)

Lynch, Sandra, Bethne Hart and Catherine M Costa, 'Giving Voice to Values: An Undergraduate Nursing Curriculum Project' (2014) 21 Collegian 367


McKee, Nicole, 'Revalidation: Do We Need It?' MJA InSight (Online) (17 February 2014) <http://www.doctorportal.com.au/mjainsight/2014/5/revalidation-do-we-need-it/>

Macklin, Ruth, 'Dignity is a Useless Concept' (2003) 327 BMJ 1419


Madden, Bill and Tina Cockburn, 'Bundaberg and Beyond: Duty to Disclose Adverse Events to Patients' (2007) 14 Journal of Law and Medicine 501

Madden, Bill and Tina Cockburn, 'Duty to Disclose Medical Error in Australia' (2005) 14 Australian Health Law Bulletin 13

Magnusson, Roger S, Angels of Death (Melbourne University Press, 2002)

Makary, M A and Michael Daniel, 'Medical Error—the Third Leading Cause of Death in the US' (2016) BMJ (Online) <http://www.bmj.com/content/353/bmj.i2139>

Makeham, M A B et al, 'Patient Safety Events Reported in General Practice: A Taxonomy' (2008) 17 Quality and Safety in Health Care 53

Makeham, Meredith A B et al, 'The Threats to Australian Patient Safety (TAPS) Study: Incidence of Reported Errors in General Practice' (2006) 185 MJA 95


Mason, J K and G T Laurie, *Law and Medical Ethics* (Oxford University Press, 8th ed, 2011)


McCammon, Susan D and Howard Brody, 'How Virtue Ethics Informs Medical Professionalism' (2012) 24 *HEC Forum* 257


McDermott, Quentin, Karen Michelmore and Hagar Cohen, 'Monash Medical Centre Senior Surgeon Helen Maroulis under Investigation over Claims of Bullying, Intimidating Colleagues' *Four Corners* (25 May 2015) <http://www.abc.net.au/news/2015>


Medical Board of Australia, *Options for Revalidation in Australia* (Discussion Paper, August 2016)
Medical Board of Australia, *Expert Advisory Group on Revalidation* (Interim Report, August 2016)

Medical Board of Australia, *Expert Advisory Group on Revalidation* (Interim Report, Executive Summary, August 2016)

Megarry, R E, 'Administrative Quasi-Legislation' (1944) 60 *Law Quarterly Review* 125

Mello, Michelle M, David M Studdert and Allen Kachalia, 'The Medical Liability Climate and Prospects for Reform' (2014) 312 *JAMA* 2146


Monrouxe, Lynn V and Charlotte E Rees, "'It's Just a Clash of Cultures": Emotional Talk within Medical Students' Narratives of Professionalism Dilemmas' (2012) 17 *Advances in Health Science Education* 671


Nagel, Thomas, 'What Is It Like to be a Bat?' (1974) 83 Philosophical Review 435


Nath, Vijaya, Becky Seale and Mandip Kaur, Medical Revalidation (The Kings Fund, March 2014)

National Health Performance Authority, Towards Public Reporting of Standardised Hospital Mortality in Australia (Progress Report, February 2016)


Newton, Bruce W et al, 'Is There a Hardening of the Heart During Medical School?' (2008) 83 Academic Medicine 244

Nussbaum, Martha C, Upheavals of Thought (Cambridge University Press, 2001)


Osler, William, Aequanimitas With Other Addresses to Medical Students, Nurses and Practitioners of Medicine (Blakiston, 1904)

Ozolins, Ieva, Helen Hall and Ray Peterson, 'The Student Voice: Recognising the Hidden and Informal Curriculum in Medicine' (2008) 30 Medical Teacher 606

Palmer, Henry, 'Dr Adams' Trial for Murder' [1957] Criminal Law Review 365

Papadakis, Maxine A et al, 'Disciplinary Action by Medical Boards and Prior Behaviour in Medical School' (2005) 353 NEJM 2673


Peabody, Francis W, 'The Care of the Patient' (1927) 88 (March 19) JAMA 877

Pham, Julius Cuong, Kevin D Frick and Peter J Pronovost, 'Why Don't We Know Whether Care is Safe?' (2013) 28 American Journal of Medical Quality 457


Pols, Jeanette, 'Through the Looking Glass: Good Looks and Dignity in Care' (2013) 16 Medicine Health Care and Philosophy 953


Powers, Brian W, Christine K Cassell and Sachin H Jain, 'Ending the Cycle of Blame in US Health Care' (2014) 312(20) JAMA 2091


Productivity Commission, Australia's Health Workforce, Research Report, 2005
Productivity Commission, *Disability Care and Support*, Inquiry Report No 54 (31 July 2011)


Roth, Loren H, Alan Meisel and Charles W Lidz, 'Tests of Competency to Consent to Treatment' (1977) 134 *American Journal of Psychiatry* 279


Rothschild, Alan, 'Capacity and Medical Self-Determination in Australia' (2007) 14 Journal of Medical Ethics 403


Runciman, W B and J Moller, Iatrogenic Injury in Australia (Australian Patient Safety Foundation, 2000)


Sage, William M, 'Medical Malpractice Reform: When is it about Money? Why is it about Time?' (2014) 312(20) JAMA 2103


Satchell, Claudette S et al, 'Approaches to Management of Complaints and Notifications about Health Practitioners in Australia' (2016) 40 Australian Health Review 311

Savulescu, Julian, 'Conscientious Objection in Medicine' (2006) 332 BMJ 294


Silvester, William and Karen Detering, 'Advance Care Planning and End-of-Life Care' (2011) 195 *MJA* 435


Skene, Loane, 'Risk-Related Standard Inevitable in Assessing Competence' (1991) 5 *Bioethics* 113


Smiley, Marion, 'Paternalism and Democracy' (1989) 23 *Journal of Value Inquiry* 299

Smith, Dame Janet, 'The Shipman Inquiry' (First Report *Death Disguised* 19 July 2002)


Smith, Dame Janet, 'The Shipman Inquiry' (Fourth Report *The Regulation of Controlled Drugs in the Community* 15 July 2004)


Snowball, Kim, Review of the National Registration and Accreditation Scheme for Health Professions (Consultation Paper, Australian Health Ministers' Advisory Council, August 2014)

Social Development Committee, Parliament of Victoria, Inquiry into Options for Dying with Dignity (1987)


Southgate, Lesley and Cees P M van der Vleuten, 'A Conversation about the Role of Medical Regulators' (2014) 48 Medical Education 215

Southgate, Lesley and Mike Pringle, 'Revalidation in the United Kingdom: General Principles Based on Experience in General Practice' (1999) 319 BMJ 1180


'Squeezing Out the Doctor', The Economist (International), 2 June 2012, 25


Stapleton, Jane, 'Occam's Razor Reveals an Orthodox Basis for Chester v Afshar' (2006) 122 Law Quarterly Review 426

Statman, Daniel, 'Humiliation, Dignity and Self-Respect' (2000) 13 Philosophical Psychology 523


Stewart, Cameron and Andrew Lynch, 'Undue Influence, Consent and Medical Treatment' (2003) 96 Journal of the Royal Society of Medicine 598


Stewart, M, 'Towards a Global Definition of Patient Centred Care' (2001) 322 BMJ 444

Stone, Deborah, 'Moral Hazard' (2011) 36 Journal of Health Politics, Policy and Law 887


Studdert, David M et al, 'Negligent Care and Malpractice Claiming Behavior in Utah and Colorado' (2000) 38 Medical Care 250


Studdert, David M et al, 'Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?' (1997) 60 Law and Contemporary Problems 1


Swartz, Martha S, "Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities' (2006) 6 Yale Journal of Health Policy, Law, and Ethics 269

Swick, Herbert M et al, 'Teaching Professionalism in Undergraduate Medical Education' (1999) 292 JAMA 830


Teunissen, Pim W and Michiel Westerman, 'Opportunity or Threat: The Ambiguity of the Consequences of Transition in Medical Education' (2011) 45 *Medical Education* 51


The Senate Finance and Public Administration References Committee, *The Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHPRA)* (June 2011)


Thomas, Eric J et al, 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado' (2000) 38 *Medical Care* 261


Veitch, Scott, *Law and Irresponsibility* (Routledge-Cavendish, 2007)


Vines, Prue, 'Apologising to Avoid Liability: Cynical Civility or Practical Morality' (2005) 27 Sydney Law Review 483


Wallace, Professor Euan M, Report of an Investigation into Perinatal Outcomes at Djerriwah Health Services (Executive Summary)


Wear, Delese et al, 'Making Fun of Patients: Medical Students' Perceptions and Use of Derogatory and Cynical Humour in Clinical Settings' (2006) 81 Academic Medicine 454


Weisbrot, David and Kerry J Breen, 'A No-Fault Compensation System for Medical Injury is Long Overdue' (2012) 197 MJA 296


Wheatland, Fiona Tito, 'Medical Indemnity Reform in Australia: "First Do No Harm"' (2005) 33 Journal of Law, Medicine & Ethics 429

White, Andrew A et al, 'The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients' (2008) 83 Academic Medicine 250

White, Ben, Lindy Willmott and John Allen, 'Withholding and Withdrawing Life-Sustaining Treatment; Criminal Responsibility for Established Medical Practice?' (2010) 17 Journal of Law and Medicine 849

White, Ben, Fiona McDonald and Lindy Willmott, Health Law in Australia (Lawbook Co, 2010)

367
White, Ben et al, 'The Legal Role of Medical Professionals in Decisions to
Withhold or Withdraw Life-sustaining Treatment: Part 1 (New South Wales)'
(2011) 18 Journal of Law and Medicine 498

White, Ben et al, 'Doctors' Knowledge of the Law on Withholding and
Withdrawing Life-Sustaining Medical Treatment' (2014) 201(4) MJA 1


Wiese, Marlene et al, 'Australia's Systems of Primary Healthcare' (2011) 40
Australian Family Physician 995

Bioethics 413

Tim J Wilkinson et al, 'The Impact on Students of Adverse Experiences during
Medical School' (2006) 28 Medical Teacher 129

Willmott, Lindy, Ben White and Donna Cooper, 'Interveners or Interferers:
Intervention in Decisions to Withhold and Withdraw Life-Sustaining Medical
Treatment' (2005) 27 Sydney Law Review 597

Willmott, Lindy, 'Advance Directives to Withhold Life-Sustaining Medical
Treatment: Eroding Autonomy through Statutory Reform' (2007) 10 Flinders
Journal of Law Reform 287

Willmott, Lindy, 'Advance Directives Refusing Treatment as an Expression of
Autonomy: Do the Courts Practise What They Preach?' (2009) 38 Common Law
World Review 295

Willmott, Lindy, 'Advance Directives and the Promotion of Autonomy: A
Comparative Australian Statutory Analysis' (2010) 17 Journal of Law and
Medicine 556

Willmott, Lindy et al, 'The Legal Role of Medical Professionals in Decisions to
Withhold or Withdraw Life-sustaining Treatment: Part 3 (Victoria)' (2011) 18
Journal of Law and Medicine 773

Willmott, Lindy et al, 'The Legal Role of Medical Professionals in Decisions to
Withhold or Withdraw Life-sustaining Treatment: Part 2 (Queensland)' (2011) 18
Journal of Law and Medicine 523

Willmott, Lindy, Ben White and Jocelyn Downie, 'Withholding and Withdrawal of
"Futile" Life-Sustaining Treatment: Unilateral Medical Decision-Making in
Australia and New Zealand' (2013) 20 Journal of Law and Medicine 907

MJA 458

Wilson, Ross McL and Martin B van der Weyden, 'The Safety of Australian
Healthcare: 10 Years after QAHCS' (2005) 182 MJA 260

Practice' (2009) 13 Critical Care 210

368


Woolf, Lord, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) 9 *Medical Law Review* 1


Wynia, Matthew K, 'The Role of Professionalism and Self-Regulation in Detecting Impaired or Incompetent Physicians' (2010) 2010 *JAMA* 210
B  CASES

*A v A Health Authority* [2002] 1 FCR 481

*Aintree University Hospitals NHS Foundation v James* [2014] AC 591

*Airedale NHS Trust v Bland* [1993] AC 789

*Alroe v Medical Board of Australia* [2015] QCAT 482

*An NHS Trust v J* [2006] EWHC 3152 (Fam)

*Anne Christina Benton v Tea Tree Plaza Nominees* (1995) 64 SASR 494

*Attorney General (Vic) v Commonwealth (the Pharmaceutical Benefits case)* (1945) 71 CLR 237

*Auckland Area Health Board v Attorney General* [1993] 1 NZLR 235

*Australian Capital Territory v JT* [2009] ACTSC 105

*Bahramy v Medical Council of New South Wales* [2014] NSWCATOD 116

*Banks v Goodfellow* (1870) LR 5 QB 549

*Bernadt v Medical Board of Australia* [2013] WASCA 259

*Blyth v Bloomsbury Health Authority* [1993] 4 Med LR 151

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

*Bolitho v Hackney and City Health Authority* [1998] AC 232

*Breen v Williams* (1995-1996) 186 CLR 71

*Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229

*Briginshaw v Briginshaw* (1938) 60 CLR 336

*British Medical Association v Commonwealth* (1949) 79 CLR 201

*Canterbury v Spence* (1972) 464F. 2d 772

*Caparo Industries PLC v Dickman* [1990] 2 AC 605

*Carter v Canada (Attorney General)* [2012] BCSC 886

*Carter v Canada (Attorney General)* [2015] 1 RCS 331

*CES v Superclinics Australia Pty Ltd* (1995) 38 NSWLR 47
Chester v Afshar [2005] 1 AC 134
Christopherson v Bare (1848) 11 QB 473
Clyne v NSW Bar Association (1960) 104 CLR 186
Collins v Wilcock [1984] 1 WLR 1172, 1177
Crickitt v Medical Council of NSW (No 2) [2015] NSWCATOD 115
Cruzan v Director, Missouri Department of Health, 110 S Ct 2841 (1990)

Donoghue v Stevenson [1932] AC 562
Dovuro Pty Limited v Wilkins (2003) 215 CLR 317
Dr A v Health District (No 2) [2014] NSWIRComm 50
Dr Reid v Medical Council of NSW [2014] NSWCAT 152
Drake v Minister for Immigration and Ethnic Affairs (1979) 46 FLR 409

F v R (1983) 33 SASR 189
FI v Public Guardian [2008] NSWADT 263
Furniss v Fitchett [1958] NZLR 396

Gardner; Re BWV [2003] VSC 173
General Practitioners Society v Commonwealth (1980) 145 CLR 532
Gibbons v Wright (1954) 91 CLR 423
Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 AC 112
Gold v Haringey Health Authority [1988] 1 QB 481
Gorman v NSW Health Care Complaints Commission [2012] NSWCA 251

H Ltd v J [2010] SASC 176
Harriton v Stephens (2006) 225 CLR 52
HCCC v Chen [2016] NSWCATOD 144
HCCC v Chowdhury (No 2) [2015] NSWCATOD 127
HCCC v Do [2014] NSWCA 307
HCCC v Gorman [2011] NSWMT 7
HCCC v Dr Maendel (No 2) [2013] NSWMT 10
HCCC v Nair [2013] NSWMT 19
HCCCv Orr [2015] NSWCATOD 124
HCCC v Priyamanna No 2 [2016] NSWCATOD 3
HCCC v Quach [2015] NSWCATOD 2
HCCC v Quach (No 2) [2015] NSWCATOD 32
HCCC v Dr Maendel (No 2) [2013] NSWMT 10
HE v A Hospital NHS Trust [2003] EWHC 1017
Hillyer v The Governors of St Bartholomew’s Hospital [1909] 2 KB 820
Hocking v Medical Board of Australia [2014] ACTSC 48
Home Office v Dorset Yacht Co Ltd [1970] AC 1004
Hucks v Cole [1993] 4 Med LR 393
Hunter v Mann [1974] 1 QB 767

In re Agar-Ellis (1878) 10 ChD 49; (1883) 24 ChD 317
In re B (A Minor)(Wardship: Medical Treatment) [1981] 1 WLR 1421
In re C. (Adult: Refusal of Treatment) [1994] 1 WLR 290
In re F (Mental Patient: Sterilisation) [1990] 2 AC 1
In re J (A Minor) (Wardship: Medical Treatment) [1991] Fam 33
In re J (A Minor)(Child in Care: Medical Treatment) [1993] Fam 15
In re T (Adult: Refusal of Treatment) [1993] Fam 95
In re W (A Minor)(Medical Treatment: Court’s Jurisdiction) [1993] Fam 64
In the Matter of SA [2005] EWHC 2942 (Fam)

Isaac Messiha (By His Tutor Magdy Messiha) v South East Health [2004] NSWSC 1061
K v Minister for Youth and Community Services (1982) 8 Fam LR 768
Kings College Hospital NHS Foundation Trust v C [2015] EWCOP 80
Krommydas v Sydney West Area Health Service [2006] NSWSC 901

Lee v South West Thames Regional Health Authority [1985] 1 WLR 845

March v E & MH Stramare Pty Limited (1990-1991) 171 CLR 506
Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634
McBain v Victoria (2000) 177 ALR 320
Medical Board of Australia v Adams [2017] VCAT 796
Medical Board of Australia v Al-Naser [2015] ACAT 15
Medical Board of Australia v Curran [2015] SAHPT 4
Medical Board of Australia v Fox [2016] VCAT 408
Medical Board of Australia v Griffiths [2017] VCAT 822
Medical Board of Australia v Henning [2014] SAHPT 7
Medical Board of Australia v Hocking and Hocking v Medical Board of Australia [2015] ACAT 44
Medical Board of Australia v Kanapathipillai [2016] ACAT 16
Medical Board of Australia v Koniuszko (Review and Regulation) [2016] VCAT 492
Medical Board of Australia v Lewis [2017] SAHPT 1
Medical Board of Australia v Mbo [2015] ACAT 69
Medical Board of Australia v Melhuish [2016] ACAT 29
Medical Board of Australia and Veettill [2015] WASAT 124
Minister for Immigration, Local Government and Ethnic Affairs v Gray (1994) 50 FCR 189
Mohr v Williams (1905) 104 NW 11 (Sup Ct.Minn)
Montgomery v Lanarkshire Health Board [2015] UKSC 11
Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam)

Naylor v Preston Area Health Authority [1987] 2 All ER 353

NHS Trust A v M; NHS Trust B v H [2001] 2 WLR 942

NHS Trust v T (adult patient: refusal of medical treatment) [2004] 3 FCR 297

Nitschke v Medical Board of Australia [2015] NTSC 39

Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549

NSW Bar Association v Evatt (1968) 117 CLR 177

Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd (The Wagon Mound) [1961] AC 388

Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty (Wagon Mound No 2) [1967] AC 617

Pearce v United Bristol Healthcare NHS Trust [1999] PIQR 53

Pillai v Messiter (No 2) (1989) 16 NSWLR 197

Podrebersek v Australian Iron & Steel Pty Ltd (1985) 59 ALR 529

Pratt v Davis (1905) 118 Ill App 161

Presland v Hunter Area Health Service [2003] NSWSC 754

Pretty v United Kingdom (2002) 35 EHHR 1

Professional Standards Committee Inquiry in Dr Joachim Fluhrer [2013] NSWMPSC 7

Qumsieh v Guardianship and Administration Board [1998] VSCA 45

Qumsieh v Pilgrim [2000] HCA Trans 34

R (Burke) v General Medical Council [2005] QB 424

R (Burke) v General Medical Council [2006] 1 QB 273

R (on the application of Morris) v Trafford Healthcare NHS Trust [2006] EWHC 2334 (Admin)
R (on the application of Nicklinson) v Ministry of Justice [2014] UKSC 38

R (on the application of Purdy) v DPP [2010] 1 AC 345

R (Pretty) v DPP [2002] 1 AC 800

R (Smeaton) v Secretary of State for Health [2002] EWHC 610

R v Bourne [1938] 3 All ER 615

R v Bourne [1939] 1 KB 687

R v Brown [1992] 2 WLR 441

R v Cambridge Health Authority, Ex parte B [1995] 1 WLR 898

R v Davidson [1969] VR 667

R v Dudley and Stephens (1884) 14 QBD 273

R v Justins [2008] NSWSC 1194

R v Wald and Others (1971) 3 NSWDCR 25

Re A (children) (conjoined twins: surgical separation) [2004] 4 All ER 961

Re A (Male Sterilisation) [2000] 1 FLR 549

Re AK (Medical Treatment: Consent) [2001] 1 FLR 129

Re Drake and Minister for Immigration and Ethnic Affairs (No 2) [1979] 2 ALD 634

Re JT (Adult: Refusal of Medical Treatment) [1998] 1FLR 48

Re Marion (No 2) (1992) 17 Fam LR 336

Re MB [1997] EWCA Civ 3093

Re McBain; Ex parte Australian Catholic Bishops Conference (2002) 188 ALR 1

Re R (Adult: Medical Treatment) [1996] 2 FLR 99

Reeves v The Queen [2013] HCA 57

Reibl v Hughes (1980) 114 DLR (3rd) 1

Roe v Ministry of Health [1953] 2 All ER 131

Rogers v Whitaker (1992) 175 CLR 479

Rosenberg v Percival (2001) 205 CLR 434

Schloendorff v Society of New York Hospital (1914) 211 NY 125
Secretary, Department of Health and Community Services v JWB and SMB [Marion's Case] (1991-1992) 175 CLR 218

Sheffield Teaching Hospitals NHS Foundation Trust v TH [2014] EWCOP 4

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1984] 1 QB 493

Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871

Smith v Wairarapa Medical Centre (Wellington) [2009] NZERA 356

St. George's Healthcare NHS Trust v S [1999] Fam 26

Stanley-Clarke v Australian Health Practitioner Regulation Agency [2012] QSC 250

State of Queensland v Nolan [2002] 1 Qd R 454

Stuart v Kirkland-Veenstra (2009) 237 CLR 215

Sue Rodriguez v Attorney General of Canada and Attorney General of British Columbia [1993] 3 SCR 519

Sullivan v Moody (2001) 207 CLR 562

Syme v Medical Board of Australia [2016] VCAT 2150

Tasmanian Board of the Medical Board of Australia v Dr David Edis [2014] TASHPT 1

The Gratitude (1801) C Rob 240

The Sydney Children's Hospital Network v X [2013] NSWSC 368

Tobin v Ezekiel: Estate of Lily Ezekiel [2011] NSWSC 81

Todorovic v Waller (1981) 150 CLR 402

Vairy v Wyong Shire Council (2005) 223 CLR 422

W Healthcare NHS Trust v H [2005] 1 WLR 834

W v M [2011] EWHC 2443 (Fam)

Wallace v Kam (2013) 87 ALJR 648

Whetstone v Medical Protection Society Limited [2014] EWHC 1024 (QB)

Whitehouse v Jordan [1980] 1 All ER 650

Whitehouse v Jordan [1981] 1 WLR 246

Wighton v Arnot [2005] NSWSC 637

Wilsher v Essex Area Health Authority [1987] 1 QB 770 (CA)

Wilsher v Essex Area Health Authority [1988] 1 AC 1074

Wong v Commonwealth (2009) 236 CLR 573 (the PSR case)

Woollard v The Medical Board of Australia Sitting as a Performance and Professional Standards Panel [2015] WASC 332

Woolminton v DPP [1935] AC 463

Woods v Lowns (1995) 36 NSWLR 344

Wyatt v Curtis [2003] EWCA Civ 1779

Wye Valley NHS Trust v B [2015] EWCOP 60

Wynbergen v Hoyts Corporation Pty Limited (1997) 149 ALR 25

Wyong Shire Council v Shirt (1979-1980) 146 CLR 40
C  LEGISLATION

Administrative Decisions (Judicial Review) Act 1977 (Cth)

Advance Care Directives Act 2013 (SA)

Advance Personal Planning Act 2013 (NT)

Carers Recognition Act 2010 (Cth)

Charter of Human Rights and Responsibilities Act 2006 (Vic)

Civil and Administrative Tribunal Act 2013 (NSW)

Civil Law (Wrongs) Act 2002 (ACT)

Civil Liability Act 2002 (NSW)

Civil Liability Act 2003 (Qld)

Civil Liability Act 1936 (SA)

Civil Liability Act 2002 (Tas)

Civil Liability Act 2002 (WA)

Commonwealth of Australia Constitution Act 1900 (Imp 63 & 64 Vict, c 12, s 9)

Consent to Medical Treatment and Palliative Care Act 1995 (SA)

Coroners Act 1997 (ACT)

Coroners Act 2009 (NSW)

Coroners Act 1993 (NT)

Coroners Act 1958 (Qld)

Coroners Act 1975 (SA)

Coroners Act 1995 (Tas)

Coroners Act 1985 (Vic)

Coroners Act 1996 (WA)

Guardianship Act 1987 (NSW)

Guardianship and Administration Act 2000 (Qld)

Guardianship and Administration Act 1986 (Vic)
Guardianship and Administration Act 1990 (WA)

Health Care Complaints Act 1993 (NSW)

Health Insurance Act 1973 (Cth)

Health Ombudsman Act 2013 (Qld)

Health Practitioner Regulation National Law Act 2009 (Qld)

Health Practitioner Regulation National Law Act (ACT)

Health Practitioner Regulation National Law (NSW) No 86a

Health Practitioner Regulation (New South Wales) Regulation 2016 (NSW)

Health Quality and Complaints Commission Act 2006 (Qld)

Health Services Act 1997 (NSW)

Human Rights Act 2004 (ACT)

Human Tissue Act 1983 (NSW)

Judiciary Act 1903 (Cth)

Law Reform (Miscellaneous Provisions) Act (NT)

Legislation Act 2003 (Cth)

Limitation Act 1985 (ACT)

Limitation Act 1969 (NSW)

Limitation Act (NT)

Limitation Act 1974 (Tas)

Limitation Act 2005 (WA)

Limitation of Actions Act 1936 (SA)

Limitation of Actions Act 1974 (Qld)

Limitation of Actions Act 1958 (Vic)

Lord Ellenborough's Act (43 Geo III, c58)

Medical Act 1858 (UK)
Medical Act 1894 (WA)
Medical Practitioners Act 1930 (ACT)
Medical Practice Act 1992 (NSW)
Medical Practice Act 2004 (SA)
Medical Practice Act 1994 (Vic)
Medical Act 1894 (WA)
Medical Practice Act 1992 (NSW)
Medical Practitioners Act 1930 (ACT)
Medical Practice Act 2004 (SA)
Medical Practice Act 1994 (Vic)
Medical Practice Regulation 1998 (NSW)
Medical Practice Regulation 2003 (NSW)
Medical Treatment Act 1988 (Vic)
Medical Treatment (Health Directions) Act 2006 (ACT)
Medical Treatment Planning and Decisions Bill 2016 (Vic)
Mental Capacity Act 2005 (UK)
Mental Health Act 2000 (Qld)
Minors (Property and Contracts) Act 1970 (NSW)

National Health Reform Act 2011 (Cth)
Natural Death Act 1988 (NT)

Personal Injuries (Civil Claims) Act (NT)
Personal Injuries (Liability and Damages) Act 2003 (NT)
Personal Injuries Proceedings Act 2002 (Qld)
Pharmaceutical Benefits Act 1947 (Cth)
Powers of Attorney Act 2006 (ACT)
Powers of Attorney Act 2003 (NSW)

380
Powers of Attorney Act 1998 (Qld)

Registration of Births, Deaths and Marriages Act 1962 (Qld)

Work Health and Safety Act 2011 (ACT)

Wrongs Act 1958 (Vic)
E OTHER

ACT Government, Mental Health, Justice, Health and Alcohol & Drug Services (MJHADS), Decision Making Capacity (February 2016)

ACT Health, About the Australian Charter of Healthcare Rights

ACT Health, Open Disclosure Policy (February 2010)

Advance Care Directive for Care at the End of Life


American Medical Association, Principles of Medical Ethics (1903)

American Medical Association, Principles of Medical Ethics (June 1957)

American Medical Association, Principles of Medical Ethics (June 1980)


ANZAAG - ANZCA, Anaphylaxis Management Guidelines (June 2013)

Austin Health, Respecting Patient Choices (January 2006)

Australian Bureau of Statistics, Feature Article: Population by Age and Sex, Australian States and Territories


Australian Bureau of Statistics, 1301.0 - Year Book Australia 2006 Religious Affiliation
<http://www.abs.gov.au/ausstats/abs@.nsf/46d1bc47ac9d0c7bca256c470025f987/BFDDA1CA506D6CFACA2570DE0014496E?opendocument>

Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare Rights

Australian Commission on Safety and Quality in Health Care, Draft National Patient Charter of Rights, (Consultation Paper, 22 January 2008)

Australian Commission on Safety and Quality in Health Care, National Patient Charter of Rights (Consultation Report, June 2008)

382

Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework (2013)

Australian Commission on Safety and Quality in Healthcare, Australian Safety and Quality Framework for Healthcare (at December 2010)

Australian Commission on Safety and Quality in Health Care, Australian Safety and Quality Goals for Health Care

Australian Commission on Safety and Quality in Healthcare, Development of the National Safety and Quality Health Service Standards

Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012)

Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard (at July 2003)

Australian Commission on Safety and Quality in Health Care, Open Disclosure Standard Review Report (June 2012)

Australian Commission on Safety and Quality in Health Care, Patient-Centred Care, Discussion Paper (September 2010)

Australian Commission on Safety and Quality in Health Care, Patient-Centred Care (August 2011)

Australian Commission on Safety and Quality in Health care, Proposed National Safety and Quality Framework (Consultation Report, May 2010)

Australian Commission on Safety and Quality in Health Care, Review of the Department of Health and Human Services' Management of a Critical Issue at Djerriwah Health Services (November 2015)

Australian Commission on Safety and Quality in Healthcare, Roles in Realising the Australian Charter of Healthcare Rights

Australian Commission on Safety and Quality in Health Care, Safety and Quality of End-of-life Care in Acute Hospitals: A Background Paper, (August 2013)

Australian Council for Safety and Quality in Health Care, Setting the Human Factor Standards for Health Care: Do Lessons from Aviation Apply? (July 2004)

Australian Commission on Safety and Quality in Health Care, Windows into Safety and Quality in Health Care 2008

Australian Commission on Safety and Quality in Health Care, Windows into Safety and Quality in Health Care 2009

Australian Commission on Safety and Quality in Health Care, Windows into Safety and Quality in Health Care 2010
Australian Commission on Safety and Quality in Health Care, *Windows into Safety and Quality in Health Care 2011*


Australian Health Practitioner Regulation Agency, *Guidelines for Mandatory Notifications* (March 2014)


Australian Medical Association, *Code of Medical Ethics* (at 1859)

Australian Medical Association, *Code of Medical Ethics* (at 1989)

Australian Medical Association, *Code of Ethics* (July 1992)

Australian Medical Association, *Code of Medical Ethics* (at 1965)


Australian Medical Association, *More Than Just a Union* (June 2012)


Australian Medical Association, Restraint in the Care of Older People (at 2001)

Australian Medical Association, Role of the Doctor - 2011 (at April 2011)

Australian Medical Association, The Role of the Medical Practitioner in Advance Care Planning - 2006

Australian Medical Council, Good Medical Practice: A Code of Conduct for Doctors in Australia (at July 2009)


British Medical Association, Resuscitation Council (UK) and Royal College of Nursing, Decisions Relating to Cardiopulmonary Resuscitation (at October 2007)


Clinical Excellence Commission, Clinical Incident Management in the NSW Public Health System, NSW Health (January to June 2010)

Clinical Excellence Commission, Clinical Incident Management in the NSW Public Health System, NSW Health (July to December 2010)

Clinical Excellence Commission, Clinical Supervision at the Point of Care (2012)


COAG, Communiqué 9 June 2017

Code of Medical Ethics of the American Medical Association (American Medical Association Press, 1847)

Commonwealth of Australia, Parliamentary Debates, House of Representatives, 3 April 1946

Commonwealth of Australia, Parliamentary Debates, House of Representatives, 4 April 1946

Commonwealth of Australia, Parliamentary Debates, House of Representatives, 5 April 1946

Commonwealth of Australia, Parliamentary Debates, House of Representatives, 9 April 1946

Council of Australian Governments, Communique (Meeting, 14 July 2006)


Department of the Attorney-General and Justice, *Advance Personal Planning Bill 2013 - Issues Paper* (June 2013)


Department of Health and Human Services, *Simplifying Medical Treatment Decision Making and Advance Care Planning* (January 2016)

Director of Public Prosecutions, *Interim Policy for Prosecutors in Respect of Cases of Assisted Suicide* (at 23 September 2009)

Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (at February 2010)


General Medical Council, *End of Life Care: Consultation* (at 25 February 2009)

General Medical Council, *Good Medical Practice* (at 22 April 2013)

General Medical Council, *The Good Medical Practice Framework for Appraisal and Revalidation* (March 2013)
General Medical Council, *Professional Conduct and Discipline: Fitness to Practise* (April 1985)

General Medical Council, *Revalidation Update* (March/April 2010)

General Medical Council, *Treatment and Care Towards the End of Life: Good Practice in Decision Making* (at 1 July 2010)

Government of Western Australia, WA *Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia* (May 2009 (amended July 2012))

*Hippocratic Oath* - Classical Version

Hippocratic Oath - Modern Version

*Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* (26 March 2008)

*International Covenant on Economic, Social and Cultural Rights*<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>


Medical Board of Australia, *Board Commissions Research on Revalidation'* (Media Statement, 24 March 2015)

Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at 2009)

Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at March 2014)

Medical Board of Australia, *Registrant Data*, (Reporting Period: October 2015 - December 2015)


National Health Reform, *Performance and Accountability Framework*


New South Wales, *Parliamentary Debates*, Legislative Assembly 8 November 1983

New South Wales, *Parliamentary Debates*, Legislative Council, 22, 23 and 24 November 1983

New South Wales, *Parliamentary Debates*, Legislative Assembly, 28 October 2009


Northern Territory, *Parliamentary Debates*, Legislative Assembly, 17 August 1988

Northern Territory, *Parliamentary Debates*, Legislative Assembly, 24 and 25 May 1995

Northern Territory, *Parliamentary Debates*, Legislative Assembly, 22 February 1995

NSW Government, *Your Health Rights and Responsibilities* (20 April 2011)

NSW Health, *Consent to Medical Treatment - Patient Information* (at 27 January 2010)


NSW Health, *Using Advance Care Directives* (22 March 2005)

Oregon Public Health Division, *Oregon's Death with Dignity Act - 2010* (as at 7 January 2011)

Personal correspondence with AHPRA 13 November 2014.

Picker Institute, *The Eight Principles of Patient Centered Care* (Online) (15 May 2015) <http://pickerinstitute.org/about/picker-principles/>

Queensland, *Parliamentary Debates*, Legislative Assembly, 8 October 1997

Royal Australasian College of Physicians, *Budget Submission: Adverse Drug Event Reporting*


Royal Australasian College of Physicians, *Improving Care at End of Life: Our Roles and Responsibilities* (May 2016)


Royal Australasian College of Surgeons, *Code of Conduct*


Royal Australasian College of Surgeons, *Surgical Safety Checklist* (Oct 09)

Royal College of Nursing, *When Someone Asks for Your Assistance to Die* (at October 2011)

South Australia, *Parliamentary Debates*, House of Assembly, 3 November 1994


*The Universal Declaration of Human Rights* 

Victoria, *Parliamentary Debates*, Legislative Assembly, 5 May 1988
Victoria, *Parliamentary Debates*, Legislative Assembly, 6 May 1988

Victoria, *Parliamentary Debates*, Legislative Assembly, 15 October 2009

Victoria, *Parliamentary Debates*, Legislative Assembly, 12 November 2009

Victoria, *Parliamentary Debates*, Legislative Assembly, 15 September 2016

(Proof)


World Health Organisation, *Quality of Care* (WHO Press, 2006)


## APPENDIX IIIA

### Tribunal and Supreme Court Decisions 1 July 2013 to 30 June 2014

Victoria - 7  
Boundary violations - 2  
Self-medication - alcohol or drugs - 1  
Improper prescribing - 2  
Deficient clinical standards - 3  
Inadequate record keeping - 1  
Impairment - 3

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<tr>
<th>Case Name</th>
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<th>Result</th>
<th>Date of Judgement</th>
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<tbody>
<tr>
<td>Medical Board of Australia v Crawford (Review and Regulation)</td>
<td>[2013] VCAT 1946</td>
<td>Failure to advise possible complications from proposed surgery, inappropriate procedure - complainant prone to exaggeration, breakdown in trust</td>
<td>Divergence of expert opinions so not persuaded that allegations made out - not unprofessional conduct</td>
<td>18 November 2013</td>
</tr>
<tr>
<td>Medical Board of Australia v McGrath (Review and Regulation)</td>
<td>[2014] VCAT 641</td>
<td><em>Health Professions Registration Act 2005</em> - agreed statement of facts - 9 consultations, failed to provide privacy for patient while she undressed, leave room or aids to privacy - physical examination when only there to discuss MRI, no informed consent - failure to make adequate notes on 2 occasions</td>
<td>Unprofessional conduct - caution, reprimand, conditions upon registration - appropriate penalties to protect the public</td>
<td>28 May 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Myers (Review and Regulation)</td>
<td>[2013] VCAT 1315</td>
<td>Unprofessional conduct not of serious nature for allegation 1 &amp; 4 - allegation 3 not proven to Tribunal’s satisfaction - allegation 5, unprofessional conduct - allegation 2, unprofessional conduct of serious nature - reprimand for unprofessional conduct</td>
<td>Relist for submission about appropriate disposition</td>
<td>31 July 2013</td>
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caution with respect of obtaining informed consent concerning treatment and fees, need to communicate clearly, written notification of fee structure, counselling

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<tr>
<th>Case Title</th>
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<tbody>
<tr>
<td><strong>Orchard v Medical Board of Australia (Review and Regulation)</strong></td>
<td>9 October 2013</td>
<td>Application for review of decision of respondent not to renew registration on grounds of impairment, not fit and proper, inability to practise safely. Respondent ordered to register applicant, but subject to conditions.</td>
</tr>
<tr>
<td><strong>Medical Board of Australia v O'Toole (Review and Regulation)</strong></td>
<td>14 February 2014</td>
<td>Agreed that unprofessional conduct - agreed caution, reprimand, conditions upon registration - challenging patient, previously unblemished record.</td>
</tr>
<tr>
<td><strong>Medical Board of Australia v Perry (Review and Regulation)</strong></td>
<td>29 November 2013</td>
<td>Allegations, boundary violations, sexual, 19 October 2010 - complaint to police not proceeded with - notification to Board - differences about the evidence - relevance of context - formal hearing 17 December 2013.</td>
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</tbody>
</table>
Western Australia - 6
Boundary violations
Self-medication - alcohol or drugs
Improper prescribing
Deficient clinical standards - 5
Inadequate record keeping - 1
Impairment

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<tr>
<td>Medical Board of Australia and Boyd</td>
<td>[2013] WASAT 123</td>
<td>Medical Act 1894 - ‘alternative’ treatment of cancer patients in 2005 - 5 patients died within weeks of commencing treatment, subject of coroner inquest - treatment not in accord with accepted medical practice and probably led to earlier death of at least 4 patients - allegations of improper or infamous conduct in professional respect or alternatively, gross carelessness or incompetency</td>
<td>Surrendered registration 10 January 2010, but tribunal can still order removal of name from register, seriousness of behaviour recognised by removal of name, sufficient deterrent to others, no need for further penalties</td>
<td>9 August 2013</td>
</tr>
<tr>
<td>Medical Board of Australia and Dekker</td>
<td>[2013] WASAT 182</td>
<td>Medical Practitioners Act 2008 - Failure to stop and render assistance after 'near miss' accident, reported to police - improper conduct in professional respect</td>
<td>Guilty of improper conduct in professional respect, sufficiently close nexus between conduct and profession - reasonably regarded as disgraceful or dishonourable by colleagues of good repute and competency - further hearing to determine penalty and costs</td>
<td>14 November 2013</td>
</tr>
<tr>
<td>Langton and Medical Board of Australia</td>
<td>[2013] WASAT 170</td>
<td>Application to vary conditions on registration - mediation - payment of Board’s costs?</td>
<td>Prima facie each party bears own costs - no reason to vary in this case</td>
<td>14 October 2013</td>
</tr>
<tr>
<td>Medical Board of Australia and Whiteside</td>
<td>[2013] WASAT 18</td>
<td>Medical Practitioners Act 2008 - Allegation that lack of medical knowledge and skill to practise safely as GP, some failure of records of medical history and clinical notes, following Professional Services Review - illustrative of broad concerns</td>
<td>Some failings but did not amount to ‘competency’ matter - application dismissed</td>
<td>20 November 2013</td>
</tr>
<tr>
<td>Medical Board of</td>
<td>[2013]</td>
<td>Medical Practitioners Act 2008 - Allegations of</td>
<td>Reprimand, registration subject to conditions, review in 5</td>
<td>3 July 2013</td>
</tr>
<tr>
<td>Australia and Woollard</td>
<td>WASAT 101</td>
<td>Carelessness about treatment of two patients - agreed facts after mediation - also professional misconduct</td>
<td>Years, fine of $75,000.00, costs of Board</td>
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<tr>
<td>Bernadt v Medical Board of Australia</td>
<td>[2013] WASCA 259</td>
<td>Order to suspend, application to set aside - factual findings being challenged - immediate action as interim procedure, need further action?</td>
<td>Performance and conduct aspects of professional misconduct - construction of s 158 National Law, immediate action still valid even if no further action taken - any immediate action can be overtaken by a decision of a panel or the Tribunal - no express option to do nothing but omission did not vitiate anterior decision - dismiss the appeal</td>
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<td>18 November 2013</td>
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### ACT - 3

**Boundary violations 2**

- Self-medication - alcohol or drugs
- Improper prescribing
- Deficient clinical standards - 1
- Inadequate record keeping
- Impairment

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<tbody>
<tr>
<td>Medical Board of Australia v Speldewinde (Occupational Discipline)</td>
<td>[2014] ACAT 27</td>
<td>Inappropriate conversation and physical contact with 2 female patients - contrary to [8.2.1] of Good Medical Practice - s 40 [sic] National Law code as evidence</td>
<td>Unsatisfactory professional performance - Reprimand, consent order</td>
<td>2 May 2014</td>
</tr>
<tr>
<td>Hocking v Medical Board of Australia (Occupational Discipline)</td>
<td>[2014] ACTSC 48</td>
<td>Immediate decision by MBA to suspend registration - a number of notifications - application for declaration and prohibition</td>
<td>Application dismissed</td>
<td>21 March 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Khalil (Occupational Discipline)</td>
<td>[2013] ACAT 76</td>
<td>Sexual/romantic relationship with patient</td>
<td>Professional misconduct - Reprimand - registration suspended for 9 months from 17 May 2013 to 17 February 2014 - conditions upon return to practice</td>
<td>21 November 2013</td>
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South Australia - 2

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<tr>
<td>Bradley v Medical Board of Australia</td>
<td>[2013] SAHPT 5</td>
<td>Appeal against MBA decision to refuse general or specialist registration - failed to comply with conditions on earlier determination</td>
<td>No power of tribunal to overturn original decision of Medical Professional Conduct Tribunal made 23 March 2007 - no appeal under s 199 Nat Law</td>
<td>20 September 2013</td>
</tr>
<tr>
<td>Larsen v Medical Board of Australia</td>
<td>[2013] SAHPT 4</td>
<td>Appeal against refusal of limited registration - three (four?) previous applications</td>
<td>s 65 and 66 Nat Law, does not have approved program of study ss 5 &amp; 49(5) Nat Law, or any other under ss 53 and 58 appeal dismissed</td>
<td>3 September 2013</td>
</tr>
</tbody>
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Tasmania - 2
Boundary violations - 1
Self-medication - alcohol or drugs
Improper prescribing
Deficient clinical standards - 1
Inadequate record keeping
Impairment

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<tr>
<td><em>Tasmanian Board of the Medical Board of Australia v Dr David Edis</em></td>
<td>[2014] TASHPT 1</td>
<td>Surgery on spine, wrong level, did not disclose error for several months - not fact of error but failure to disclose - remorseful, has insight - need for general deterrent, but one-off event - no indication that clinical or professional skills require remedial treatment, or need to protect the public</td>
<td>s 196 Nat Law - professional misconduct - reprimand - one month suspension - conditions - fine, costs of applicant</td>
<td>24 March 2014</td>
</tr>
<tr>
<td><em>Tasmanian Board of the Medical Board of Australia v Dr Ian Stefan Visagie</em></td>
<td>[2013] TASHPT 2</td>
<td>Intimate sexual relationship with female patient - admit allegations, professional misconduct - option of cancellation of registration if case involves exploitation of vulnerable patient, otherwise can consider mitigating factors eg character, community standing - expressed remorse - agreed sanctions, appropriate in interests of justice, protection of public, integrity of medical profession</td>
<td>Reprimand, suspend registration for 12 months - conditions before reregistration, pay costs of Board</td>
<td>22 October 2013</td>
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</tbody>
</table>
Northern Territory - 2  
Boundary violations - 2  
Self-medication - alcohol or drugs  
Improper prescribing  
Deficient clinical standards  
Inadequate record keeping  
Impairment  

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<tr>
<td>Medical Board of Australia v Keith Forrest</td>
<td>[2014] NTHPRT 1</td>
<td>Sexual relationship with patient - prescriptions in name of wife, but self use - stress of practice - admitted both allegations no previous disciplinary actions - 31 years -</td>
<td>Professional misconduct and unprofessional conduct - reprimand - practice to continue subject to conditions - pay Board’s costs</td>
<td>18 February 2014</td>
</tr>
<tr>
<td>Dr Shahin Alam v Medical Board of Australia</td>
<td>[2013] NTHPRT 4</td>
<td>Immediate action requiring female chaperon - Costs sought by Board - appeal by medical practitioner withdrawn, expert evidence did not provide firm basis for appeal, delays by Alam before withdrawing</td>
<td>Costs awarded to the Board</td>
<td>29 October 2013</td>
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</tbody>
</table>
Queensland - 25  
Boundary violations - 5  
Self-medication - alcohol or drugs - 1  
Improper prescribing - 1  
Deficient clinical standards - 8  
Inadequate record keeping - 1  
Impairment

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<tr>
<td>Azam v Medical Board of Australia</td>
<td>[2013] QCAT 588</td>
<td>Immediate action under s 156 Nat Law, impose conditions - application for interim order to review decision of Board and to remove conditions</td>
<td>No jurisdiction to grant stay of immediate action decision - stay refused</td>
<td>26 July 2013</td>
</tr>
<tr>
<td>Azam v Medical Board of Australia</td>
<td>[2013] QCAT 611</td>
<td>Immediate action under s 156 Nat Law, reasonable belief - chaperone conditions on registration - application to remove or amend conditions - Review under s 125 Nat Law</td>
<td>Application refused</td>
<td>4 November 2013</td>
</tr>
<tr>
<td>Medical Board of Australia v Bhamjee</td>
<td>[2013] QCAT 259</td>
<td>Registration suspended 2 February 2011, application for stay refused -Disciplinary proceedings commenced - all allegations conceded - conduct constituted professional misconduct- s 159 Nat Law - diagnosis and treatment, inadequate records, prescribing medications not clinically indicated, narcotic analgesics, (some patients drug-dependent), anabolic steroids</td>
<td>Professional misconduct - registration cancelled from 2 February 2011, cannot reapply for 5 years - no other sanction appropriate because of variety, scope, degree and period of unprofessional conduct, reregistration in 5 years a generous concession by the Board, had shown increased insight into conduct</td>
<td>25 July 2013</td>
</tr>
<tr>
<td>Medical Board of Australia v Blomeley</td>
<td>[2014] QCAT 160</td>
<td>s 193 Nat Law - sexual relationship, admitted, acknowledged inappropriate, confessed shame and apology - conditions imposed, including chaperone</td>
<td>Professional misconduct - registration suspended for 15 months from 1 July 2014, chaperone conditions to continue, reprimand, pay Board’s costs</td>
<td>23 May 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Chandra</td>
<td>[2014] QCAT 271</td>
<td>Sexual and inappropriate conduct to female patient - s 196 Nat Law - imposed chaperone conditions by immediate action on 22 May 2012 - many breaches of conditions, 4 false statutory declarations that had complied - forged letters threatening legal action - has admitted</td>
<td>Reprimand - registration suspended for 2 years, chaperone conditions on registration for 1 year following resumption of practice - further education and counselling, $85,000.00 costs of MBA</td>
<td>20 May 2014</td>
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<tr>
<td>Case</td>
<td>Year</td>
<td>Reference</td>
<td>Description</td>
<td>Decision</td>
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<tr>
<td>Chaudhry v Medical Board of Australia (No 2)</td>
<td>2014</td>
<td>QCAT 288</td>
<td>s 140, 1411, 160 Nat Law - complaint that applicant had not checked reports on computer - no relationship of independent contractor - operated his own immunology practice - access records of patients - misapprehension but no <em>mala fides</em></td>
<td>Application to set aside conditions granted, immediate effect - no serious risk to patients</td>
</tr>
<tr>
<td>Cruceru v Medical Board of Australia</td>
<td>2014</td>
<td>QCAT 353</td>
<td>s 112 Nat Law - renew limited registration, imposed new condition - application for stay - required to proceed to general registration by certain date, but wife terminally ill, unreasonable to burden applicant</td>
<td>Stay granted - de novo hearing on merits may raise other factors - costs by applicant</td>
</tr>
<tr>
<td>Medical Board of Australia v Doolabh</td>
<td>2013</td>
<td>QCAT 702</td>
<td>Health Practitioners (Disciplinary Proceedings) Act 1999 - delivery of 2 babies, 2008 &amp; 2009, neither survived - allegation of unprofessional conduct - should Board call one expert, or one for each incident, dispute concerning documents to go before Tribunal</td>
<td>Board to call one expert only for each baby - agreed documents to be presented</td>
</tr>
<tr>
<td>Escamilla v Medical Board of Australia</td>
<td>2013</td>
<td>QCAT 632</td>
<td>Ss 67, 73, 112, 202, 272, 279 Nat Law - limited registration held, renewed 3 times - not eligible to apply for general or specialist registration - Board’s decision not to register or renew - no utility in granting stay</td>
<td>Applications for stay refused</td>
</tr>
<tr>
<td>Jaravaza v Medical Board of Australia (No 2)</td>
<td>2013</td>
<td>QCAT 475</td>
<td>Unaware whether had sat OSCE exam in May 2013 - practitioner advised that had sat but failed, now no longer contesting decision of Board, not pursue proceedings further - wanted time to wind up his practice</td>
<td>Stay order cease to have effect, withdrawn application for review</td>
</tr>
<tr>
<td>Ladhams v Medical Board of Australia (No 2)</td>
<td>2014</td>
<td>QCAT 286</td>
<td>Ss 156, 157 Nat Law - immediate action - Treatment of Lyme Disease - disagreement, does it exist in Australia? - proposed conditions on registration - disagreement on treatment - conditions prohibits diagnosis of Lyme disease in all circumstances, some conditions onerous</td>
<td>Confirm decision of MBA to take immediate action, but remove some conditions and substitute others</td>
</tr>
<tr>
<td>Li v Medical Board of Australia (No 2)</td>
<td>2013</td>
<td>QCAT 594</td>
<td>Ss 156, 157, 201, 202 - appeal from MBA decision to take immediate action, imposing conditions on registration, English proficiency etc - consent order, set aside immediate action, remove conditions - had passed oral exam of RANZCOG, able to communicate effectively</td>
<td>Decision to impose conditions set aside and conditions removed - Board did not interview Li but relied on report, capacity to opine queried - costs of Li payable by MBA</td>
</tr>
<tr>
<td>Medical Board of</td>
<td>2013</td>
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<td>s 196 Nat Law - retired October 2008, finished medical</td>
<td>professional misconduct - reprimand - prohibit ability</td>
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<tr>
<td>Application to set aside conditions granted, immediate effect - no serious risk to patients</td>
<td>7 May 2014</td>
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<tr>
<td>Stay granted - de novo hearing on merits may raise other factors - costs by applicant</td>
<td>12 June 2014</td>
</tr>
<tr>
<td>Board to call one expert only for each baby - agreed documents to be presented</td>
<td>13 September 2013</td>
</tr>
<tr>
<td>Applications for stay refused</td>
<td>11 October 2013</td>
</tr>
<tr>
<td>Stay order cease to have effect, withdrawn application for review</td>
<td>26 July 2013</td>
</tr>
<tr>
<td>Confirm decision of MBA to take immediate action, but remove some conditions and substitute others</td>
<td>14 April 2014</td>
</tr>
<tr>
<td>Decision to impose conditions set aside and conditions removed - Board did not interview Li but relied on report, capacity to opine queried - costs of Li payable by MBA</td>
<td>5 November 2013</td>
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<tr>
<td>professional misconduct - reprimand - prohibit ability</td>
<td>1 November</td>
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<tr>
<td>Australia v Love</td>
<td>QCAT 608</td>
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<tr>
<td>Medical Board of Australia v Martin</td>
<td>QCAT 376</td>
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<td>Medical Board of Australia v Martin</td>
<td>QCAT 304</td>
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<td>Nigah v Medical Board of Australia</td>
<td>QCAT 204</td>
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<td>Noblela v Medical Board of Australia</td>
<td>QCAT 730</td>
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<td>Noblela v Medical Board of Australia (No 2)</td>
<td>QCAT 77</td>
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<td>Pearse v Medical Board of Australia</td>
<td>QCAT 392</td>
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<tr>
<td>Medical Board of Australia v Patha</td>
<td>[2014] QCAT 159</td>
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<td>Reben v Medical Board of Australia</td>
<td>[2014] QCAT 410</td>
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<td>Medical Board of Australia v Rosenbaum</td>
<td>[2013] QCAT 722</td>
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<tr>
<td>Sharma v Medical Board of Australia</td>
<td>[2014] QCAT 305</td>
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<tr>
<td>Vega Vega v Medical Board of Australia</td>
<td>[2014] QCAT 328</td>
</tr>
<tr>
<td>WD v Medical Board of Australia</td>
<td>[2013] QCAT 614</td>
</tr>
</tbody>
</table>
New South Wales - 10
Boundary violations - 2
Self-medication - alcohol or drugs
Improper prescribing - 4
Deficient clinical standards - 2
Inadequate record keeping - 4
Impairment - 4

<table>
<thead>
<tr>
<th>Case</th>
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</thead>
<tbody>
<tr>
<td>Health Care Complaints Commission v Athour</td>
<td>[2014] NSWCATOD 28</td>
<td>Works as GP but also at Opioid Substitution Clinic - not performed rapid detoxification procedures since advised to stop - potentially risky, high rate of relapse - not aware that required authority to prescribe, consent required - conditions imposed on registration - conduct serious, 14 complaints</td>
<td>Unsatisfactory professional conduct and professional misconduct - Reprimand and conditions insufficient, so fine, pay costs of HCCC</td>
<td>14 March 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Baez</td>
<td>[2014] NSWCATOD 3</td>
<td>Not registered since 1 January 2008 - allegations of sexual misconduct with 4 women - denial - affair with D, Baez confronted by wife</td>
<td>Complaints re A,C , D proved, B dismissed- professional misconduct</td>
<td>3 February 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Bennett</td>
<td>[2014] NSWCATOD 46</td>
<td>Allegation re inappropriate prescribing of drugs, 27 May 2008 - 12 October 2010 - failed to maintain adequate records - complaint for January 2008 to November 2011, inappropriate prescribing and contravention of conditions of registration - agreed statements of fact - no longer registered</td>
<td>If registered would have cancelled registration, disqualified for 5 years, pay costs of HCCC - MBA record in national register that would have cancelled registration</td>
<td>6 May 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Dr Della Bruna</td>
<td>[2014] NSWCATOD 31</td>
<td>3 complaints - failure to account for, and improper administration of pethidine and other restricted substances, 1 January 2009 to 30 March 2010, inadequate record keeping - admitted substance, if not entirety of each complaint, conditions imposed 23 August 2010 - remorse, insight shown, undertaken</td>
<td>Professional misconduct and unsatisfactory professional conduct - sufficiently serious to justify suspension or cancellation, not necessarily appropriate - not necessary to protect health and safety of public or to maintain reputation of profession - not necessary to prohibit practice other than in hospital, 3 years only - reprimand, conditions on registration, pay costs of HCCC</td>
<td>8 April 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Howe</td>
<td>2014 NSWCATOD 30</td>
<td>Complaint that physical and mental impairments, PD, mild cognitive impairment etc, sufficiently serious to impair physical and mental capacity to practise - impairment for PD proven - not proven that impair capacity to practise - previous chaperone conditions - registration suspended 16 December 2011</td>
<td>Re-registration subject to conditions - each party to pay its own costs</td>
<td>7 April 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Dr Janieson</td>
<td>2014 NSWCATOD 56</td>
<td>unsatisfactory professional conduct in treatment of 10 patients, improper/unethical conduct relating to practice, repeated occurrences - admitted subject to clarification of inaccuracies - prescribing for addicts - notifications so performance review, conditions on registration imposed June 2010 - failure to keep adequate records</td>
<td>Conclusion that conduct sufficiently serious to justify suspension or cancellation of registration, but not compelled to, need to show that permanently unfit to practise, not order only if unfit - other protective orders? - reprimand and impose conditions, not apply to vary for 3 years, pay costs of HCCC</td>
<td>21 May 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Naiyer (No 1)</td>
<td>2014 NSWCATOD 54</td>
<td>3 complaints - contested factual circumstances - failure to detail examinations of genital and anal regions, pelvic - knowledge skill etc substantially below reasonably expected, improper/unethical conduct in practise, provided false information to HCCC, unnecessary - inappropriate sexual conduct</td>
<td>Hearing of evidence, findings of inappropriate conduct of sexual nature, failure to maintain appropriate professional boundaries</td>
<td>13 May 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Qasim</td>
<td>2014 NSWCATOD 42</td>
<td>Allegations of unsatisfactory professional conduct, professional misconduct in practice of medicine, impairment, paranoid or delusional disorder - letters to other practitioners, medical receptionist gave evidence, made up a referral as doctor had refused to see patient - Prof Smith raised concerns with Medical Council - refuse to see patient if not agree with her thinking - abnormal behaviour in body corporate meetings where lived - concerns about mental health</td>
<td>Tribunal accepts that serious psychiatric disorder, constitutes impairment - limited insight to impairment - registration cancelled at once, no application to re-register for 4 years - pay two-tenths of costs of HCCC</td>
<td>2 May 2014</td>
</tr>
<tr>
<td>Health Care Complaints Commission v</td>
<td>2014 NSWCATOD 65</td>
<td>Finding of unsatisfactory professional conduct in 2007, prescribing of benzodiazepines, conditions imposed on registration - allegations that some</td>
<td>Reasons for failure to comply with condition, flagrant disregard, persistent, contumelious disregard - resent condition, unnecessary burden financially and otherwise</td>
<td>16 June 2014</td>
</tr>
<tr>
<td>Townsend</td>
<td>Conditions contravened, failure to enrol in course, issues in general prescribing, PSC reprimand - health issues, anxiety about HCCC proceedings - sought review as no evidence of current inappropriate prescribing - evidence of health issues, part time practice retire at end of 2014 - concession of unsatisfactory professional conduct</td>
<td>Importance of compliance with conditions, Cancel registration, minimum of one year before review, undertaken by Tribunal - costs against practitioner</td>
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<tr>
<td>Health Care Complaints Commission v Philipiah</td>
<td>[2013] NSWCA 342 Appeal against orders made by Medical Tribunal, reprimand, suspension, orders re lifting of suspension, no costs - impairment found, but still competent to practise - conditions when re-registered in NSW</td>
<td>Appeal allowed, conditions on re-registration</td>
<td>18 October 2013</td>
<td></td>
</tr>
</tbody>
</table>

All jurisdictions total - 57  
Boundary violations -14  
Self-medication - alcohol or drugs -1  
Improper prescribing - 7  
Deficient clinical standards - 20  
Inadequate record keeping - 7  
Impairment - 7
**APPENDIX IIIB**

**Tribunal and Supreme Court Decisions - 1 July 2014 to 30 June 2015**

Victoria - 7  
Boundary violations - 1  
Self-medication - alcohol or drugs - 1  
Improper prescribing - 2  
Deficient clinical standards - 2  
Inadequate record keeping - 2  
Impairment

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<tr>
<td><em>Medical Board of Australia v Bajpe (Review and Regulation)</em></td>
<td>[2014] VCAT 1162</td>
<td>Conviction for inappropriate drug prescribing for drug-dependent patients, numerous counts of obtaining property by deception - reprimand and registration cancelled for 2 years - several applications for re-registration - has not come to terms with his actions, embarrassed, self-pity not remorse or insight</td>
<td>Unprofessional conduct, activities before 1 July 2007, professional misconduct 1 July 2007 to 30 June 2010 - Unprofessional conduct from 1 July 2010 - cautioned and reprimanded - disqualified from applying for re-registration until 31 December 2016.</td>
<td>17 September 2014</td>
</tr>
<tr>
<td><em>Medical Board of Australia v Dixit (Review and Regulation)</em></td>
<td>[2015] VCAT 809</td>
<td>Patient asleep, could not be woken - failed to call ambulance or seek further treatment, never regained consciousness - died a week later, brain injury from drug overdose - remorse, tried to save family from embarrassment because of overdose - breach of professional boundaries, treating family friend</td>
<td>Professional misconduct and unprofessional conduct, reprimand - conditions on registration, updating education especially regarding emergencies</td>
<td>9 June 2015</td>
</tr>
<tr>
<td><em>Medical Board of Australia v Garland</em></td>
<td>[2015] VCAT 873</td>
<td>Prescribed Schedule 8 poisons in breach of <em>Drugs Poisons and Controlled Substances</em></td>
<td>Reprimand, specific and general deterrence - conditions on registration</td>
<td>17 June 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Kumar (Review and Regulation)(Revised)</td>
<td>2014 VCAT 1267</td>
<td>Failure to keep adequate clinical notes concerning medication, prescription or sample pack, psychiatrist - failure to inform patient’s GP - findings made with consent of parties</td>
<td>Caution, practice subject to periodic inspection</td>
<td>8 October 2014</td>
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<tr>
<td>Taj v Medical Board of Australia (Correction) (Review and Regulation)</td>
<td>2015 VCAT 250</td>
<td>Review of decision of Medical Board not to approve application for specialist registration under s 57 National Law</td>
<td>Satisfied that applicant has not completed the requisite training for recognition as a specialist physician - has spent years in practice but has not followed recognised pathways to ensure all competencies have been met</td>
<td>4 March 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Zebic (Review and Regulation)</td>
<td>2015 VCAT 139</td>
<td>Application by medical practitioner for re-registration - suspended in 2010 - history of drug abuse, diagnosed illnesses - breached registration conditions requiring urinalysis and hair sampling - wrote 4 prescriptions while suspended - professional misconduct</td>
<td>Reprimanded - stringent conditions imposed on registration - review period of 12 months - suspension revoked so can practise as a medical practitioner</td>
<td>16 February 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Dr ZOF (Review and Regulation)</td>
<td>2014 VCAT 1548</td>
<td>Inappropriate romantic/sexual relationship with patient/employee - failure to keep proper patient records for this patient - failure to monitor this patient on anti-depressants - great power imbalance</td>
<td>Majority finding of professional misconduct and unprofessional conduct - future hearing date to address issue of determinations</td>
<td>12 December 2014</td>
</tr>
</tbody>
</table>
Western Australia - 5  
Boundary violations - 1  
Self-medication - alcohol or drugs  
Improper prescribing - 2  
Deficient clinical standards - 4  
Inadequate record keeping - 1  
Impairment

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<tr>
<td>Medical Board of Australia v Bowles</td>
<td>[2014] WASAT 115</td>
<td>Inadequate procedure alleged for colonoscopy and gastroscopy, removal of polyp for biopsy using diathermy, too close to ampulla, pancreatitis developed and patient died - unsatisfactory professional performance? Professional misconduct?</td>
<td>Application dismissed - no evidence that conduct engaged in showed either professional misconduct or unsatisfactory professional performance - no basis to find that conduct substantially below standard reasonably expected of practitioner of equivalent training and experience - application dismissed</td>
<td>5 September 2014</td>
</tr>
<tr>
<td>Medical Board of Australia and Myers</td>
<td>[2014] WASAT 137</td>
<td>Application by MBA to suspend registration - inappropriate conduct with patient in hospital - no therapeutic relationship - pattern of boundary violations dating back to 2004 - failed to be deterred by caution, counselling or fine - persistent inability to recognise appropriate boundaries, escalating pattern of conduct- poses too great a risk to the public to continue practise</td>
<td>Guilty of professional misconduct - currently not registered, disqualified for 5 years from reapplying for registration, fine of $10,000.00, pay board’s costs</td>
<td>23 October 2014</td>
</tr>
<tr>
<td>Medical Board of Australia and Palaniappan</td>
<td>VR:156/2014</td>
<td>Limited registration for area of need, application for surgical trainee program RACS 2013 - altered certificate of registration to read general registration - applied for 2014, altered registration certificate again - RACS advised MBA that discovered falsification, failed to display qualities of integrity and truthfulness</td>
<td>Professional misconduct, reprimand, fine and pay Board’s costs</td>
<td>29 January 2015</td>
</tr>
<tr>
<td>Medical Board of</td>
<td>[2014]</td>
<td>Treatment of 2 children with ADHD -</td>
<td>Finding of unprofessional conduct - reprimand and fine of</td>
<td>1 July 2014</td>
</tr>
<tr>
<td><strong>Australia and Roberts</strong></td>
<td>WASAT 76</td>
<td>recommended corporal punishment - derogatory and accusatory notes about the children</td>
<td>$15,000.00 - condition on registration, certificate from senior medical practitioner that note taking and written communication with patients of acceptable standard - pay half Board’s costs</td>
<td>20 October 2014 27 January 2015</td>
</tr>
<tr>
<td><strong>Yoong and Medical Board of Australia</strong></td>
<td>[2015] WASAT 6</td>
<td>Performance and Professional Standards Panel determined that in consultation with a patient, behaved in a way that constituted unprofessional conduct (abrupt and discourteous, failure to communicate and remain courteous, respectful and compassionate) - reprimand and two conditions on registration - application to set decision aside but need to determine whether right of appeal on substantive finding or only on penalty</td>
<td>Appeal under s 199 Nat Law is hearing de novo, so can look at both outcome and conduct leading to it finding by Panel that unprofessional conduct so Yoong has right of appeal to Tribunal, not limited to appeal against the penalty imposed by the Panel</td>
<td>28 January 2015</td>
</tr>
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</table>
**ACT - 4**

Boundary violations
Self-medication - alcohol or drugs - 1
Improper prescribing - 1
Deficient clinical standards - 2
Inadequate record keeping - 1
Impairment

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<tbody>
<tr>
<td>Medical Board of Australia v Hocking and Hocking v Medical Board of Australia (Occupational Discipline)</td>
<td>[2015] ACAT 44</td>
<td>Specialist orthopaedic surgeon - FRACS - complaints led to conditions upon registration, including retraining and supervision - failure to advise patient B’s mother of restrictions upon registration, needed for informed consent - should refer patient when proposed procedure not within scope of surgeon’s practice - attempt at cover-up in operation report - Patient A, injected with Platelet Rich Plasma, unproven technology, failed to advise parents, failed to refer to surgeon who was not restricted about surgery - has exhibited insight, personal responsibility</td>
<td>Patient B, unsatisfactory professional performance and unprofessional conduct, failure to refer, cover up in second record, poor clinical performance, but improvements in last 12 months so conduct does not merit deregistration - Patient A treatment was novel, should have referred, no case to answer - Professional misconduct has a performance aspect and a conduct component - previous conditions on registration set aside, impose new conditions which are not unduly restrictive and provide correct balance between practice and public safety.</td>
<td>19 June 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Tausif (Occupational Discipline)</td>
<td>[2015] ACAT 4</td>
<td>Allegations of inappropriate prescribing of Schedule 4 &amp; 8 drugs - inadequate examination of patients - inadequate record keeping - extensive reference by Tribunal to Code provisions - admitted professional misconduct - proposal for immediate action under s 156 Nat Law, breach of previous conditions, not proceeded with - registration suspended by MBA - appeal</td>
<td>Registration restored subject to conditions - professional misconduct substantially contributed to by lack of clinical supervision and mentorship - found practice where mentor to supervise her - 6 monthly reports, review conditions in 24 months</td>
<td>16 January 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Adams</td>
<td>[2015] ACAT 8</td>
<td>Taking amounts of opiates larger than required and using himself - anaesthetist - conditions on registration - agreed to urine and blood testing but</td>
<td>Undertaking that not practise medicine from 13 November 2013, seek approval of Board before returning to work - applicant did not suspend - respondent still</td>
<td>27 January 2015</td>
</tr>
<tr>
<td>(Occupational Discipline)</td>
<td>not hair - Board proposed to suspend registration, show cause</td>
<td>subject to undertakings, no evidence that not complying - engage in professional misconduct, reprimand, practise and health conditions for first years after return to practise</td>
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<tr>
<td><strong>Medical Board of Australia v Al-Naser (Occupational Discipline)</strong></td>
<td>Employed medical practitioner in sexual relationship with patient - not aware until 2012, conflict of interest by treating the patient, did not refer her to another medical practitioner - did not report (mandatory) sexual activity of employed medical practitioner, - boundary violations by respondent</td>
<td>Professional misconduct - reprimand - conditions imposed on registration - 2 years before review of bar on acting as supervisor</td>
<td></td>
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<tr>
<td>[2015] ACAT 15</td>
<td></td>
<td>4 February 2015</td>
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</table>
South Australia - 6
Boundary violations - 3
Self-medication - alcohol or drugs - 1
Improper prescribing - 1
Deficient clinical standards - 2
Inadequate record keeping - 2
Impairment - 1

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<tr>
<td>Medical Board of Australia v Henning</td>
<td>[2014] SAHPT 7</td>
<td>Inadequate treatment of female patient who was medical practitioner and former colleague - 90 particulars of allegations and 36 sub-particulars - presumption that innocence of inappropriate professional conduct? facts admitted deemed proved but otherwise Board bears onus of proof - failure to advise of possible attempted suicide, failure to detain under Mental Health Act 1993</td>
<td>Un satisfactory professional performance, professional misconduct - submissions to be heard s 193 Nat Law</td>
<td>18 August 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Dr I</td>
<td>[2014] SAHPT 18</td>
<td>Use of prescription pad of another practitioner - wrote prescriptions for drugs of dependence for herself - admissions in writing, formally admitted professional misconduct - two charges plea of guilty - no conviction recorded but fined - already punished, so concern about protection of the public - has insight into problems, seeking help - conditions imposed by Board on registration</td>
<td>Professional misconduct - reprimand in strongest possible terms, conditions on registration, name suppressed</td>
<td>5 December 2014</td>
</tr>
<tr>
<td>Crowe v Medical Board of Australia</td>
<td>[2014] SAHPT 8</td>
<td>Appeal against MBA decision to impose conditions on registration - denies that cognitively impaired, leading to executive dysfunction, affects ability to plan, carry out cognitive tasks, defective monitoring of performance, reasonable belief of Board</td>
<td>Appeal dismissed - evidence points one way, there is cognitive impairment - decision of MBA confirmed - impose conditions on registration s 193 Nat Law</td>
<td>17 July 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Curran</td>
<td>[2015] SAHPT 4</td>
<td>Psychiatrist - Treatment of Patient, and daughter of practitioner - not proper psychiatric examination - mindfulness based therapy - based reside in practitioner’s home - prescribing drugs for daughter - failure to keep adequate records - failure to</td>
<td>Reprimand in strongest possible terms - fine of $15,000.00 - conditions on registration - costs of board</td>
<td>29 May 2015</td>
</tr>
<tr>
<td><strong>Medical Board of Australia v Gale</strong> [2015] SAHPT 3</td>
<td>Sexual relationship with 2 patients - prescribed drugs of dependence to 9 patients without proper authorities - breach of confidentiality - admitted to both professional misconduct and unprofessional conduct</td>
<td>Purpose of disciplinary proceedings, to protect the public, not punish the practitioner - high end of both professional misconduct and unprofessional conduct - reprimand, not practise for 5 years, take into account 2 years already non practising</td>
<td>13 May 2015</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Board of Australia v Trewren</strong> [2015] SAHPT 5</td>
<td>Sexual relationship with patient - failure to keep adequate records - referral to psychologist, vulnerable patient - previous fine for assault - professional misconduct, unsatisfactory professional performance</td>
<td>Orders are primarily to protect the public - reprimand, suspension for 6 months, no fine conditions imposed on registration - pay board’s costs</td>
<td>29 May 2015</td>
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Tasmania - 4
Boundary violations
Self-medication - alcohol or drugs
Improper prescribing
Deficient clinical standards - 1
Inadequate record keeping
Impairment - 2

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</thead>
<tbody>
<tr>
<td>Sansom v Medical Board of Australia</td>
<td>[2014] TASSC 67</td>
<td>s 144 Nat Law notification - complaint about who had treated man who died - insufficient evidence, allegations lacking in substance, no evidence of bias or fraud in decision</td>
<td>Decision by MBA under s 155 Nat Law to take no further action - application to review decision refused, no merit in any grounds</td>
<td>18 December 2014</td>
</tr>
<tr>
<td>Dr Humphrey Gomes v Tasmanian Board of the Medical Board of Australia</td>
<td>[2014] TASHPT 3</td>
<td>Show cause why not suspend - notifications to February 2014 - conditions imposed on 7 December 2012 - 7 further notifications so more conditions - drinking alcohol - failure to comply with restrictions, contemptuous/dismissive attitude - immediate action to suspend - little insight - contempt for sanctions, unwilling to accept that others can restrict his activities</td>
<td>Immediate action warranted - but suspension open-ended - need further submissions</td>
<td>11 August 2014</td>
</tr>
<tr>
<td>Tasmanian Board of the Medical Board of Australia v Dr Humphrey Gomes</td>
<td>[2015] TASHPT 4</td>
<td>Conditions requiring breathalyser and blood alcohol tests previously imposed, breached - cautioned for non-compliance - arrogance and contempt for imposed authority - deliberate breach - prescribed narcotic drugs for 5 patients without proper authorities, failed to respond to warnings - prescribed antidepressant and antipsychotic medication for his wife but took it himself - failed to notify National Board of 2 convictions for PSA - practised with alcohol in blood in reckless disregard of patient safety</td>
<td>Professional misconduct is inclusory and not exhaustive, including conduct not falling within paragraphs of definition - unprofessional conduct has both performance and conduct components - unsatisfactory professional performance has only performance aspect (Roberts [2014] WASAT 76) - found both professional misconduct and unprofessional conduct - relist for sanctions hearing</td>
<td>6 May 2015</td>
</tr>
<tr>
<td>Tasmanian Board of the Medical</td>
<td>[2015] TASHPT 3</td>
<td>Two patients with prostate enlargement and urine flow issues - failed to perform digital rectal examination -</td>
<td>All categories of defective standard of care are judged against expectations of medical peers - unprofessional</td>
<td>23 April 2015</td>
</tr>
<tr>
<td>Board of Australia v Dr Anthony Alfred Lyall</td>
<td>failed to refer to specialist urologist - clearly indicated by symptoms - used complementary medicines, assist urine flow but affected other test results, ought not be used before diagnosis</td>
<td>conduct - relist for sanctions hearing</td>
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<tr>
<td>Wijeneka Liyanage v Medical Board of Australia</td>
<td>[2014] NTHPRT 4</td>
<td>Registration suspended under immediate action s 156 Nat Law - allegation of sexual relationship with a patient - no previous disciplinary proceedings - relationship terminated, but reported by patient’s new medical practitioner - deception of wife - experimenting with dating web site - deplorable behaviour but does not tend to bring disgrace to the profession</td>
<td>isolated incident - no evidence that will be repeated, protection of public does not require immediate action to suspend - set aside decision of Medical Board - further submission</td>
<td>8 December 2014</td>
</tr>
<tr>
<td>Philip Nitschke v Medical Board of Australia</td>
<td>[2014] NTHPRT 5</td>
<td>Contacted as advocate for assisted dying - no doctor/patient relationship, but was there sufficient connection to the profession - action with man who subsequently committed suicide - duty to protect and promote health including prolonging life - suicide is not illegal</td>
<td>Reasonable belief that need for immediate action to protect public health or safety - serious risk to persons, confusion ass activities inconsistent with Code of Conduct</td>
<td>22 December 2014</td>
</tr>
<tr>
<td>Daniel Van Dijk v Medical Board of Australia</td>
<td>[2014] NTHPRT 2</td>
<td>Prescribed Schedule 8 medication for his own use, using names of others without their consent - admitted facts, conduct constituted professional misconduct - agreement about action, Suspension for 6 months, return to work subject to conditions - but did not admit conduct and set about putting it right, in fact did not admit for 4 years and</td>
<td>Not fit at this stage to return to practice - reprimand - remove name from register, refrain from reapplying for registration for 9 months</td>
<td>28 October 2014</td>
</tr>
</tbody>
</table>
during that period did what he could to thwart Board’s investigation, lies - eventually sought assistance - but no independent evidence that he had changed - admits that guilty of professional misconduct, but no demonstrable contrition or remorse, no demonstrated insight
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<tr>
<td>Medical Board of Australia v Andersen</td>
<td>[2014] QCAT 374</td>
<td>Inappropriate prescribing of pseudoephedrine - no previous disciplinary proceedings - jointly proposed suspension, but suspension of that for 12 months - not authorised by Nat Law - also proposed conditions</td>
<td>s 225 Nat Law - professional misconduct - amend proposed orders - suspend from 1 September 2014 to 28 September 2014</td>
<td>30 July 2014</td>
</tr>
<tr>
<td>Medical Board of Australia v Andrew</td>
<td>[2015] QCAT 94</td>
<td>Issued certificates, contrary to specialist report, that patient fit to drive motor vehicle - patient struck and killed pedestrian, evidence that seizure - no independent verification that seizure - free for 12 months - also certificate for Centrelink, dangers to co-workers in workplace setting - difficult patient, insisting on certificate - certificates given in 2006 and 2009</td>
<td>Admission that unsatisfactory professional conduct - tribunal found professional misconduct - prohibition on issuing certificates of fitness to drive - course in managing difficult patients - general deterrence served by fine rather than suspension - $10,000.00 and costs of MBA</td>
<td>23 March 2015</td>
</tr>
<tr>
<td>Aziz v Medical Board of Australia</td>
<td>[2015] QCAT 99</td>
<td>Registered vascular surgeon, conditions imposed 26 November 2014 by Medical Board of Australia under s 178 National Law - error occurred in complex procedure - admitted - no other complaints</td>
<td>Agreed orders by parties - set aside finding of unsatisfactory professional performance and imposition of conditions - parties bear their own costs</td>
<td>9 February 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Cooke</td>
<td>[2015] QCAT 103</td>
<td>Hip replacement, hip fractured a few days later - further surgery - deep wound infection, reviewed several times, failure to diagnose, treatment inappropriate</td>
<td>Finding of unsatisfactory professional conduct, grounds for disciplinary action - later submissions about penalty</td>
<td>27 March 2015</td>
</tr>
<tr>
<td>Clarke v Medical Board of Australia</td>
<td>[2014] QCAT 630</td>
<td>Performance and Professional Standards Panel of MBA found unsatisfactory professional performance, reprimand and conditions on registration - s 199 Nat Law application to review - failure to note blood test results pre total knee arthroplasty, proper consent, collaborate</td>
<td>Reprimand, review of conditions - mentoring conditions to address shortcomings, not generally - also retraining</td>
<td>21 November 2014</td>
</tr>
<tr>
<td>Case</td>
<td>Year</td>
<td>Court Case Number</td>
<td>Description</td>
<td>Order/Result</td>
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<tr>
<td>Dey v Medical Board of Australia</td>
<td>2014</td>
<td>QCAT 546</td>
<td>s 201 Nat Law - review of MBA decision not to renew limited registration - passed RACGP exams but other complaints made - eligible for specialist registration, but English test required - application for stay withdrawn - Board wants costs</td>
<td>Costs of Board granted</td>
</tr>
<tr>
<td>Medical Board of Australia v Gomez</td>
<td>2015</td>
<td>QCAT 121</td>
<td>Abused trust and position of influence inherent in doctor-patient relationship by failing to maintain appropriate professional boundaries - whether to admit evidence of 3 other patients</td>
<td>Evidence of 2 patient admitted, other patient’s evidence not probative - striking similarity in evidence of two patients</td>
</tr>
<tr>
<td>Hettwer v Medical Board of Australia</td>
<td>2015</td>
<td>QCAT 146</td>
<td>Application to AHPRA for limited registration for area of need - provided false employment confirmation, inaccurate work experience in CV - false and misleading conduct, not fit and proper to hold registration - application for review subsequently withdrawn</td>
<td>Order for Hettwer to pay costs of MBA</td>
</tr>
<tr>
<td>Medical Board of Australia v Holding</td>
<td>2014</td>
<td>QCAT 632</td>
<td>s 193 Nat Law - boundary violation, text messages,</td>
<td>Reprimand, fine of $5000.00 - conditions on registration, pay Board’s costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Moodley</td>
<td>2014</td>
<td>QCAT 476</td>
<td>s 289 Nat Law - previous disciplinary proceedings - complaints of unlawful and indecent assault - also convictions - still registered but currently under suspension - no remorse, not fit and proper person</td>
<td>unsatisfactory conduct, discreditable to medical profession - application to cancel registration, protective not punitive - 5 years prohibition, pay Board’s costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Patel</td>
<td>2015</td>
<td>QCAT 133</td>
<td>MBA brought disciplinary proceedings on 9 grounds - no longer resides in Australia - first 4 grounds relate to false and misleading information provided to former Medical Board of Queensland about special registration and its renewal - 5 grounds relate to medical procedures, clinically inappropriate level of risk, conditions imposed in USA - incorrect diagnosis, incompetence demonstrated, lack of adequate knowledge - death of several patients</td>
<td>Finding of unsatisfactory professional conduct, misconduct in professional respect, conduct discreditable to profession, fraudulent and dishonest behaviour, other improper or unethical conduct - if had been registered Tribunal must decide whether would have cancelled registration, struck off in US - should never again be registered to practice medicine in Australia, pay costs of MBA</td>
</tr>
<tr>
<td>Radovic v Medical Board of</td>
<td>2014</td>
<td>QCAT 631</td>
<td>s199 Nat Law - conditional registration as psychiatrist in area of need, not renewed on expiry - treatment of</td>
<td>Agreed sanction, not depart provided within reasonable range - reprimand only, no future conditions - no order</td>
</tr>
<tr>
<td>Australia</td>
<td>patient, finding of unsatisfactory professional performance - application to review panel decision, impose less onerous conditions if re-registered - not permissible, only caution or reprimand</td>
<td>as to costs</td>
<td>2014</td>
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</tr>
</tbody>
</table>
New South Wales - 27  
Boundary violations - 4  
Self-medication - alcohol or drugs - 5  
Improper prescribing - 10  
Deficient clinical standards - 9  
Inadequate record keeping - 9  
Impairment - 10

<table>
<thead>
<tr>
<th>Case</th>
<th>Citation</th>
<th>Allegation</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>Bahrecial Board of Australia v Patelamy v Medical Council of New South Wales</td>
<td>[2014] NSWCATOD 116</td>
<td>Deregistered 2008, no practise since - application to reinstate - is he person of good character and fit for registration - inappropriate sexual conduct with 2 women - found unsatisfactory professional conduct and professional misconduct, conditions imposed on registration - 2008 complaint that falsified copy of registration card provided for application to engage in ophthalmology training</td>
<td>Question whether has learned and gained insight into behaviour, since 2008 has character reformed - no public interest in forever denying chance of redemption and rehabilitation - risk of further sexual misconduct low, but lack of remorse or insight to past mistakes - application for reinstatement dismissed, not apply to CAT for further 2 years, pay costs of respondent</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Baraz</td>
<td>[2015] NSWCATOD 39</td>
<td>FRACGP - Agreed 2012 to be placed on Impaired Registrants Panel, drug addiction and depression - conditions on registration - prescribing and self-administering Schedule 8 drugs - breach of conditions</td>
<td>Instances of unsatisfactory professional conduct, justify suspension or cancellation of registration, so amount to professional misconduct - finding of serious professional misconduct - need protective orders reprimand, suspend for 3 months, conditions during suspension and on subsequent registration - pay costs of HCCC</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Edwards</td>
<td>[2014] NSWCATOD 90</td>
<td>Failed to comply with conditions of order of Medical Tribunal on 14 September 2011 - issue of depression - findings of unsatisfactory professional conduct and professional misconduct, reprimand, conditions on registration</td>
<td>Registration cancelled, not eligible to seek review for 1 year, pay costs of HCCC</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Epstein</td>
<td>[2015] NSWCATOD 21</td>
<td>General physician of many years’ standing - interest in anti-ageing medicine - inadequate record keeping, failure to conduct clinical examination of patients, inappropriate prescribing - no judgement about</td>
<td>Unsatisfactory professional conduct and professional misconduct found - numerous breaches of relevant regulations, serious departure from appropriate standard of care to be expected of practitioner with similar</td>
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<table>
<thead>
<tr>
<th>Date of Judgement</th>
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<tbody>
<tr>
<td>16 October 2014</td>
<td>27 April 2015</td>
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<tr>
<td>13 August 2014</td>
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<tr>
<td>30 March 2015</td>
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<tr>
<td>Health Care Complaints Commission v Follent</td>
<td>[2015] NSWCATOD 31</td>
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<tr>
<td>HCCC has consulted with Medical Council of NSW - allegation of unsatisfactory professional conduct - failure to maintain adequate medical records - failure to conduct physical examinations - failure to organise appropriate investigations, refer to specialists - inappropriate prescribing of restricted and addictive drugs - professional misconduct because of more than one instance of unsatisfactory professional conduct - concessions made by respondent - burden on practitioner to show matters which support right to continue to practise medicine</td>
<td>Proceedings stood over on interim basis - hear evidence of ability of respondent to safety practise medicine, hearing August 2015 - conditions imposed on registration, monitoring of compliance</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Goh</td>
<td>[2014] NSWCATOD 106</td>
</tr>
<tr>
<td>Complaint from HCCC, improper or unethical conduct relating to practice of medicine, wrote prescriptions for self and patients and falsely signed as other medical practitioners - contravened conditions imposed on 8 July 2011, guilty of professional misconduct by engaging in unsatisfactory professional conduct on number of occasions, impairment, addiction and major depressive episode - insufficient physical or mental capacity, knowledge or skill to practise medicine - 8 July 2014 requested name be removed from register</td>
<td>On the evidence, would have removed from register if not already applied for removal - would have been for 2 years but time has already elapsed so one year - should be recorded, respondent to pay applicant’s costs</td>
</tr>
<tr>
<td><strong>Health Care Complaints Commission v Dr Hofer</strong></td>
<td>[2014] NSWCATOD 74</td>
</tr>
<tr>
<td><strong>Ibrahim v Medical Board of Australia</strong></td>
<td>[2014] NSWCATOD 108</td>
</tr>
<tr>
<td><strong>Health Care Complaints Commission v Ivits</strong></td>
<td>[2014] NSWCATOD 148</td>
</tr>
<tr>
<td><strong>Health Care Complaints Commission v Khan</strong></td>
<td>[2014] NSWCATOD 83</td>
</tr>
<tr>
<td><strong>Health Care Complaints Commission v Kwan</strong></td>
<td>[2014] NSWCATOD 72</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Low</td>
<td>[2015] NSWCATOD 18</td>
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<tr>
<td>Health Care Complaints Commission v Manners</td>
<td>[2014] NSWCATOD 156</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Dr Nikolova-Trask</td>
<td>[2014] NSWCATOD 149</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Osborne</td>
<td>[2014] NSWCATOD 118</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Quach</td>
<td>[2015] NSWCATOD 2</td>
</tr>
<tr>
<td><strong>Reimers v Medical Board of Australia</strong></td>
<td>[2015] NSWCATOD 26</td>
</tr>
<tr>
<td><strong>Rahman v Medical Board of Australia</strong></td>
<td>[2015] NSWCATOD 26</td>
</tr>
<tr>
<td><strong>Dr Reid v Medical Council of NSW</strong></td>
<td>[2014] NSWCATOD 152</td>
</tr>
<tr>
<td><strong>Reimers v Medical Council of NSW</strong></td>
<td>[2015] NSWCATOD 38</td>
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<td>Case</td>
<td>Year</td>
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<tr>
<td><strong>Roberts v Medical Council of New South Wales</strong></td>
<td>2015</td>
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<td><strong>HealthCare Complaints Commission v Shinwari</strong></td>
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<td><strong>Singh v Medical Council of NSW (No 2)</strong></td>
<td>2015</td>
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<td><strong>Health Care Complaints Commission v Street</strong></td>
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<tr>
<td>Healthcare Complaints Commission v Thomas</td>
<td>[2015] NSWCATOD 60</td>
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<td>Health Care Complaints Commission v Vo</td>
<td>[2014] NSWCATOD 127</td>
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<tr>
<td>Health Care Complaints Commission v XC</td>
<td>[2015] NSWCATOD 9</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Do</td>
<td>[2014] NSWCA 307</td>
</tr>
</tbody>
</table>
All jurisdictions total - 59
Boundary violations - 11
Self-medication - alcohol or drugs - 10
Improper prescribing - 17
Deficient clinical standards - 27
Inadequate record keeping - 16
Impairment - 13
APPENDIX IIIC

Tribunal and Supreme Court Disciplinary Decisions 1 July 2015 to 30 June 2016

Victoria - 5
Boundary violations - 1
Self-medication - alcohol or drugs - 2
Improper prescribing - 2
Deficient clinical standards - 1
Inadequate record keeping - 2
Impairment -

<table>
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<tr>
<th>Case Name</th>
<th>Citation</th>
<th>Allegation</th>
<th>Result</th>
<th>Date of Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Board of Australia v Black (Review and Regulation)</td>
<td>[2016] VCAT 892</td>
<td>Pleased guilty to 2 charges of knowingly possessing child pornography, no term of imprisonment but good behaviour bond - agrees with board that professional misconduct - victim of molestation as a child - being treated for consequences - psychiatric treatment, depression - remorse and shame, low risk of reoffending - protective not punitive orders - factors against cancellation</td>
<td>Reprimand, suspend for 3 months, health and practice conditions imposed</td>
<td>7 June 2016</td>
</tr>
<tr>
<td>Medical Board of Australia v Fox (Review and Regulation)</td>
<td>[2016] VCAT 408</td>
<td>Inappropriate prescribing - inappropriate medical management - criminal conviction - breach of permit obligations Schedule 8 drugs - inadequate record keeping - professional misconduct, unprofessional conduct - 115</td>
<td>Reprimand, suspension for 12 months, conditions on registration Principles applicable to determinations for disciplinary offences protection of the public - maintenance of professional</td>
<td>11 April 2016</td>
</tr>
<tr>
<td>Case</td>
<td>Decision/Order</td>
<td>Details</td>
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<tr>
<td><em>Kemp v Medical Board of Australia (Review and Regulation)</em></td>
<td>Immediate action by board, imposing conditions on registration, necessary for public safety where possible risk - application for stay for 6 weeks only, only for 2 of conditions - concerns about treatment of multiple sclerosis patient, investigation led to requirement for performance assessment, propose suspension but conditions requested - concerns with treatment of Lyme’s disease -</td>
<td>stay of part of conditions for limited time granted, 24 February 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Medical Board of Australia v Koniuszko (Review and Regulation)</em></td>
<td>Ophthalmologist, but practise outside that specialty - failure to refer patients - Failed to obtain permits to prescribe Schedule 8 drugs - inadequate storage for Schedule 8 drugs - prescribing for family members - incomplete records - Professional misconduct,</td>
<td>Reprimand - conditions upon registration for 5 years, 1 April 2016</td>
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<tr>
<td><em>Medical Board of Australia v Smith (Review and Regulation)</em></td>
<td>Sexual relationship with mother of a patient - professional misconduct - notification from psychiatrist</td>
<td>Reprimand - conditions upon registration, review after 14 months, 23 February 2016</td>
<td></td>
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<tr>
<td><em>Medical Board of Australia v Win (Review and Regulation)</em></td>
<td>Made false declaration to obtain provisional registration in Australia - admission that conduct amounted to professional misconduct - qualified in Burma but blacklisted - knowing it was wrong, created false certificate of good standing - Australian citizenship granted - conduct bringing medical profession and system into question - unacceptable conduct so reprimand appropriate</td>
<td>Caution, reprimand, conditions on registration, 19 August 2015</td>
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</tr>
</tbody>
</table>
Western Australia - 2  
Boundary violations - 1  
Self-medication - alcohol or drugs -  
Improper prescribing -  
Deficient clinical standards - 1  
Inadequate record keeping - 2  
Impairment -

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<tr>
<th>Case</th>
<th>Citation</th>
<th>Allegation</th>
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<th>Date of Judgement</th>
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</thead>
<tbody>
<tr>
<td>Medical Board of Australia and Paterson</td>
<td>[2016] WASAT 60</td>
<td>Finding of deficient record keeping - questions about diagnosis of ADHD</td>
<td>Conduct not a scale of gravity sufficiently serious in eyes of professional colleagues of good repute and competence, to warrant punishment and disciplinary action to protect the public</td>
<td>25 May 2016</td>
</tr>
<tr>
<td>Medical Board of Australia and Veettill</td>
<td>[2015] WASAT 124</td>
<td>Allegations of sexual assault of patient - breach of professional boundaries by telephoning, attend home met for coffee, unsatisfactory professional performance - sexual misconduct so professional misconduct, power imbalance and breach of trust</td>
<td>Conditions on registration previously imposed to continue for 12 months after the period of suspension for 12 months - pay Board’s costs</td>
<td>23 February 2016</td>
</tr>
<tr>
<td>Woollard v The Medical Board of Australia Sitting as a Performance and Professional Standards Panel</td>
<td>[2015] WASC 332</td>
<td>Challenge to Board’s panel finding that unsatisfactory professional performance because patient suffered stroke during coronary angioplasty - failed to obtain informed consent, failed to maintain clear and accurate records of discussions with the patient - board resolved to caution</td>
<td>Application to review dismissed</td>
<td>9 September 2015</td>
</tr>
</tbody>
</table>
ACT - 2
Boundary violations - 1
Self-medication - alcohol or drugs - 1
Improper prescribing -
Deficient clinical standards -
Inadequate record keeping -
Impairment -

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<tbody>
<tr>
<td>Medical Board of Australia v Kanapathipillai (Occupational Discipline)</td>
<td>[2016] ACAT 16</td>
<td>Repeated self-medication with drugs, and alcohol - misleading Board and other medical practitioners - personality disorder? impairment? - Professional misconduct - no evidence that permanently unfit to practise, but failure to follow Board conditions</td>
<td>Registration suspended for 2 years - after resumption of practice, registration subject to conditions for 2 years - abstaining from drug use, see psychiatrist regularly - pay Board’s costs</td>
<td>9 March 2016</td>
</tr>
<tr>
<td>Medical Board of Australia v MBO (Occupational Discipline)</td>
<td>[2015] ACAT 69</td>
<td>Two notifications, boundary violations SMS messages with one patient - intimate relationship with another former patient - consent orders - Professional misconduct</td>
<td>Reprimand, suspend registration - conditions once re-registered</td>
<td>8 October 2015</td>
</tr>
</tbody>
</table>
South Australia - 1
Boundary violations -
Self-medication - alcohol or drugs -
Improper prescribing -
Deficient clinical standards - 1
Inadequate record keeping -
Impairment -

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<th>Result</th>
<th>Date of Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Board of Australia v Siow</td>
<td>[2016] SAHPT 1</td>
<td>Caused patient with terminal illness and patient’s family to have unreasonable expectations of beneficial treatment and prolongation of life, failure to organise palliative care or provide counselling to family - professional misconduct - has developed insight - agreed penalty</td>
<td>Reprimand, fine of $12,000, conditions on registration for 12 months - pay Board’s costs</td>
<td>22 January 2016</td>
</tr>
</tbody>
</table>
Tasmania - 2
Boundary violations - 1,
Self-medication - alcohol or drugs -
Improper prescribing -
Deficient clinical standards - 1
Inadequate record keeping -
Impairment -

<table>
<thead>
<tr>
<th>Case</th>
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<th>Allegation</th>
<th>Result</th>
<th>Date of Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasmanian Board of the Medical Board of Australia v Dr Wijtek Majchrzak</td>
<td>[2016] TASHPT 2</td>
<td>Supplied testosterone to two patients where not medically indicated, only for body building - practitioner conceded that professional misconduct, possible ill effects on patients - challenging and insistent patients</td>
<td>reprimanded, subjected to conditions about prescribing of anabolic steroids, also to attend course on dealing with demanding clients, pay costs of the board</td>
<td>2 May 2016</td>
</tr>
<tr>
<td>Dr Edward Sibahi v Tasmanian Board of Australia of the Medical</td>
<td>[2015] TASHPT 7</td>
<td>Notification to respondent, personal interactions in workplace, complaint about vaginal examination of patient in labour, complaint from patient about personal nature of conversation - board considered boundaries violated, imposed conditions, requiring notification to employer, colleagues - need reports from employer addressing professional conduct and performance, chaperone for intimate examination of females - seeking stay</td>
<td>Tribunal accepts serious issue to be tried, but risk that compliance with conditions could adversely affect employment - grant partial stay, modified conditions</td>
<td>15 July 2015</td>
</tr>
<tr>
<td>Dr Edward Sibahi v Tasmanian Board of Australia of</td>
<td>[2016] TASHPT 1</td>
<td>Following 2015 case, tribunal issued notice to Tweed Hospital NSW to produce documents including complaints against practitioner - practitioner’s counsel inspected documents and objected to their being inspected by Board - court may allow inspection if apparently relevant or are subject matter of</td>
<td>Allow inspection by Board</td>
<td>22 March 2016</td>
</tr>
<tr>
<td>the Medical</td>
<td>litigation, don’t have to be relevant to prove or not a fact in issue - relevant to question of whether professional boundaries maintained</td>
<td></td>
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</tr>
</tbody>
</table>
## Northern Territory - 2
### Boundary violations - 1
### Self-medication - alcohol or drugs -
### Improper prescribing -
### Deficient clinical standards -
### Inadequate record keeping - 1
### Impairment -

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<tr>
<th>Case</th>
<th>Citation</th>
<th>Allegation</th>
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<th>Date of Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Board of Australia v Ajay Naidu</strong></td>
<td>[2015] NTHPRT 6</td>
<td>Medical care to patient A, sexual relationship - treated husband and children without recognising conflict - inadequate notes, children were practitioner’s not husband’s - now aware that professional misconduct - notification to AHPRA by husband - practitioner not aware that boundary violations - breach of trust No uneven power relationship with patient A, - practitioner considers that no harm done!!</td>
<td>Reprimand, suspended for 4 months, complete ethics course, report of board - review of conditions in 12 months - practitioner to pay Board’s costs</td>
<td>27 November 2015</td>
</tr>
<tr>
<td><strong>Naidu v Medical Board of Australia</strong></td>
<td>[2016] NTSC 8</td>
<td>Appeal on grounds that only unprofessional conduct not professional misconduct, tribunal misdirected itself, made findings of fact without evidence - four month suspension manifestly excessive for protection of public and maintenance of ethical and professional standards</td>
<td>Clear evidence of effect on patient’s husband, factual allegations not dispute by appellant - tribunal's quoting from codes and guidelines OK because they simply repeat long-established ethical principles, providing for health and safety of community, reliance on Do case overemphasised this - nothing to suggest this had occurred - no error of principle - appeal dismissed</td>
<td>18 February 2016</td>
</tr>
<tr>
<td><strong>Nitschke v Medical Board of Australia</strong></td>
<td>[2015] NTSC 39</td>
<td>Decision by Board to suspend registration, immediate action - not function of court to determine if appellant behave in way that constitutes professional misconduct, rather whether posed a serious risk to persons so necessary to take immediate action, interim action - impact on practitioner, also safety of public</td>
<td>Accept some grounds of appeal (1, 2.1.4), dismiss others (2.2, 2.3, 3.1, 3.2) - Set aside decision of Tribunal and substitute decision setting aside immediate action decision of the board</td>
<td>6 July 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Alam</td>
<td>[2015] NTHPRT 7</td>
<td>Police notification, allegations of indecent assaults - agreed facts, unsatisfactory professional performance</td>
<td>Conditions upon registration, review in 12 months</td>
<td>11 December 2015</td>
</tr>
</tbody>
</table>
Queensland - 14
Boundary violations - 5
Self-medication - alcohol or drugs -
Improper prescribing - 3
Deficient clinical standards - 4
Inadequate record keeping - 4
Impairment - 2

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<tr>
<th>Case</th>
<th>Citation</th>
<th>Allegation</th>
<th>Result</th>
<th>Date of Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alroe v Medical Board of Australia</td>
<td>[2015] QCAT 482</td>
<td>Application to set aside decision of Medical Board to refuse registration as specialist general practitioner - had complied with required conditions - extensive discipline and registration history - failure to demonstrate remorse - board wanted to impose further conditions - fit and proper has both character and competence aspects - no risk to public</td>
<td>No need for further conditions, has discharged onus to demonstrate that fit and proper - no further conditions required, should be unconditionally registered</td>
<td>23 November 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Bethania Surgery</td>
<td>[2015] QCAT 550</td>
<td>Dr Sylvia Yu - husband is Chinese medical practitioner, not registered in Australia - allowed him to perform 2 procedures, claimed for them on Medicare as if she had performed them - provided false and misleading information to Board’s investigators - 1 allegation not substantiated but admitted other procedure - no background of prior offending - practice changes made</td>
<td>Reprimand only, 6 months on Board’s register - not appropriate to order costs, other allegations by Board not substantiated</td>
<td>20 October 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Bourke</td>
<td>[2015] QCAT 400</td>
<td>Notification from coroner - death of child following surgery - common ground that failed to take swab of neck region or give prophylactic antibiotics, serious infection - practitioner conceded that unsatisfactory professional conduct - failures were isolated error of clinical judgement</td>
<td>Finding of unsatisfactory professional performance, reprimand, to remain on register for 12 months</td>
<td>6 October 2015</td>
</tr>
<tr>
<td>Chaudhry v Medical Board of</td>
<td>[2015] QCAT 414</td>
<td>Decision of tribunal to set aside conditions imposed by Medical Board</td>
<td>Medical Board to pay costs related to review proceedings</td>
<td>3 October 2015</td>
</tr>
<tr>
<td>Case</td>
<td>Court</td>
<td>Date of Decision</td>
<td>Nature of Offence</td>
<td>Sanction</td>
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<tr>
<td>De Lacy v Medical Board of Australia</td>
<td>QCAT 53</td>
<td>2016</td>
<td>Application to remove conditions refused by board following consent order - treatment of 11 patients - out of practise, need reskilling</td>
<td>Registration subject to conditions of supervision -</td>
</tr>
<tr>
<td>Medical Board of Australia v de Silva</td>
<td>QCAT 63</td>
<td>2016</td>
<td>Unsatisfactory professional conduct, statement of agreed facts - post-surgical patient, perforated duodenum by original surgeon - lack of communication between surgeons - agreed sanctions</td>
<td>Caution, undertakings given to Board, no record on Board’s register, bear own costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Ferguson</td>
<td>QCAT 511</td>
<td>2015</td>
<td>Practising subject to conditions - Breach of conditions regarding prescribing of restricted substances, failure to attend meetings with supervisor - poor prescribing of drugs of dependency, poor medical management of some patients - lack of insight, brief and unclear notes - professional misconduct alleged - finding of impairment of executive functioning</td>
<td>Practitioner must not be registered until establishes to satisfaction of Board that fit to practise, pay costs of the Board</td>
</tr>
<tr>
<td>Medical Board of Australia v Gomez (No 2)</td>
<td>QCAT 539</td>
<td>2016</td>
<td>Finding of inappropriate conduct relating to examination of 2 female patients - breach of undertakings given in respect of previous disciplinary proceedings - voluntarily ceased practice, practical suspension of 6 months</td>
<td>Further suspension of 6 months, undertaking not to treat female patients - pay Board’s costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Kapadia</td>
<td>QCAT 401</td>
<td>2016</td>
<td>False or misleading information given in application for limited registration - failed to disclose pending UK complaint, also when renewing specialist registration - errors in treatment and patient died, very poor records, but had remediated himself so no concern about fitness to practise - admitted that unprofessional conduct, no intention to deliberately mislead - has shown insight and remorse</td>
<td>Reprimand, pay Board’s costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Kelly</td>
<td>QCAT 35</td>
<td>2016</td>
<td>Provided medical certificate, not a patient - pressure to provide certificate - conduct amounts to unprofessional conduct - agreed sanction</td>
<td>Reprimand on register for 12 months, pay board’s costs</td>
</tr>
<tr>
<td>Medical Board of Australia v Kyaw</td>
<td>QCAT 34</td>
<td>2016</td>
<td>Improperly obtained registration, certificate of registration status Myanmar Medical Board - no advantage to practitioner, was eligible by other experience - dishonesty which attracts sanction - genuine</td>
<td>Has paid board’s agreed costs - reprimand to remain on register for 2 years</td>
</tr>
<tr>
<td>Case Description</td>
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<td>Result</td>
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<td>Dr Choo-Tian Lee v Medical Board of Australia [2016] QCAT 23</td>
<td>Application to stay operation of decision of respondent to change condition 3 of conditions imposed on registration, require chaperone register - application for non-publication order - inappropriate sexual behaviour - no adverse effect on reputation if stay of change and non-publication order not granted</td>
<td>Application for stay refused - non-publication of material that might identify complainant ordered</td>
<td>23 January 2016</td>
<td></td>
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<tr>
<td>Ofili v Medical Board of Australia [2015] QCAT 438</td>
<td>Application by Medical Board to vary directions made</td>
<td>Application refused - convenience of MBA irrelevant to compliance with the directions made - also prejudice to the doctor</td>
<td>16 October 2015</td>
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<tr>
<td>Medical Board of Australia v Ong [2016] QCAT 54</td>
<td>Inappropriate prescribing of restricted drugs, inadequate record-keeping - conditions on registration- admitted that professional misconduct</td>
<td>Suspension for 1 month, conditions upon registration, requires continuing mentoring, regular audits to review record-keeping, review in 12 months, pay costs of Board</td>
<td>20 May 2016</td>
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<tr>
<td>Medical Board of Australia v Pearse [2015] QCAT 442</td>
<td>Allegation of inappropriate examination of female patient - course of events related by patient unlikely - seeing psychiatrist, traumatic experiences in childhood</td>
<td>Board has not proven alleged misconduct, referral dismissed</td>
<td>4 November 2015</td>
<td></td>
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<tr>
<td>Medical Board of Australia v Shah [2016] QCAT 158</td>
<td>Inappropriately trying to involve himself in treatment of now-deceased former wife without her consent, including accessing her medical records, knowingly making and failing to correct false statements made to AHPRA - problems with marriage - unconvincing witness, his version of events at odds with other evidence - failed to maintain professional boundaries, breached professional code of conduct - tribunal satisfied that he knew what he was doing was wrong, character flaw in inability to be honest with collages and frank with regulatory authorities - professional misconduct found</td>
<td>Suspension of registration for 6 monthss, conditions imposed on registration, no review of conditions for 3 months, pay costs of the board</td>
<td>22 March 2016</td>
<td></td>
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<tr>
<td>Small v Medical Board of Australia [2015] QCAT 396</td>
<td>Immediate action by Medical Board, conditions imposed on registration, subsequently withdrawn - application for costs</td>
<td>Costs of medical practitioner for review proceedings to be paid by Board</td>
<td>6 October 2015</td>
<td></td>
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<tr>
<td>Medical Board of Australia v Stark [2016] QCAT 175</td>
<td>Agreed statements of facts, and joint submission on sanction thereby avoiding substantive hearings some</td>
<td>Reprimand and suspension of two years, retraining by completing tertiary level course on clinical record</td>
<td>2 March 2016</td>
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<tr>
<td>Medical Board of Australia v Tabriz</td>
<td>[2015] QCAT 530</td>
<td>Allegation of sexual relationship and breaches of confidentiality - sexual impropriety admitted, breaches of confidentiality not proven - not all Board’s allegations substantiated, unnecessarily protracted proceedings</td>
<td>Keeping, conditions in place for four years after suspension lifted - tribunal is satisfied with agreed sanctions, payment of Board’s costs</td>
<td>6 November 2015</td>
</tr>
<tr>
<td>Medical Board of Australia v Vucak</td>
<td>[2015] QCAT 367</td>
<td>Sexual relationship with former patient, exploited therapeutic relationship - slow to recognise that that conduct inappropriate, no real relationship! - unlikely that events occur again, no need for specific deterrence</td>
<td>Reprimand to remain on register for 12 months, suspended for 3 months, comply with conditions, course in professional boundary management</td>
<td>20 August 2015</td>
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<tr>
<td>Medical Board of Australia v Wong</td>
<td>[2016] QCAT 112</td>
<td>Voluntary cessation of practice after multiple charges of sexual assault - concedes that decision of impairment can be made - long-standing schizophrenia - now has good insight into illness and need for treatment - fit to practise under supervision - Board not seeking finding of professional misconduct but conduct capable of amounting to unprofessional conduct - but suitable to practise under conditions</td>
<td>May continue to practise subject to conditions</td>
<td>21 June 2016</td>
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</tbody>
</table>
New South Wales - 21
Boundary violations - 7
Self-medication - alcohol or drugs -2
Improper prescribing - 9
Deficient clinical standards - 5
Inadequate record keeping - 10
Impairment - 5

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<tr>
<th>Case</th>
<th>Citation</th>
<th>Allegation</th>
<th>Result</th>
<th>Date of Judgement</th>
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<tr>
<td>Health Care Complaints Commission v Astor-Finn</td>
<td>[2016] NSWCATOD 73</td>
<td>Recurring mental illness, conditions on registration 2010-2014 - registration suspended 2014, failure to comply with conditions - failure to respond to communications of HCCC - hearing in absence of practitioner, difficulty in service of documents - finding of impairment - finding that lack of mental competence to practise medicine</td>
<td>Registration cancelled - not reapply for 18 months</td>
<td>7 June 2016</td>
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<tr>
<td>Health Care Complaints Commission v Athour</td>
<td>[2016] NSWCATOD 5</td>
<td>Sexual relationship with patient A, inappropriate prescribing of Schedule 4 and Schedule 8 drugs to patient A - previous tribunal findings of unsatisfactory professional conduct and professional misconduct, permitted to continue practice with conditions - gifts and money to patient A, inadequate records - no admission that caused harm to patient A - power imbalance, deficient understanding of professional responsibilities - no insight</td>
<td>Cancel registration - not reapply for 3 years, pay Board’s costs</td>
<td>14 January 2016</td>
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<tr>
<td>Health Care Complaints Commission v BXD (No 1)</td>
<td>[2015] NSWCATOD 134</td>
<td>Wrongful or inappropriate prescription of drugs to family members (daughters A &amp; B, husband C) also self-prescriptions relying on false prescriptions in name of husband - A with mental health problems, failed to disclose that her daughter, B with mental</td>
<td>Reprimand, registration subject to conditions, pay costs of Board</td>
<td>7 December 2015</td>
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<tr>
<td>Case</td>
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<td>Allegations</td>
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<td>Health Care Complaints Commission v Cheng (No 1)</td>
<td>[2016] NSWCATOD 61</td>
<td>Allegations of inappropriate conduct in examination of 5 female patients - application for non-publication order</td>
<td>Application refused</td>
<td>16 May 2016</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Chowdhury</td>
<td>[2015] NSWCATOD 65</td>
<td>Conditions imposed on re-registration in 2011 - false notification to Medical Council that conditions of observed practice completed - failure to respond to requests from Medical Council - not a witness of credit - lack of honesty and candour with Medical Council - breaches of conditions found, constitutes professional misconduct</td>
<td>Reconvene for hearing related to disciplinary orders</td>
<td>2 July 2015</td>
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<tr>
<td>Health Care Complaints Commission v Chowdhury (No 2)</td>
<td>[2015] NSWCATOD 127</td>
<td>Finding of professional misconduct - findings bore on honesty and candour, prior disciplinary history, similar findings, submission that does impact fitness to practise - lack of contrition or remorse - no problem with competence, problem lies with question of honesty, integrity and fitness of character - not satisfied that respondent has addressed deficiency of character identified 10 years before</td>
<td>Cancel registration, not reapply for 2 years, pay costs of respondent</td>
<td>11 November 2015</td>
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<tr>
<td>Health Care Complaints Commission v CNU</td>
<td>[2016] NSWCATOD 50</td>
<td>Allegation of inappropriate behaviour on examining one female patient - excellent character references for medical practitioner - none of complaints established - non-publication order of both complainant and medical practitioner</td>
<td>Non-publication order, no disciplinary order</td>
<td>6 May 2016</td>
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<tr>
<td>Dr Crickett v Medical Council of New South</td>
<td>[2015] NSWCATOD 86</td>
<td>Appeal from decision of Medical Council to suspend practice - charged with murder, solicitor notified Council, free on conditional bail - denied application to have appeal upheld before Board reopens case - health and safety, public interest to be upheld</td>
<td></td>
<td>20 August 2015</td>
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<tr>
<td>Wales</td>
<td>suspended despite no immediate concerns that medical practice posed significant risk to health and safety of anyone - concern about impact of allegations on reputation and standing of medical profession, public confidence, focus of public trust - respondent wanted to reopen case, appellant wanted appeal upheld before that permitted - rejected</td>
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<td>Crickitt v Medical Council of New South Wales (No 2)</td>
<td>[2015] NSWCATOD 115 Appeal from decision to suspend registration, charged with murder of wife - not concerned about risk to public but impact of allegations on standing of medical profession - treating wife, inadequate records - could exhibit similar misconduct to patients, lies to police, manipulation of patient records</td>
<td>Appeal dismissed - Continue suspension for 6 months or until terminated by Medical Council or it decides whether to pursue formal complaints - reserve costs</td>
<td>22 October 2015</td>
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<tr>
<td>Health Care Complaints Commission v Daly</td>
<td>[2015] NSWCATOD 113 Treatment of 12 patients not accord with level of knowledge, skill or judgment of equivalent experience practitioner - records inadequate - found unsatisfactory professional conduct and professional misconduct - incorrect prescribing of Schedule 4D and 8 drugs - ignored conditions on registration - highly regarded by peers, compassionate with patients - taken steps to remedy problems</td>
<td>Reprimand, conditions on registration, some critical compliance conditions regarding Schedule 4 and 8 drug prescribing - pay costs of HCCC</td>
<td>19 October 2015</td>
<td></td>
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<tr>
<td>Health Care Complaints Commission v Flekser</td>
<td>[2016] NSWCATOD 1 Claimed right to private practice, not entitled to do so - claimed and paid fees when not present at procedure - knowingly? recklessly indifferent? - inconsistencies in evidence before HCCC and Medical Council - deliberate fraud? - seeing psychiatrist, keep up with Jones!! - stress, financial pressures - repeated resort to lack of memory, adversely reflect on his credit - Tribunal concluded that deliberate scheme to claim for as many procedures as possible whether or not participated - conduct amounts to professional misconduct</td>
<td>Parties to consider reasons for decision - timetable for further submission, and orders to be sought. Further hearing?</td>
<td>19 January 2016</td>
<td></td>
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<tr>
<td>Health Care</td>
<td>[2016] Findings of deliberate claims for assisting</td>
<td>Cancel registration - pay costs of HCCC - should be at</td>
<td>23 May 2016</td>
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<td>Case Details</td>
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<td>Description</td>
<td>Outcome</td>
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<tr>
<td>Complaints Commission v Fleker (No 2)</td>
<td>NSWCATOD 65</td>
<td>Operations - false entries in audit - submissions that expected registration to be cancelled, making arrangements to repay incorrect payments - doing everything to accept responsibility for his actions - good references about professional competence, did not address character</td>
<td>least 3 years before application for re-registration, need to establish a case</td>
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<tr>
<td>Health Care Complaints Commission v Follent (No 2)</td>
<td>[2015] NSWCATOD 106</td>
<td>31 March 2015 finding of professional misconduct, matter stood over while audit of practice - dramatic improvement of medical records, diagnosis improving</td>
<td>Reprimanded, continue practice subject to conditions, pay costs of applicant 30 September 2015</td>
<td></td>
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<tr>
<td>Health Care Complaints Commission v Ghannoum</td>
<td>[2015] NSWCATOD 149</td>
<td>Prescribing of restricted and addictive drugs, some to addicted patients - inadequate records, treating family members - inadequate examination of patients - ceased practising in 2009/10 - conditions on non-practising registration, breached conditions when back in practice - professional misconduct</td>
<td>Reprimand, conditions on registration proposed 17 December 2015</td>
<td></td>
</tr>
<tr>
<td>Health Care Complaints Commission v Ghannoum (No 2)</td>
<td>[2016] NSWCATOD 17</td>
<td>Examination of proposed orders - finding of professional misconduct</td>
<td>Reprimand, conditions on registration - pay costs of applicant 8 February 2016</td>
<td></td>
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<tr>
<td>Health Care Complaints Commission v Khan</td>
<td>[2016] NSWCATOD 32</td>
<td>Death of 8 year old child, septic shock after ruptured appendix - inappropriate prescribing for self and relatives, failed to maintain proper records - mild cognitive impairment and/or vascular dementia - guilty of unsatisfactory professional conduct not professional misconduct - registration suspended so could not surrender registration - not competent to practise - impaired Registrants Panel found impairment</td>
<td>Registration cancelled, because of age unlikely to reapply, pay costs of HCCC 23 March 2016</td>
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<tr>
<td>Dr Marburg v Medical Council of New South Wales</td>
<td>[2015] NSWCATOD 87</td>
<td>ENT Surgeon - History of complaints to Medical Board of NSW - recent decision to preclude applicant from performing surgical procedures in any setting, private or hospital - appeal from that</td>
<td>Imposed practice conditions, substituted for those imposed by Medical Council 7 August 2015</td>
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<tr>
<td>Date</td>
<td>Case Description</td>
<td>Summary</td>
<td>Decision</td>
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<tr>
<td>5 April 2016</td>
<td>Health Care Complaints Commission v Marino</td>
<td>Matter stood over to hear submissions concerning protective orders to be made</td>
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<td>10 June 2016</td>
<td>Health Care Complaints Commission v Marino (No. 2)</td>
<td>Registration suspended for 9 months, conditions imposed - practitioner to pay complainant’s costs</td>
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<tr>
<td>7 August 2015</td>
<td>Health Care Complaints Commission v Nguyen-Phuoc</td>
<td>Adjourn proceedings for further hearing</td>
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<tr>
<td>14 September 2015</td>
<td>Health Care Complaints Commission v Bao-Quy Nguyen-Phuoc (No 2)</td>
<td>Cancellation of registration, not permit to reapply for a further three years - prohibition on providing ‘alternative’ health services until re-registered as medical practitioner - pay costs of HCCC</td>
<td></td>
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<tr>
<td>22 April 2016</td>
<td>Health Care Complaints</td>
<td>Registration cancelled, two years before reapply - notify Medical Council of NSW - recommend that AHPRA</td>
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<tr>
<td>Case Study</td>
<td>Page</td>
<td>Description</td>
<td>Decision/Action</td>
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<tr>
<td>Commission v Pakalu</td>
<td>49</td>
<td>has demonstrated remorse - but risk of reoffending ‘fairly high’ - dishonestly giving history to psychiatrist - lacks insight</td>
<td>notify PNG authorities - pay costs of HCCC</td>
<td></td>
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<tr>
<td>Health Care Complaints Commission v Priyamanna</td>
<td>[2015] NSWATOD 138</td>
<td>Examination of patient, sexually inappropriate manner - admits unsatisfactory professional conduct, not professional misconduct - focus on credibility of witness - found unsatisfactory professional conduct and professional misconduct - history of inappropriate examination of female patients in Queensland, denied sexual element - accept veracity of patient rather than practitioner - inappropriate behaviour found, caused distress to patient - non-publication order for patient’s name</td>
<td>List for Stage 2 Hearing</td>
<td>10 December 2015</td>
</tr>
<tr>
<td>Health Care Complaints Commission v Priyamanna (No 2)</td>
<td>[2016] NSWCATOD 3</td>
<td>In light of findings in Stage 1 - not automatic to suspend or cancel registration when professional misconduct found, must assess if practitioner is unfit to practise, gravity of circumstances, remorse and insight, not punitive, must protect the public, also educative and deterrent role - also point to Queensland matters - penalty not referable to worst case but extent conduct departs from proper standards</td>
<td>Cancel registration, not reapply for 2 years - pay costs of HCCC</td>
<td>13 January 2016</td>
</tr>
<tr>
<td>Ristevski v Medical Council of New South Wales</td>
<td>[2016] NSWCATOD 18</td>
<td>Application for reinstatement of former medical practitioner - had been struck off, inappropriate sexual relationship with much younger woman, had been a patient, not kept records for whole time - charged with assault, found guilty - guilt of professional misconduct - now must determine if appropriate to reinstate, fit and proper? - now has insight, has maintained professional knowledge, supported by colleagues - likelihood of reoffence is low - problem with the assault</td>
<td>Reinstates subject to conditions, pay costs of respondent</td>
<td>1 June 2016</td>
</tr>
<tr>
<td>Health Care Complaints</td>
<td>[2016] NSWCATOD</td>
<td>Breaches of conditions on registration - has impairment, major depressive disorder, long-term</td>
<td>Guilty of professional misconduct, discharged suspension of registration - conditions imposed - pay costs of HCCC</td>
<td>23 February 2016</td>
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<tr>
<td>Case Title</td>
<td>Details</td>
<td>Order Details</td>
<td>Date</td>
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<tr>
<td>Commission v Rixon</td>
<td>24 severe anxiety disorder, alcohol abuse or dependence - impaired registrant’s panel - undertakings about conduct given - HCCC proposed orders on mentoring and practice restrictions, accepted by Rixon -</td>
<td>Reprimand, conditions upon registration, audit of practice, professional mentor and supervision - pay costs of the Board</td>
<td>14 August 2015</td>
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</tr>
<tr>
<td>Health Care Complaints Commission v Saldevar</td>
<td>[2015] NSWCATOD 96 “inherited” small cohort of patients - prescribed Schedule 8 drugs for drug-dependent patients - inadequate records - professional misconduct - onus on medical practitioner to show that should be permitted to continue to practise - had insight into his problems dealing with difficult patients - well-liked - not passive, but attempt to adopt shared decision-making approach - serious allegations normally require suspension or cancellation - primarily protective, not to punish practitioner - no longer prescribes drugs of addiction</td>
<td>Disqualified from registration - cannot reapply for 2 years - pay costs of HCCC</td>
<td>23 September 2015</td>
<td></td>
</tr>
<tr>
<td>Health Care Complaints Commission v Sharah</td>
<td>[2015] NSWCATOD 99 Registration suspended 21 October 2013, 16 January 2015 advised AHPRA that decided to relinquish registration - now 80 years old - application to stop enquiry into treatment of some patients - complaint that guilty of professional misconduct, unsatisfactory professional conduct had impairment therefore not competent, disputed particulars - violations of professional boundaries, inappropriate religious advice - complaints proven - application for prohibition order</td>
<td>Reprimand, conditions imposed on registration - pay costs of applicant</td>
<td>8 October 2015</td>
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<tr>
<td>Health Care Complaints Commission v Shinwari (No 2)</td>
<td>[2015] NSWCATOD 107 involved in rapid detoxification treatment - professional misconduct found, what protective orders are required - in some respects, lack of insight, need to deter</td>
<td>Order to withdraw proceedings, not determined so suspension remains in place and public is protected</td>
<td>29 June 2016</td>
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<tr>
<td>Health Care Complaints Commission v Singh</td>
<td>[2016] NSWCATOD 85 Complaint of unsatisfactory professional conduct and professional misconduct, registration currently suspended - unable to serve documents - adjourn sine die or withdraw proceedings</td>
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<td>Case Title</td>
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<td>Summary</td>
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<tr>
<td><em>Smithson v Medical Council of New South Wales</em></td>
<td>[2016] NSWCATOD 82</td>
<td>Application for reinstatement to register of medical practitioners - registration cancelled in 2000, addiction to heroin and failure to maintain professional boundaries - impaired - application that addiction now overcome, has obtained law degrees in interim - has demonstrated insight into behaviour- has overcome hurdle to being reinstated, but should be subject to conditions to ensure patient safety and personal well-being and health</td>
<td>Reinstated subject to both supervision and mentoring conditions, pay costs of Medical Council</td>
<td>28 June 2016</td>
</tr>
<tr>
<td><em>Health Care Complaints Commission v Suri</em></td>
<td>[2016] NSWCATOD 54</td>
<td>Inappropriate prescribing of drugs of addiction, breach of regulations re drugs of addiction, stolen prescription pads, failure to store correctly, failure to record, discrepancies in records - conceded that professional misconduct - protective order required but not cancel registration - will outsource pain management in future</td>
<td>Suspend registration for 3 month, when re-registered will be subject to conditions pay costs of HCCC</td>
<td>6 May 2016</td>
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<tr>
<td><em>Health Care Complaints Commission v Tan</em></td>
<td>[2016] NSWCATOD 77</td>
<td>Inappropriate prescribing of drugs of addiction and restricted drugs - failure to maintain adequate medical records - conceded serious misconduct - Medical Council recommended seeking of psychiatric treatment - greater insight into vulnerabilities but had not completely resolved - referred to forensic psychiatrist for opinion, finding of impairment - no explanation by psychiatrists for behaviour - registration not renewed but can be dealt with as if still registered - finding of conduct which is contemptible, outrageous and unethical, facile explanations of misconduct</td>
<td>Finding of professional misconduct, registration cancelled, prohibition order on directly providing mental health services unless re-registered - disqualified from re-registration for 3 years</td>
<td>17 June 2016</td>
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<tr>
<td><em>Health Care Complaints Commission v Torrinello</em></td>
<td>[2015] NSWCATOD 90</td>
<td>Application to hear disciplinary matter, request of HCCC and solicitor for Torrinello complaint withdrawn and application dismissed - not in public interest to hear complaint - alleged inappropriate prescribing, failed to maintain professional boundaries with 4 patients, breach confidentiality,</td>
<td>Consent to withdrawal of complaint, application for disciplinary order and findings dismissed - no order as to costs</td>
<td>1 September 2015</td>
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<td>Category</td>
<td>Cases</td>
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<tr>
<td>Inadequate records</td>
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<td>Has retired, ill health, undertakes not to practise</td>
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<td>Risk to public</td>
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All jurisdictions total - 49
Boundary violations - 17
Self-medication - alcohol or drugs - 3
Improper prescribing - 14
Deficient clinical standards - 13
Inadequate record keeping - 19
Impairment - 7
## APPENDIX IVA

### Civil Liability Legislation

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<thead>
<tr>
<th>Limitation Period</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limitation Act 1969 (NSW) s 50C(1)(a) - 3 years from date on which cause of action is discoverable; (b) - 12 years from date act or omission where injury alleged to have occurred; whichever is the earlier</td>
<td>Limitation of Actions Act 1958 (Vic) s 27D(1)(a) - 3 years from date where cause discoverable; (b) 12 years from date of act or omission where injury alleged to have occurred; whichever is earlier</td>
<td>Limitation of Actions Act 1974 (Qld) s 11(1) - 3 years from date cause of action arose (2) - no limitation for dust related injury</td>
<td>Limitation Act 2005 (WA) s 14(1) - 3 years from date on which cause of action accrued; s 55 - when cause of action accrues</td>
<td>Limitation of Actions Act 1936 (SA) s 36(1) - 3 years after cause of action accrued;</td>
<td>Limitation Act 1974 (Tas) s 5A (a) - 3 years commencing on date of discoverability; (b) 12 years commencing on date of act or omission resulting in injury; whichever is earlier</td>
<td>Limitation Act 1985 (ACT) s 16B(2)(a) - 3 years after day injured person first knows of injury (b) - 3 years after date injury happened</td>
<td>Limitation Act (NT) s 12(1) - 3 years from date on which cause of action accrues</td>
</tr>
<tr>
<td>Limitation Period where disability at time of accrual of action</td>
<td>s 50F -(1) - running of limitation period suspended for period of</td>
<td>s 27E(2)(a) - 6 years from date where cause discoverable; (b) - 12 years from date of act</td>
<td>s 29(2)(c) - 3 years from date person ceased to be under disability, or died; whichever</td>
<td>s 30(1) - where under 15 years, cannot commence after 6 years from date since cause</td>
<td>s 45(1) extends time in s 36 by time whilst legal disability exists or continues after</td>
<td>s 26(1) - 6 years</td>
<td>s 30 - running of limitation period suspended for period of disability;</td>
<td>s 36(1) - running of limitation period suspended for period of</td>
</tr>
</tbody>
</table>
duration of disability (3) - unless facts known by capable parent or guardian
or omission where injury alleged to have occurred; whichever is earlier
is earlier
Personal Injuries Proceedings Act 2002 (Qld) s 19 - limitation periods suspended while claimant under legal disability
of action accrued s 31(1) - if person is 15, 16 or 17 when cause accrued, cannot commence if person has reached 21 years s 32(1) - limitation period suspended for period when no guardian s 35(1) if under mental disability, limitation period suspended for period where no guardian
time right to bring the action arose s 45A (1) - if time extended to more than 6 years, must give notice within 6 years from date of incident except if action against person committing the tort
s30B(3)(a) - claims relating to health services for children - 6 years after aware of the injury; (b) - 12 years after day of accident giving rise to injury; whichever is earlier

<p>| Apologies or Expressions of Regret | Civil Liability Act 2002 (NSW) s 60(1) - not admission of liability, not relevant to deciding fault; (2) evidence of apology not | Wrongs Act 1958 (Vic) s 14J(1) - apology is not admission of liability, or unprofessional conduct, carelessness, incompetence | Civil Liability Act 2003 (Qld) s 72 - expressions of regret inadmissible in proceedings; s 72D(1) - apology not admission of | Civil Liability Act 2002 (WA) s 5AH(1) - apology is not admission of fault or liability, not relevant to determine fault or liability; (2) evidence of | Civil Liability Act 1936 (SA) s 75 - no admission of liability or fault inferred from expression of regret for incident | Civil Liability Act 2002 (Tas) s 7(1) - apology is not express or implied admission of fault or liability, not relevant to determining fault or liability; (2) evidence of | Civil Law (Wrongs) Act 2002 (ACT) s 14(1) - apology is not admission of liability, not relevant to deciding fault | Personal Injuries (Liabilities and Damages) Act 2003 (NT) s 13 - expression of regret is not admissible in evidence |</p>
<table>
<thead>
<tr>
<th>Notice of Claims for Personal Injuries</th>
<th>Personal Injuries Proceedings Act 2002 (Qld) s 9 - notice of claim to proposed defendant; s 9A(2) - medical negligence cases, must give initial notice; earlier of (4) within 9 months of medical incident or when symptoms become apparent, or within 1 month of instructing</th>
<th></th>
<th></th>
<th>Personal Injuries (Civil Claims) Act (NT) s 8(1) - notice of claim to be given within 12 months of incident, or within 12 months of symptoms becoming apparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>admissible as evidence of fault or liability or unsatisfactory professional performance, for any profession fault or liability, not relevant to determine fault or liability; (2) - evidence of apology not admissible as evidence of fault or liability apology not admissible as evidence of fault or liability (2) - evidence of apology not admissible as evidence of fault or liability apology not admissible as evidence of fault or liability</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Protection of Good Samaritans from Liability</td>
<td>s 57 - act or omission made in good faith for assisting person apparently injured or at risk of injury</td>
<td>s 31B(2) - act or omission done in good faith to assist at scene of provide information to someone else at the scene</td>
<td>s 5AD(1) - act or omission done in good faith and without recklessness in assisting person in apparent need of emergency assistance; (2) medically qualified good samaritans</td>
<td>s 74(2) - no liability for act or omission done in good faith and without recklessness in assisting person in in apparent need of emergency assistance; (2) medically qualified good samaritans</td>
</tr>
<tr>
<td>Protection of Volunteers from Liability</td>
<td>s 61 - act or omission done in good faith when doing community work for community organisation</td>
<td>s 37(1) - act or omission done in good faith when doing community work for community association</td>
<td>s 39(1) - act or omission done in good faith when doing community work for community association</td>
<td>s 47(1) - no liability for anything done in good faith when doing community work</td>
</tr>
<tr>
<td>Protection of Food Donors from Liability</td>
<td>s 58C - no liability for donated food in good faith and charitable purpose, and if food fit at time it was left, was handled correctly and within relevant time limits</td>
<td>s 31F(2) - no liability for donated food in good faith and charitable purpose, and if food fit at time it was left, was handled correctly and within relevant time limits</td>
<td>s 38A - no liability for distributing food where food fit at time it was left, was handled correctly and within relevant time limits</td>
<td>s 74A(2) - no liability arising from consumption of food donated or distributed; (3) no immunity if knew or recklessly indifferent to fact that when food left control it was unsafe</td>
</tr>
<tr>
<td>Breach of Duty of Care</td>
<td>s 5B(1) - not negligent unless risk foreseeable and not insignificant, reasonable person would take precautions</td>
<td>s 48(1) - not negligent unless risk foreseeable and not insignificant, reasonable person would take precautions</td>
<td>s 9 - no breach of duty against risk of harm unless risk foreseeable, not insignificant, and reasonable person take precautions</td>
<td>s 5B - no liability unless risk foreseeable, not insignificant, and reasonable person take precautions</td>
</tr>
<tr>
<td>Causation</td>
<td>s 5D(1) - negligence was a necessary condition of harm, appropriate for scope of liability to include defendant; (2) - court to consider where negligence cannot be established as necessary condition, whether and why responsibility should be imposed on negligent party; (3) determine factual causation subjectively in light of all relevant circumstances, statements by injured person about what would have done are</td>
<td>s 5I(1) - negligence was a necessary condition of harm, appropriate for scope of liability to include defendant; (2) - court to consider where negligence cannot be established as necessary condition, whether and why responsibility should be imposed on negligent party; (3) determine factual causation subjectively in light of all relevant circumstances, statements by injured person about what would have done are</td>
<td>s 11(1) - negligence was a necessary condition of harm, appropriate for scope of liability to extend to tortfeasor; (2) - court to consider where negligence cannot be established as necessary condition, whether and why responsibility should be imposed on negligent party or left to lie where it fell; (3) determine factual causation by considering what injured person would have done if tortfeasor not at fault, evidence of injured person about</td>
<td>s 5C (1)- fault was a necessary condition of harm, appropriate for scope of liability to extend to tortfeasor; (2) - court to consider where negligence cannot be established as necessary condition, whether and why responsibility should be imposed on negligent party or left to lie where it fell; (3) determine factual causation by considering what injured person would have done if tortfeasor not at fault, evidence of injured person about</td>
</tr>
<tr>
<td>Onus/Burden of Proof</td>
<td>s 5E - plaintiff bears onus on balance of probabilities of proving any fact relevant to issue of causation</td>
<td>s 52 - plaintiff bears burden on balance of probabilities of proving any fact relevant to issue of causation</td>
<td>s 12 - plaintiff bears onus on balance of probabilities of proving any fact relevant to issue of causation</td>
<td>s 5D - plaintiff bears onus on balance of probabilities of proving any fact relevant to issue of causation</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Legal disability</td>
<td>s 5O - (1) A person practising a profession (a professional) does not incur a liability if shown that acted in manner widely accepted by peers as</td>
<td>s 59 - no liability if breach of duty if established that acted in way widely accepted by peers as</td>
<td>s 22(1) - no breach of duty if established that acted in way widely accepted by peers as</td>
<td>s 5PB - no negligent act or omission of health professional if in accordance</td>
</tr>
<tr>
<td>Professional Negligence/Standard of Care</td>
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</tbody>
</table>
liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) and (4) can rely on more than one widely competent professional practice in circumstances, provided the court does not consider that the opinion is irrational.

peers as competent professional practice in circumstances

with practice widely accepted by peers as competent professional practice in circumstances

by members of same profession as competent professional practice

competent professional practice
<table>
<thead>
<tr>
<th>accepted opinion</th>
<th>Damages for Non-economic Loss</th>
<th>Contributory Negligence</th>
</tr>
</thead>
<tbody>
<tr>
<td>$s\ 16$ - minimum of $15%$ of most extreme case - $$350,000.00$ - sliding scale</td>
<td>$s\ 28\text{LE}$ - no damages unless significant injury; $s\ 28\text{LF}$ - determination of significant injury; $s\ 28\text{LG}$ - as determined by medical practitioner;</td>
<td>$s\ 5\text{R}(1)$ - same principles for determining contributory negligence in determining whether the person who suffered harm was contributorily negligent ($2)(a)$ - standard of care required by person who suffered harm is that of reasonable person in the position of that person;</td>
</tr>
<tr>
<td>$s\ 9$ - restrictions on damages for non-pecuniary loss</td>
<td>$s\ 52$ - restrictions on damages for non-economic loss</td>
<td>$s\ 23\text{B}(1)$ - same principles for determining contributory negligence in determining whether the person who suffered harm was contributorily negligent ($2)(a)$ - standard of care required by person who suffered harm is that of reasonable person in the position of that person;</td>
</tr>
<tr>
<td>$s\ 27$ - restrictions on damages for non-economic loss</td>
<td></td>
<td>$s\ 5\text{K}(1)$ - same principles for determining contributory negligence in determining whether the person who suffered harm was contributorily negligent ($2)(a)$ - standard of care required by person who suffered harm is that of reasonable person in the position of that person;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$s\ 62$ - same principles for determining contributory negligence in determining whether the person who suffered harm was contributorily negligent ($2)(a)$ - standard of care required by person who suffered harm is that of reasonable person in the position of that person;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$s\ 27$ - maximum amount limited ($$350,000.00$) - restrictions on how awarded</td>
</tr>
</tbody>
</table>

**Law Reform (Miscellaneous Provisions) Act (NT)**

$s\ 15$ - “wrong” means an act or omission (whether or not an offence - (a) that gives rise to a liability in tort in relation to which a defence of contributory negligence is available at common law; $s\ 47$ - court may determine reduction of $100\%$.

$s\ 19$ - wrong means an act or omission (whether or not an offence - (a) that gives rise to a liability in tort in relation to which a defence of contributory negligence is available at common law; $s\ 47$ - court may determine reduction of $100\%$.
<table>
<thead>
<tr>
<th>(b) determine matter of basis of what person knew or should have known at the time</th>
<th>(b) determine matter of basis of what person knew or should have known at the time</th>
<th>(b) determine matter of basis of what person knew or should have known at the time</th>
<th>(b) determine matter of basis of what person knew or should have known at the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>s 5S - court may determine reduction of 100%</td>
<td>s 63 - court may determine reduction of 100%</td>
<td>s 4 - court may determine reduction of 100%</td>
<td></td>
</tr>
<tr>
<td>Exemplary Damages excluded</td>
<td>s 21 - excluded for personal injury</td>
<td>s 52 - excluded for personal injury</td>
<td>claimants share of responsibility</td>
</tr>
<tr>
<td>Personal Injuries (Liabilities and Damages) Act s 17 - court must assess damages on basis that damages to which claimant may be entitled in absence of contributory negligence are to be reduced by 25% or greater percentage determined by court to be appropriate in the circumstances</td>
<td>Personal Injuries (Civil Claims) Act s 19 - excluded for personal injury</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX VA

Advance Directives Legislation

<table>
<thead>
<tr>
<th>Name</th>
<th><strong>Advance Care Directives Act 2013 (SA)</strong></th>
<th><strong>Guardianship and Administration Act 1990 (WA)</strong></th>
<th><strong>Medical Treatment (Health Directions) Act 2006 (ACT)</strong></th>
<th><strong>Advance Personal Planning Act 2013 (NT)</strong></th>
<th><strong>Powers of Attorney Act 1998 (Qld)</strong></th>
<th><strong>Medical Treatment Planning and Decisions Bill 2016 (Vic)</strong></th>
<th><strong>Mental Capacity Act 2005 (UK)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interstate Recognition</td>
<td>Yes - s 33</td>
<td>Yes - s 110ZA</td>
<td>Not specified</td>
<td>Yes - s 88</td>
<td>Yes - s 40</td>
<td>Yes - cl 95</td>
<td>Advance decision - s 24</td>
</tr>
<tr>
<td>Common Law preserved</td>
<td>Probably</td>
<td>Yes - s 110ZB</td>
<td>Yes - s 6</td>
<td>Yes - s 55</td>
<td>Yes - s 39 (but see s 66(1) Guardianship and Administration Act 2000)</td>
<td>Yes - cl 10 - nothing in this Part affects any right of a person under any other law to refuse medical treatment</td>
<td>No</td>
</tr>
<tr>
<td>Registrati on</td>
<td>No provisions</td>
<td>No provision</td>
<td>Copy of direction or note about direction to be placed on patient’s file - s 14</td>
<td>May be registered - s 87 optional registration so validity or effect not affected - s 87(2)</td>
<td>No provision to register advance health directive or revocation</td>
<td>No provision</td>
<td>No provision</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Person 18 years or</td>
<td>Person who has</td>
<td>Adult may make</td>
<td>Adult who has</td>
<td>Adult principal - s</td>
<td>Any person</td>
<td>Person who has</td>
</tr>
</tbody>
</table>
and capacity over and of sound mind - s 7(1)

reached 18 years of age and has full legal capacity - s 110P
s 3 - mental disability includes an intellectual disability, a psychiatric condition, an acquired brain injury and dementia;
s 4(3) - Every person shall be presumed to be capable of:
(a) looking after his own health and safety;
(b) making reasonable judgments in respect of matters relating to his person;
(c) managing his own affairs; and
(d) making reasonable judgments in respect of matters relating to his estate,
until the contrary is shown.

planning capacity - s 8
Adult has planning capacity when he or she has decision-making capacity for making an advance personal plan - s 4(a)
Adult has decision-making capacity where the adult can understand and retain information, and communicate the decision in some way - s 6(1)
Adult is presumed to have decision-making capacity until the contrary is shown - s 6(2)

35 Principal may only make directive where understands (a) nature and likely effects of each direction (b) it operates only while principal has impaired capacity - s 42(1)
Capacity of an adult is presumed - Schedule 1 Part 1 Section 1
Capacity means person is capable of (a) understanding nature and effect of decisions (b) freely and voluntarily making decision (c) communication decision in some way - Schedule 3 s 3
(including a child) who has decision making capacity in relation to each statement in the directive and understands the nature and effect of each statement in the directive - cl 13 Decision-making capacity - cl 4
1(a) understand information relevant to decision; (b) retain information necessary to make decision; (c) use or weigh information as part of making decision; (d) communicated decision in some way.
c 4(2) - for purposes of ss (1), adult presumed to have decision-making capacity unless there is evidence to the contrary

reached 18 years and has capacity - s 24(1)
Person lacks capacity if he is unable to make a decision for himself because of impairment or or disturbance in functioning of the brain - s 2(1)
Unable to make decision where unable to (a) understand relevant information (b) retain that information (c) use or weigh information in making decision (d) communicate decision in any way - s 3(1)
<p>| Direction | Enable directions about future health care - s 9(a), in accordance with person’s wishes and values | Can make advance health directive containing treatment decisions for future treatment - s 110P | An adult can make a direction to refuse, or require withdrawal of medical treatment generally, or of a particular kind - s 7(1) | Adult with planning capacity can make an advance personal plan to make consent decisions about future health care action - s 8(1)(a) | Principal may give directions and information for future health care, and may appoint one or more persons as attorneys if directions inadequate - s 35(1) and may consent or direct that treatment be withdrawn - s 35(2) | Instructional directive in advance care directive - medical treatment - cl 6(1)(a) | Values directive in advance care directive - basis for medical treatment outcomes - cl 6(2) | Makes a decision that (a) if at later time in specified circumstances a treatment is proposed or continued and (b) he lacks capacity, then treatment is not to be carried out or continued - s 24(1) May be expressed in layman’s terms - s 24(2) |
| Condition of use | Reference to provision of health care includes reference to withhold or withdraw treatment, including life-sustaining treatment - s 5 | Maker must understand the nature of the treatment decision or consequences of the treatment decision - s 110R(2) Treatment decision | Person must be informed about (a) nature of illness (b) alternative available treatment (c) consequences of available forms of treatment (d) consequences of health care action for an adult means commencing, continuing, withholding or withdrawing health care for the adult - s 3 may apply to all or | Direction to withhold life-sustaining treatment is not valid unless (a) principal has a terminal illness and is expected to die within 1 year, or | Person with decision-making capacity if - understands the information relevant to the decision and effect of the decision, retains that | Must be applicable to the treatment in question - s 25(1) Advance decision is not applicable where person has capacity to give or refuse consent - s 25(3) |</p>
<table>
<thead>
<tr>
<th>Health practitioner cannot be compelled to provide specific health care - s 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can only be implemented when impaired decision-making capacity - s 34</td>
</tr>
<tr>
<td>Health practitioner operates any time maker is unable to make reasonable judgements about treatment as if the decision had been made while of full legal capacity - s 110S</td>
</tr>
<tr>
<td>Does not operate if circumstances not reasonably anticipated at time treatment decision made, or would have caused a reasonable person the change mind - s 110S(3)</td>
</tr>
<tr>
<td>current health care action, in all circumstances, only stated or only where not stated - s 11</td>
</tr>
<tr>
<td>Has effect for all purposes as if decision made by the adult and the adult had full legal capacity and was fully informed about the health care action - s 41</td>
</tr>
<tr>
<td>(b) is in a persistent vegetative state, or</td>
</tr>
<tr>
<td>(c) is permanently unconscious with no prospect of regaining consciousness, or</td>
</tr>
<tr>
<td>(d) severe illness where no prospect of recovery other than with life-sustaining measures - s 36(2)</td>
</tr>
<tr>
<td>Any direction to withhold or withdraw artificial hydration or nutrition must not be inconsistent with good medical practice - s 36(2)(b)</td>
</tr>
<tr>
<td>information necessary to make that decision, uses or weighs that information as part of process of making the decision, communicates the decision and view and needs as to decision in some way - cl 4</td>
</tr>
<tr>
<td>Adult is presumed to have decision-making capacity unless there is evidence to the contrary - cl 4(2)</td>
</tr>
<tr>
<td>Not applicable to life-sustaining treatment unless patient’s decision verified by statement that it will continue to apply - s 25(5) and is in writing and signed by the patient in presence of witness who signs in patient’s presence - s 25(6)</td>
</tr>
</tbody>
</table>

### Formal Requirements

<table>
<thead>
<tr>
<th>Must use advance care directive form - s 3(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must be in (a) form prescribed by regulations (b) maker encouraged to seek legal advice (c) witnessed by 2 persons authorised to take declarations</td>
</tr>
<tr>
<td>In writing, orally or any other way - s 7(2)</td>
</tr>
<tr>
<td>Signed in presence of 2 witnesses who sign in each other’s presence - s 8</td>
</tr>
<tr>
<td>Where direction is not written, must be witnessed by 2 health professionals</td>
</tr>
<tr>
<td>In form approved under s 86(1) - s 9</td>
</tr>
<tr>
<td>Signed and witnesses by an authorised witness who believes the adult is the person the adult purports to be and is at least 18 years of age, understands nature</td>
</tr>
<tr>
<td>Must be in approved form - s 44(1)</td>
</tr>
<tr>
<td>In writing - s 44(2)</td>
</tr>
<tr>
<td>Signed by principal and signed and dated by eligible witness - s 44(3)</td>
</tr>
<tr>
<td>Witness must sign certificate stating</td>
</tr>
<tr>
<td>Formal requirements - cl 16</td>
</tr>
<tr>
<td>Witnessing and certification requirements - cl 17</td>
</tr>
<tr>
<td>Two adult witnesses, sign and date in presence of donor and each other - one witness must be authorised</td>
</tr>
<tr>
<td>If applicable to life-sustaining treatment, must be in writing and witnessed - s 25(6)</td>
</tr>
<tr>
<td>Revocation</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Decision in advance health directive taken to have been revoked if maker has changed mind since making the directive - s 110S(6)</td>
</tr>
<tr>
<td>May be revoked by the person who made the direction by clearly expressing decision to health professional or any other person to revoke - s 10(1)</td>
</tr>
<tr>
<td>May be amended or revoked at any time as long as has planning capacity, in accordance with ss 9 &amp; 10</td>
</tr>
<tr>
<td>Amendment or revocation - cl 20 - amendment made on face of original advance care directive - revocation by an later advance care directive given by the donor - if not in accordance with cl 21, amendment or revocation has no effect, but may be taken into account as statement of preferences and values</td>
</tr>
<tr>
<td>May withdraw or alter advance decision at any time while has capacity - s 24(3)</td>
</tr>
</tbody>
</table>

legal advice - s 11(5) (e) signed in the presence of the maker and each other - s 110QA(1) Form in directions must include provision if maker wishes to indicate whether legal and medical advice obtained and who signed in the presence of the maker and each other - s 110QA

including a medical practitioner present at the same time - s 9 and effect of plan and is acting voluntarily - s 10 Where non-compliance with formal requirements, may have effect as statement of adult’s views and wishes - s 13 Court may declare attempt valid where intention is clear - s 13(3) signed in presence of principal who appeared to have capacity - s 44(5)

Also certificate signed and dated by non-witness doctor certifying capacity of principal - s 44(6)–(7) witness - cl 3 - registered medical practitioner or person authorised to take affidavits
<table>
<thead>
<tr>
<th>Vitiating Factors</th>
<th>Not valid if decision not made voluntarily or is made as result of inducement or coercion - s 110R(1)</th>
<th>Must be acting voluntarily - s 10</th>
<th>a person must not induce another person to give an advance care directive - cl 14. A person must not knowingly make a false or misleading statement about another person’s advance care directive - some statements in directive forbidden - cl 18</th>
<th>Undue influence - common law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Treatment</td>
<td>Act does not apply to palliative care - s 6(2) but patient has a right to adequate pain relief - s 17</td>
<td>Health care action commencing, continuing, withholding or withdrawing, subject to restrictions specified - s3 &amp; s 38</td>
<td>Does not apply to medical treatment for mental illness, or neurosurgery for mental illness - cl 48. Before treating anyone without capacity, must make reasonable efforts to ascertain if person has advance care directive - cl 50(1)(a) may refuse to comply with instructional</td>
<td></td>
</tr>
<tr>
<td>Medical practitioner</td>
<td>The objects of this Act include the following: (f) to protect health practitioners and others giving effect to the directions, wishes and values of a person who has given an advance care directive; s 9(f) - Medical practitioner must comply with binding provision in advance care directive, act in consistency with specified principles - s 35(1) but can refuse to comply if believes on reasonable grounds that provision not apply in particular circumstances, or reflect current wishes - s 36(2) -</td>
<td>If treatment action taken reasonably believing patient is unable to make decisions, relying in good faith on advance health directive, then health professional is taken to have taken treatment action as if decision had been made by the patient with full legal capacity - s 110ZL(2)</td>
<td>Duty of health professional or anyone else to advise and inform the patient - s 6(3)(a) - Duty to provide medical treatment other than medical treatment refused or withdrawn - s 6(3)(b)</td>
<td>health care provider protected if reasonably believes adult has impaired decision-making capacity and relies on consent - applies even if health care action will hasten the adult’s death - s 45</td>
</tr>
<tr>
<td>May refuse to act on conscientious grounds - s 37</td>
<td></td>
<td></td>
<td>to perform futile or non-beneficial treatment - cl 8</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX VIA

Incidence of Iatrogenic Injury

<table>
<thead>
<tr>
<th></th>
<th>Australia 1992%</th>
<th>Colorado/Utah 1992%</th>
<th>New York 1984%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Adverse Events</td>
<td>16.6%</td>
<td>2.9%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Negligence</td>
<td></td>
<td>32.6% Utah</td>
<td>27.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27.5% Colorado</td>
<td></td>
</tr>
<tr>
<td>Human Error</td>
<td></td>
<td></td>
<td>69%</td>
</tr>
<tr>
<td>High Preventability</td>
<td>51.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Injury</td>
<td>46.6%</td>
<td>50%</td>
<td>70.5%</td>
</tr>
<tr>
<td>Permanent Injury</td>
<td>13.7%</td>
<td>20.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Death</td>
<td>4.9%</td>
<td>6.6%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Operations</td>
<td></td>
<td>44.9%</td>
<td></td>
</tr>
<tr>
<td>Adverse Drug Reactions</td>
<td></td>
<td>19.3%</td>
<td></td>
</tr>
</tbody>
</table>


2. Eric J Thomas et al, 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado' (2000) 38 Medical Care 261