

Expert Medical Evidence: The Australian Medical Association's Position

The Australian Medical Association and its members have had an increasing interest in this field for many years, with the level of interest reaching a high point with the medical indemnity crisis in 2002. With the build-up to the medical indemnity crisis, expert medical evidence, legal processes and judgments in public liability and medical negligence cases became an increasing focus for medical practitioners in Australia. Many doctors were stating their concerns that the Bolam principle had been overturned. There was a widespread concern amongst medical practitioners that sound medical scientific principles did not seem to carry relevant weight in medical negligence Court cases and that at times maverick opinions from those who were considered to be hired guns, seemed to be the favoured evidence. As a member of the Federal Council of the Australian Medical Association during that time and up to the current time, I can attest as to the intensity of feelings expressed by doctors on these issues.

Doctors are involved in giving expert evidence from two perspectives. Firstly, doctors are often called on to give expert medical evidence in all manner of legal cases, including civil actions and criminal cases. We are required to give evidence to Mental Health Tribunals, administrative Tribunals, coronial enquiries, compensation matters, family law, criminal proceedings and civil claims for damages for personal injuries, including medical negligence claims. There is wide concern in the medical community with regards to the adversarial processes involved in obtaining our opinions. There is a wide perception in the medical profession that important medical principles and reasoning often does not seem to be understood by Courts. For that reason, many medical practitioners have stated categorically that they will not be involved in providing expert medical evidence in such settings. There is concern that the medical issues are handled in a manner which makes it difficult for them to provide an accurate account in order to properly inform the Court. The doctors are interested in seeing improved expert witness processes in order that Courts and Tribunals receive properly informed, unbiased and

quality expert opinion. Secondly, medical practitioners may also be defendants in malpractice legal actions. Doctors feel that the Courts are sometimes misled into making wrong decisions as a result of hired gun or biased expert opinions being presented and not properly tested. There is concern that the legal process and the Courts seem to have difficulties in appreciating the significance of medical evidence and often have difficulty in distinguishing between evidence which is only a hypothesis and quality medical evidence. The drawn out nature of these medical negligence cases has increasingly impacted to a significant degree on medical indemnity costs. These rising costs then affect all medical practitioners, even those who do no medicolegal work and who don't ever expect to be at the wrong end of a writ. However, the costs of this are passed through to the patients in terms of higher fees and therefore to the community at large. These costs are driven not just from the damages awards but from the legal and administrative costs that accompany the proceedings. Significant contributors to this are the expert witness costs and the Court time taken in hearing the evidence. A further contributor are the settlements entered into when it is assessed that it is more economic to settle than to proceed with a long running case, be it winnable or not, in the setting of conflicting medical opinion.

The medical profession is strongly of the view that changes need to be made in order to lead to a more efficient and fairer system. Doctors have no problem with compensation where there clearly is negligence and these cases are usually settled before the matter gets to Court. Lord Woolf concluded in a report "Access to Justice Final Report, July 1996" that the taking of expert evidence is one of the two main generators of unnecessary costs of litigation. The Australian Health Minister's Advisory Council and more recently the Australian Government have recognised the contribution to medical indemnity costs of the current drawn out Court processes of taking expert medical evidence.

Doctors have in many instances been forced into a decision of adopting defensive medical practices, which has led to an increase in costs due to ordering tests that are not strictly necessary medically but are seen as part of the defence in case there is litigation. It became difficult for doctors to report systems errors that occurred under quality and

safety programs for fear of opening the door to litigation. This has all impacted on the Justice system as well, as judges have clearly been dissatisfied overall with the quality of expert medical evidence, particularly where there are conflicting opinions which have made it extremely difficult for judges to understand intricate causation issues.

Doctors generally became concerned with regards to the engaging of “hired guns” to provide opinions in medical negligence cases. It is clear that evidence tainted with bias can distort Court decisions. The Australian Medical Association’s main concerns about expert witness processes arise from the adversarial framework in which expert evidence and opinions are given. Clearly there is a need for change. Bill Madden, writing in Australian Doctor on 3 June 2005, in an article entitled “Injured Parties” stated that plaintiff lawyers are frustrated at the difficulty in finding doctors willing to give evidence in Court that is critical of other doctors. He also noted that the AMA is concerned about the quality of the evidence given. He attributed this to an AMA belief that there are patients who “win in Court because judges are misled by comment that is unduly critical”. Doctors are also concerned that many meritorious litigants get nothing. Thomas B Hugh and G Douglas Tracy, wrote in the Medical Journal of Australia, 18 March 2002, an article titled “Hindsight Bias in Medicolegal Expert Reports”. In the article the authors identified an inevitable hindsight bias in the giving of expert opinion in malpractice cases. The authors make the point that even if the experts are retained jointly or are not told whether they are providing the opinion for the plaintiff or the defendant, the fact of being asked to review the case itself indicates that something went wrong. They state that what is little known is that the studies reveal that hindsight bias is inevitable when a reviewer is aware of an adverse outcome.

The luxury of the cold, hard light of day given to the reviewer is not available to the doctor, who in the wee dark hours of the night might have to make an on the spot decision with respect to diagnosis and quick action to save a life. * This could also apply, less dramatically, to a busy general practitioner who has a six minute session to make an accurate diagnosis, with a waiting room full of sick patients. Such split second decisions do not generally have to be made by bankers, lawyers, accountants or other professionals.

They are not likely to be confronted with an unpredictable crisis and an unforeseeable situation. Doctors are concerned that in many such medical negligence cases, where a number of treatment options would have been entirely reasonable and correct treatment given the facts as they were known to the doctor at that particular time, that this does not often seem to be taken into account in Court cases where one of the treatment decisions would clearly have been the correct one, given the outcome of the case and the benefit of hindsight.

It is our belief that there are few winners when a medical negligence action goes to Court. Even if the doctor is completely exonerated of any medical negligence, the stress of years of ongoing pressure is considerable and has led to some doctors, who were valued medical practitioners in their area of expertise, ceasing that type of practice.

It is the Australian Medical Association's policy that a long-term care scheme for all Australians severely disabled, including from accidents in general and medical accidents more specifically, should be nationally adopted. Such a scheme would provide timely care for those in our community who are clearly in need of such care. Liability would not be an issue. Doctors are well aware of a considerable number of people in our community who are severely disabled but who are not receiving adequate long-term care. Some of those are waiting many years for a Court action, which may or may not be successful from their point of view. Others have no prospect of a Court action and their care is thrown back onto their families. Only a small percentage of those severely disabled in Australia, receive adequate funding for their long-term care. If such a scheme were adopted on a no fault basis, this would result in a more equitable distribution of funds to those in need of such care and would also avoid many of these individuals needing to seek compensation through Court actions. This would reflect in more manageable and affordable medical indemnity arrangements for medical practitioners, as well as private and public hospitals and other treating facilities. The Australian Medical Association through its State branches and federally, is maintaining strong advocacy for such a scheme. Contrary to a recent article in the Australian newspaper, we understand that the matter is still under serious consideration by the Australian States.

It was clear in 2002 that without government intervention, the medical indemnity industry would collapse and this would have serious ramifications in terms of the availability of medical treatment and access to doctors in Australia. The Australian Government called for State and Territory Governments to work with it to put in place nation wide tort law reforms to reduce the amount and the size of damages awards. Included in this was a call for more effective, less expensive ways of eliciting medical evidence on liability and causation issues in medical negligence cases.

In mid 2002, the Australian Government appointed Justice Ipp to chair a panel that included a medical practitioner, a consumer and an academic lawyer to receive and consider submissions and make recommendations on tort law reform. The terms of reference included the taking of expert medical evidence. The Ipp Panel Report acknowledged that there was deep dissatisfaction with expert evidence due to conflicting expert testimony and the growth in the expert evidence industry leading to a perception of partisan bias. The panel recommended that consideration be given to implementing trials of a system of court-appointed experts. The panel suggested elements to underpin the system of Court appointed experts. The panel also recommended that the “standard of care” test be revised to that of a modified Bolam test. That is, the medical practitioner is not negligent if the treatment provided was in accordance with medical opinion, so long as the medical opinion is widely held by a significant number of respected practitioners and unless the Court considers the opinion to be irrational.

After the 4,000 doctors rallied at the Randwick Racecourse on 28 September 2003, the Federal Government further elevated its action to curb the cost of medical professional indemnity cover in order to keep doctors working. The next day, 29 September 2003, Prime Minister Howard announced that Tony Abbott would take over ministerial responsibility for Health and Ageing. Mr Abbott then announced that he would head a Medical Indemnity Policy Review Panel. The AMA’s then president Dr William Glasson, the chair of its medical indemnity task force Dr Andrew Pesce, and two other doctors, a banker and an insurance lawyer, took part and considered submissions from

interested parties. By this time the Government had thrown a packet of money into the medical indemnity industry. The Abbott panel saw the need for more money. The focus of the funding is on reducing indemnity costs by subsidising higher claims costs. Its report to the Government of 10 December 2003, approved in principle State based Medical Assessment Review Panels to review claims of medical negligence before claims could proceed to Court. It was thought that this would allow early pinpointing of liability and causation issues and elicit relevant expert medical opinion in a non-adversarial setting. However, that idea had a short life and the lawyers won that round.

After lengthy deliberations in the Australian Medical Association, in early 2005 the Australian Medical Association Policy as follows, was adopted:

The AMA supports a nationally coordinated approach to the taking of expert evidence that in the context of the current adversarial civil litigation framework, provides for the following:

That parties to a proceeding select their expert medical witnesses in compliance with the following:

- Each party to a proceeding is entitled to select the expert witnesses of their choice for the purpose of providing evidence to the Court, and other than in exceptional circumstances, each party is limited to only one expert in each field of expertise in dispute before the Court.
- Each chosen expert is to be provided with identical information, that is, they should be provided with the same documentation and be asked to base their opinion or opinions on identical, if various, factual scenarios that the parties to the proceedings hope to establish.
- The expert witnesses in the same fields should be briefed jointly by the parties or separately, so long as the briefing documentation is agreed on or exchanged between the parties to the proceedings.
- Procedural time limits should be imposed to prevent the process being obstructed by the delay of one or another of the parties.

That Court appointed medical practitioners are provided to assist judges in accordance with the following:

- In the event that a case proceeds to hearing and medical issues remain in contention the Court, on hearing from the parties, would determine at a directions hearing whether the case complexities require a Court appointed medical practitioner to assist the judge at the hearing. The advisor will be drawn from the Court's preappointed panel of advisors.
- Court medical advisors are to be selected in accordance with normal selection criteria for part-time or full-time statutory appointments for a limited term of three to five years (this currently occurs in the Professional Services Review Tribunal, the AAT and other Tribunals), by selection committees that include a College or Association medical representative.
- The medical advisor would sit with the judge in Court. The medical advisor's role is limited to assisting the judge in understanding the evidence, advising on what other information might be required, and suggesting questions that might be asked of the parties or witnesses. The medical advisor does not need to be qualified in a specialist field relevant to the issues before the Court. The advisor would not have decision-making power, nor would they advise on outcomes or provide their own opinion.

Consideration may be given to appointing a specialist from the medical field particularly involved with causation issues as the doctor advising the Judge.

By way of clarification, the above assumes that Court procedures require the parties to identify the areas in dispute that are likely to require expert evidence, and that pre-trial procedures will incorporate mechanisms to ensure that the selected experts confer to reach agreement on what matters are agreed and what matters remain in contention that require expert opinion evidence.

It was considered that if each of the parties had to make a choice of one expert they would select a credible expert to minimise the risk of a biased expert or a hired-gun having their credibility damaged by cross examination. This should lead to a higher standard of evidence being presented to the Court.

The model of a medical practitioner assisting the judge is well established in the Mental Health Court in Queensland, where two expert psychiatrists assist the judge and the workings of this Court have resulted in a high level of acceptance by all parties involved. This Court addresses difficult medicolegal situations and the model would seem to have worked well.

It is not the AMA's aim only to contain indemnity costs. The AMA want to get the process right. It is our aim to see a dispute resolution model that meets with the favour of not just the medical profession but also patients and the community as a whole. The Royal Australian and New Zealand College of Psychiatrists have produced ethical guidelines and procedural guidelines for Fellows of the College to refer to with respect to preparing medicolegal reports and expert medical evidence. Adherence to these guidelines will lead to higher standards of medical psychiatric evidence being presented to Courts. However, if these guidelines are to be effective, lawyers including solicitors, barristers and judges should be aware of the guidelines in order to ensure that the reports and presentation of expert medical evidence are in accord with these guidelines.

It is the AMA's aim to promote a higher standard of expert medical evidence presented to Courts and we believe that this can be achieved if all parties work together on developing the necessary changes.