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EDITORIAL – *Ian Freckelton*

Regulation of health practitioners: National reform in Australia

From the second half of 2010 Australia has had a uniform regime for registration of health practitioners and, with the exception of New South Wales, a nationally consistent scheme for regulation of a number of categories of health practitioners. This entails a move toward validation requirements, a continuing focus on protection of titles as the principal regulatory mechanism, and an identification of those professions currently suitable for formal registration and regulation. This editorial discusses issues arising from the new national regulatory arrangements, controversies about the distinction between “conduct” and “performance” investigations, challenges in relation to assessment of impairment and what constitutes a “fit and proper person” as well as issues arising from the mandatory notification provisions within the legislation. 207

LEGAL ISSUES – *Danuta Mendelson*

Economic impact of *Wicks v State Rail Authority (NSW)* (2010) 84 ALJR 497 – *Danuta Mendelson, Andrew Torre and Michael D’Rosario*

In *Wicks v State Rail Authority (NSW)* (2010) 84 ALJR 497 the High Court of Australia held that, among other things, plaintiffs (who establish that they suffer a recognised psychiatric illness as a result of the breach of duty of care owed to them by the defendant under s 32 of the *Civil Liability Act 2002* (NSW)) are entitled to recover damages for pure mental harm under s 30 if their psychiatric injury arose “wholly or partly from” a “series of shocking experiences” in the form of “a sudden and disturbing impression on the mind and feelings” in connection with witnessing at the scene “another person (‘the victim’) being killed, injured or put in peril by the act or omission of the defendant”. The High Court construed the phrase “being ... injured or put in peril” to include plaintiffs who suffer pure mental harm by witnessing at the scene another person being injured through the process of suffering pure mental harm in the form of psychiatric injury occasioned by the defendant’s negligent act or omission. The *Wicks* decision raises the question whether the expanded liability of defendants for pure mental harm is economically sustainable. 221

MEDICAL ISSUES – *Russ Scott*

DNA evidence in jury trials: The “CSI effect” – *Russ Scott and Catherine Skellern*

In *Murdoch v The Queen* (2007) 167 A Crim R 329, *Hillier v The Queen* (2007) 228 CLR 618 and *Forbes v The Queen* (2009) 167 ACTR 1, Australian appellate courts considered the interpretation of DNA evidence and the possibility of secondary transfer of DNA samples and questions about the statistical calculations used to produce probabilities of DNA matches. Following the 2010 Victorian case of Farrah Jama, whose conviction for rape was quashed 16 months into his prison sentence after it was discovered that the incriminating DNA sample was contaminated, Mr FRH Vincent QC, in his report to the Victorian Attorney-General, was scathing of the conduct of the case and made a number of recommendations, all of which were immediately adopted by the Victorian Government. Following the release of the Vincent Report, Australia’s Attorneys-General have

established a working party to examine national standards for the use and collection of DNA evidence. The use and interpretation of DNA evidence in jury trials is considered and factors that improve jury understanding of DNA evidence are discussed. 239

BIOETHICAL ISSUES – *Grant Gillett*

Vitamin C: Ascerbic ethical discussions – *Grant Gillett*

The issue of a patient's rights to demand treatment has recently been raised by a dramatic case in which a patient made a remarkable recovery following the use of an unconventional treatment that the hospital staff initially refused to administer. The normal position in such cases is that the relatives can take part in a clinical decision but the medical staff are bound to make it according to a clinical assessment of the best interests of the patient. That assessment is only required to take into account what would be regarded as acceptable regimens of treatment for the patient's condition. There is no ethical or legal basis for the patient's relatives being able to demand any treatment that the clinical team do not consider indicated nor to demand a highly unconventional treatment. The case therefore poses a problem. When should we allow ourselves to be persuaded to step outside the bounds of accepted medical practice at the urging of relatives or patients? There are plausible arguments that a demonstration of efficacy in a particular patient or some reputable evidence of probability of efficacy would both be good enough grounds. In addition, one could argue that where the patient's predicted clinical course is terminal, then desperate measures of unproven efficacy can be tried in that the balance of harm and benefit cannot be further worsened. The implication of the actual events in the case in question is that a certain humility in the light of the incompleteness of medical knowledge is always appropriate and an objective weighing of the facts of the case, free from prejudicial theoretical commitments, is needed in the face of medical uncertainty. 263

NURSING ISSUES – *Kim Forrester*

What you see may not be what you get: Beware of patients bearing gifts – *Kim Forrester*

The professional boundaries of practice for nurses and midwives are specifically addressed in professional codes of ethics and conduct, employer policies and guidelines and more frequently in the professional literature. There are many forms in which boundary violations and boundary crossings may present or circumstances in which they may occur. This column considers a recent case (involving a bequest to a registered nurse under a will) which came before the Queensland Nursing Tribunal. The decisions of the tribunal, the District Court and the Court of Appeal provide practical guidance to nurses and midwives on the importance of establishing and maintaining the professional boundaries essential to the therapeutic relationship with their patients and clients. 268

MEDICAL LAW REPORTER – *Thomas Faunce*

The High Court's lost chance in medical negligence: *Tabet v Gett* (2010) 240 CLR 537 – *Thomas Faunce and Alexandra McEwan*

In 2010 the High Court of Australia in *Tabet v Gett* (2010) 240 CLR 537 determined an appeal in a medical negligence case concerning a six-year-old girl who had presented to a major paediatric hospital with symptoms over several weeks of headaches and vomiting after a recent history of chicken pox. The differential diagnosis was varicella, meningitis or encephalitis and two days later, after she deteriorated neurologically, she received a lumbar puncture. Three days later she suffered a seizure and irreversible brain damage. A CT scan performed at that point showed a brain tumour. As Australia does not have a no-fault system providing compensation to cover the long-term care required for such a

condition, the girl (through her parents and lawyers) sued her treating physician. She alleged that, because a cerebral CT scan was not performed when clinically indicated after the diagnosis of meningitis or encephalitis and before the lumbar puncture, she had “lost the chance” to have her brain tumour treated before she sustained permanent brain damage. She succeeded at first instance, but lost on appeal. The High Court also rejected her claim, holding unanimously that there were no policy reasons to allow recovery of damages based on possible (less than 50%) “loss of a chance” of a better medical outcome. The court held that the law of torts in Australia required “all or nothing” proof that physical injury was caused or contributed to by a negligent party. The High Court, however, did not exclude loss of chance as forming the substance of a probable (greater than 50%) claim in medical negligence in some future case. In the meantime, patients injured in Australia as a result of possible medical negligence (particularly in the intractable difficult instances of late diagnosis) must face the injustice of the significant day-to-day care needs of victims being carried by family members and the taxpayer-funded public hospital system. The High Court in *Tabet v Gett* again provides evidence that, as currently constituted, it remains deaf to the injustice caused by State legislation excessively restricting the access to reasonable compensation by victims of medical negligence. 275

ARTICLES

Legal regulation of the drug khat in Australia – Heather Douglas and Merali Pedder

The plant *Catha edulis*, known more commonly as khat, has been consumed for centuries for its stimulatory effects, especially by people living in East Africa. As people from Somalia, Ethiopia and other East African countries have migrated to Australia, they have brought with them the practice of chewing khat. This article examines the claims made about the effects of khat on health and wellbeing and explores the approaches to the regulation of khat in Australia and overseas. The article concludes with a discussion of some of the concerns associated with current regulatory approaches and makes some suggestions for reform. 284

Recovering fraudulent claims for Australian federal expenditure on pharmaceuticals and medical devices – Thomas Faunce, Gregor Urbas, Lesley Skillen and Marc Smith

The Australian Federal Government expends increasingly large amounts of money on pharmaceuticals and medical devices. It is likely, given government experience in other jurisdictions, that a significant proportion of this expenditure is paid as a result of fraudulent claims presented by corporations. In the United States, legislation such as the *False Claims Act 1986* (US), the *Fraud Enforcement and Recovery Act 2009* (US), the *Stark (Physician Self-Referral) Statute 1995* (US), the *Anti-Kickback Statute 1972* (US), the *Food, Drug and Cosmetic Act 1938* (US), the *Social Security Act 1965* (US), and the *Patient Protection and Affordable Care Act 2010* (US) has created systematic processes allowing the United States Federal Government to recover billions of dollars in fraudulently made claims in the health and procurement areas. The crucial component involves the creation of financial incentives for information about fraud to be revealed from within the corporate sector to the appropriate state officials. This article explores the opportunities for creating a similar system in Australia in the health care setting. 302

The strengths and limitations of empirical bioethics – KA Strong, W Lipworth and I Kerridge

The past two decades have been witness to an “empirical turn” in bioethics. Whereas once this field of study concerned itself purely with theoretical analysis of ethical issues emerging in the design and delivery of health care, increasingly bioethics has embraced a range of empirical research methods from the social sciences and humanities. The

emergence of “empirical bioethics” has, however, been the subject of enormous debate, both in regard to its methods and its purpose. For the most part these criticisms fail to appreciate the assumptions that underpin empirical bioethics or misrepresent the claims that are made about its moral utility. This article provides a brief account of the assumptions, strengths and limitations of empirical bioethics. 316

Proof of causation in informed consent cases: Establishing what the plaintiff would have done – *Tina Cockburn and Bill Madden*

A degree of judicial caution in accepting the assertion of a plaintiff as to what he or she would have done, if fully informed of risks, is clearly evident upon a review of decisions applying the common law. Civil liability legislation in some jurisdictions now precludes assertion evidence by a plaintiff. Although this legislative change was seen as creating a significant challenge for plaintiffs seeking to discharge the onus of proof of establishing causation in such cases, recent decisions suggest a more limited practical effect. While a plaintiff’s ex post facto assertions as to what he or she would have done if fully informed of risks may now be inadmissible, objective and subjective evidence as to the surrounding facts and circumstances, in particular the plaintiff’s prior attitudes and conduct, and the assertion evidence of others remains admissible. Given the court’s reliance on both objective and subjective evidence, statistical evidence may be of increasing importance. 320

Compensation for workplace injury leading to suicide in Australia – *Robert Guthrie and Jennifer Westaway*

Workplace-related death by suicide raises a number of difficult issues in the context of workers compensation. On first reading, workers compensation statutes usually prevent recovery of compensation where an injury is self-inflicted, suggesting that compensation for suicide will be excluded. Additionally, compensation is usually denied when the nexus between employment and injury is broken which is frequently the defence to any claim by the dependants of workers who takes their own life following a work injury. This article examines the Australian landscape in relation to the evolution of principles that apply to consideration of workers compensation claims where suicide is an element. 333

Privacy of bodily samples – *Jennifer Falcon*

Privacy law in Victoria does not cover human tissue and other bodily samples. To ensure that individuals have some control over how their samples are collected, used and transferred, legislative amendments are required. Can concerns raised by the Australian Law Reform Commission about the lack of privacy protection afforded to bodily samples be addressed in the *Human Tissue Act 1982* (Vic)? 344

Law, autonomy and advance directives – *Lindy Willmott, Ben White and Ben Mathews*

The principle of autonomy underpins legal regulation of advance directives that refuse life-sustaining medical treatment. The primacy of autonomy in this domain is recognised expressly in the case law, through judicial pronouncement, and implicitly in most Australian jurisdictions, through enactment into statute of the right to make an advance directive. This article seeks to justify autonomy as an appropriate principle for regulating advance directives and relies on three arguments: the necessity of autonomy in a liberal democracy; the primacy of autonomy in medical ethics discourse; and the uncontested importance of autonomy in the law on contemporaneous refusal of medical treatment. This article also responds to key criticisms that autonomy is not an appropriate organising principle to underpin legal regulation of advance directives. 366

Queensland general practitioners' applications of the "mature minor" principle: The role of patient age and gender – Anna Teoludzka and Terence P Bartholomew

Most Australian jurisdictions do not have legislation that stipulates an age by which a minor can make their own medical treatment decisions. Instead, they rely on *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, an English common law decision that recommends individual assessments of "maturity". This study explores how medical practitioners in the State of Queensland understand and apply this legal authority when faced with a young person wishing to make a contentious medical treatment decision. Almost 200 doctors made decisions about a hypothetical patient's competence and confidentiality, and detailed their reasoning in an open-ended format. The data indicate that the vagaries of existing legal criteria allow for a range of philosophical perspectives and idiosyncratic heuristics to play a role in assessment practices, and that particular combinations of patient age and gender made these cognitive shortcuts more likely to occur. A notable proportion of such processes are not consistent with legal guidelines, and this has implications for general practitioners' vulnerability to litigation as well as young patients' treatment trajectories.

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The role of coronial autopsies in a context of decreasing hospital autopsies: An investigation of the issues – Belinda Carpenter, Gordon Tait, Linda Jonsson, Heiko Peschl, Charles Naylor and Aurora Bermudez-Ortega

This article scrutinises the argument that decreasing hospital autopsy rates are outside the control of medical personnel, based as they are on families' unwillingness to consent to autopsy procedures, and that, as a consequence, the coronial autopsy is the appropriate alternative to the important medical and educational role of the autopsy. It makes three points which are well supported by the research. First, that while hospital autopsy rates are decreasing, they have been doing so for more than 60 years, and issues beyond the simple notion of consent, like funding formulae in hospitals, increased technology and fear of litigation by doctors are all playing their part in this decline. Secondly, the issue of consent has as much to do with families not being approached as with families declining to give consent. This is well supported by recent changes in hospital policy and procedures which include senior medical personnel and detailed consent forms, both of which have been linked to rising consent rates in recent years. Finally, the perception that coronial autopsies are beyond familial consent has been challenged recently by legislative changes in both Australia and the United States of America which allow objections based on religion and culture to be heard by coroners. For these reasons, it is argued that medical personnel need to focus on increasing hospital autopsy rates, while also addressing the complex ethical issues associated with conducting medical research within the context of the coronial autopsy.

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