Medical Administration: Navigating Litigation & Compliance

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Patient complaints, medico-legal litigation, AHPRA notifications and investigations into a practitioner's conduct are complex aspects of healthcare. Learning from a mistake or an omission is essential to any healthcare system's quality and safety improvement efforts.

Claims, complaints and investigations

In recent years, MIPS has observed a gradual increase in medico-legal litigation across all Australian jurisdictions. Being sued remains rare and going to a public trial is even rarer. However, a steady rise in medical negligence claims, complaints and investigations is apparent.

There are more 'No Win No Fee' lawyers, more medical experts routinely criticising the conduct of other medical professionals, and a public who is more aware and willing to pursue their right to make a civil claim for damages. When these shifts combine with demographic changes, such as a growing and ageing population, more registered healthcare professionals and more procedures being performed in more hospitals, the chances of claims and complaints being made against healthcare providers are naturally higher than what they were even a few years ago.

A civil claim for damages made against a healthcare provider is ultimately pursued through the Courts unless a settlement is reached prior to proceedings commencing, or during litigation.

A complaint is not made through the courts and is not a means for a claimant to seek compensatory damages. When someone submits a complaint against a healthcare practitioner or provider, several platforms are available to them. Complaints may be directed to individual practitioners (a common approach for private patients), the State-based Health Complaints Commissions (HCCs) (Table 1), the Australian Health Practitioners Regulation Agency (AHPRA) and associated Boards or to individual government departments of health. Still, the processes for managing health service complaints vary slightly across different Australian jurisdictions.

The HCCs are independent, government-funded, and state-specific regulatory entities. They focus on complaints from a patient and/or family about dissatisfaction with care, especially those related to adverse outcomes or patient harm. While the HCCs have no power to compel monetary settlements, they may facilitate settlement agreements between parties.

State	Health Care Complaint Commission
Queensland	Office of the Health Ombudsman (OHO)
New South Wales	Health Care Complaints Commission (HCCC)
Australian Capital Territory	ACT Human Rights Commission
Victoria	Health Complaints Commissioner (HCC)
South Australia	Health and Community Services Complaints Commissioner
Western Australia	Health and Disability Services Complaints Office (HaDSCO)
Tasmania	Health Complaints Commissioner
Northern Territory	Health and Community Services Complaints Commission

Table 1. List of Health Care Complaint Commission entities in Australia.

An initial complaint about a registered health care provider in all States and Territories apart from Qld and NSW can be made to AHPRA. In Qld, such complaints must be made to OHO and in NSW to the HCCC. These Agencies may decide to refer the complaint on to AHPRA. These complaints relate to a clinician's professional conduct, competence, or health, which impact their

capacity to deliver healthcare safely without putting the public at risk. **The process is not focused on punishing the health care provider but rather protecting the public.**

Regulatory actions versus civil claims

Right from the start, we need to distinguish the fundamental differences between **regulatory actions** and **medical negligence claims.**

A complaint made to the regulator, where AHPRA, OHO, the HCCC or the National Boards may be involved, is a disciplinary process where sanctions aim to protect the public, uphold professional standards, and maintain public confidence in regulated health professionals, not to punish the healthcare professional.

AHPRA collaborates with each of the 15 National Boards to carry out regulatory and investigatory roles. In contrast with complaints submitted to an individual health service provider (hospital or clinic) or one of the HCCs, notifications made to AHPRA relate only to complaints about an individual registered healthcare practitioner, not about overall health services.

Notifications where there is concern over a doctor professional conduct, competence or health affecting their clinical practice may be referred to the Medical Board of Australia (MBA) for investigation[1]. Where a finding of impaired practice or care is sustained, resolution methods used by the MBA may include re-education and further training, disciplinary charges and/or sanctions relating to a practitioner's medical registration.

With a civil claim for compensatory damages the focus is not to protect the public, but to financially compensate a person who has suffered injury or loss because of medical negligence. An award of damages is intended to place the injured person in the position that they were in as best money can do. The assessment of damages differs between the various States and Territories under their respective civil law reform legislation.

Establishing medical negligence

All **Australian** federal and state **jurisdictions** have an adversarial **system** for **civil law**. This means the party seeking the relief (the plaintiff) has to satisfy the requisite the burden of proof i.e., to prove their case on "the balance of probabilities".

While many medical negligence claims are the subject of ongoing litigation, very few go to trial. Those matters which do go to a hearing will result in a written judgement where the parties are named and may attract media attention.

Civil claims against private healthcare providers are often made alleging both breach of contract and negligence. With public hospitals providing healthcare to public patients there will be no contract, so a civil claim for damages will be limited to negligence.

How does a person establish negligence?

Medical negligence does not equal bad outcomes.

To establish negligence, it is not enough that there has simply been a bad outcome. More so with medical negligence than other professional negligence claims, there can often be bad outcomes in medicine without any negligence or fault on the part of the doctor or other health care provider. To establish negligence a plaintiff needs to prove, amongst other things, a breach of one's duty of care and that this breach caused the loss. The onus on proving negligence always rests with the plaintiff.

To establish medical negligence, a plaintiff must prove all of the following:

1. That a duty of care was owed by health care provider to the patient

It is generally straightforward to show that a duty of care was owed to the patient by the health care provider.

The modern law of negligence is based on principles established in a 1932 English decision, which remains one of**the most famous decisions in British legal history**, the case of Donoghue v Stevenson [1932] AC 562. This case established the concept of a duty of care through the "neighbour principle".

This case involved a young woman, Ms Donoghue, who went into a restaurant with a friend who bought her a bottle of ginger beer. After drinking most of it, she discovered decomposed remains of a snail in the bottle, and she alleged that as a result she became ill and suffered nervous shock.

There was no direct relationship between her and the retailer or the manufacturer. Her friend bought her the drink. She had no contract with the retailer or manufacturer. At that time, there were minimal means of bringing a case against a wrongdoer where there was no direct relationship. So, at first instance, Ms. Donoghue's case failed. However, on appeal, the House of Lords determined that Ms. Donoghue was entitled to damages from the manufacturer, because:

- A duty of care was owed to Ms. Donoghue from the manufacturer
- The drink was intended to reach the costumer. Therefore, the manufacturer ought to have foreseen injury to a person in the position of Ms. Donoghue

So, with this decision the **common law principle of duty of care** was established, which states:

> A duty of care is a duty to take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your "neighbour".

This leads us to the immediate question: Who in law is your neighbour?

> "Persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being affected when I am directing my mind to the acts or omissions which are called in question".

This is an evolving concept in law. It applies to anyone close enough to be directly affected by your acts or omissions and close enough that you should have their interests when considering acting in a particular way. Family members, colleagues, friends, neighbours.

The other key element in the definition of duty of care is the concept of **reasonable foreseeability**. It is an objective test, i.e., it is not what the doctor (in a medical negligence allegation) thought was foreseeable but what a reasonable person in their position should have foreseen.

The law accepts that not every risk is reasonably foreseeable, and not everyone will be your "neighbour". There are limits to the degree of foresight that the law expects of a doctor.

2. Was the duty of care breached?

Once the existence of a duty of care has been established, a plaintiff now needs to prove that the doctor or health care provider did not meet the standard of care required, and which a reasonable person in the circumstances would have provided. In other words:

A duty of care will be breached where the standard of care demanded by the law is not met.

Standard of care definition

If you like, the standard of care is an imaginary bar that health care providers must clear to escape liability.

And the bar may be set at different heights, depending on the circumstances. In some cases, the standard of care may be high, in others, relatively low.

It is not surprising that the standard of care owed by a doctor to his or her patients is high. The law sets the bar high in these cases because of the special relationship that is involved and the vulnerability of the person to whom the duty is owed.

The standard of care demanded of a HEALTH CARE PROVIDER is the standard of the reasonably skilled and experienced HEALTH CARE PROVIDER, in THE PARTICULAR field of healthcare.

3. Did the plaintiff suffer damage, injury, or loss?

The plaintiff must have suffered a foreseeable injury or loss, and the loss itself must be financially compensable. For example, grief, sorrow, and disappointment are not compensable injuries.

4. Did the breach of the duty cause the harm or injury?

The damage or loss must have been caused by the breach of the duty of care. The plaintiff must establish on the balance of probabilities that the doctor's (or healthcare provider's) breach of duty caused the loss complained of. In other words, the patient must show, on the balance of probabilities that the doctor's negligence was a cause, but not necessarily the only cause of the injury. If the probability of causation is less than 51%, the patient is not entitled to any financial compensation or 'damages'.

This is called the '**causation test**'.

Would the injury/loss have occurred even if there had been no negligence on the part of the healthcare practitioner? If so, the causation test will not be met, and the medical negligence case will fail.

Losses or injuries that are too remote will also fail the causation test. Also, suppose there has been a supervening event for which a doctor or healthcare provider is not responsible, which severs the causal chain or link between the defendant's negligence and the plaintiff's injury. In that case, the doctor or health service will not be liable for that (new) injury.

These are the steps that must be proved to establish medical negligence across all jurisdictions in Australia successfully. If negligence is established, then it is a matter of determining the quantum of damages to which the plaintiff is entitled.

After personal injury due to medicolegal negligence, the injured plaintiff must bring an action within 6 years (Victoria, Western Australia, and Australian Capital Territory) or within 3 years (New South Wales, Queensland, South Australia, Tasmania, and Northern Territory) after being first aware of the injury.

5. Causes of litigation

Common causes of ligation against healthcare practitioners are:

- Negligence
  - Failure to:
    - Diagnose a condition or delay in diagnosis.
    - Provide sufficient and/or adequate advice.
    - Disclose material risks.
    - Obtain valid informed consent.
- Trespass to the person
  - Undertaking a medical intervention that involves touching a person without his or her consent.
  - Performing any clinical intervention without a person's valid informed consent
- Breach of contract
  - Uncommon, but often combined with negligence.
  - Failure to provide care at the promised standard.

- Breach of fiduciary duty
  - Failure to keep fiduciary duties, such as:
    - Maintaining confidentiality
    - Avoiding conflicts of interest

6. Defending medical negligence claims

Civil liability legislation

A person does not breach a duty to take precautions against a risk of harm unless:

- The risk was foreseeable
- The risk was not significant
- In the circumstances, a reasonable person in the position of that person, would have taken the precautions.

In deciding whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following:

- The probability that the harm would occur if care were not taken
- The likely seriousness of the harm
- The burden of taking precautions to avoid the risk of harm
- The social utility of the activity that creates the risk of harm

There is an additional defence for professionals to be found in State and Territory legislation which reforms the common law. This defence essentially provides that with the standard of care that is required of healthcare professionals.

"A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice"

In cases where this section applies, the test is not what**the judge** thinks is competent and professional medical practice, but rather what **a health care provider's peers** think to be competent professional practice. So, with a case against an ophthalmologist the issue will be what is widely accepted by a significant number of opthalmologists as competent professional practice.

However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational or contrary to a written law. Peer professional opinion does not have to be universally accepted to be considered widely accepted.

The above test is often referred to as the Bolam test (it derives from the English decision in Bolam v Friern Hospital management Committee [1957] 1 WLR 582) and **does not apply to a failure to warn and consent cases.**

7. Case Study

Futile care and brain death

A 30-year-old, 32-week gestation primigravida lady is involved in a motor vehicle accident and is deemed to brain dead on testing. The partner claims he is a defacto and is the legal substitute decision maker. He insists on keeping his partner alive so that the baby can be born alive. He shows a newspaper article that shows this was legally undertaken in Prague and the Czech Republic.

The woman's parents do not agree and want futile treatment terminated. Please review this case as to the following in your jurisdiction and consider:

- Role of defacto partners in substitute decision making (note what are the criteria for valid defacto status?)
- Is a defacto partner higher in the hierarchy of substitute decision makers than the parents in your jurisdiction?
- Can the woman be kept alive on the defacto's request?
- Should the case be referred to the Supreme Court in your jurisdiction would the Czech case be 'highly persuasive' in making a determination?
- Make notes as to how you would approach this problem.

Further reading

Consent to Medical and Healthcare Treatment Manual (NSW Health)

Guide to Informed Decision-making in Health Care (QLD Health)

Informed consent (VIC Health)

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