Medical Negligence and Mental Harm: 
Practitioner Perspectives on Challenges in Litigation and Mediation

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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January 2018
DECLARATION

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis/project is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

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Martina Popa
January 2018
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ADR</td>
<td>Appropriate/Alternative Dispute Resolution</td>
</tr>
<tr>
<td>GEPIC</td>
<td>Guide to the Evaluation of Psychiatric Impairment for Clinicians</td>
</tr>
<tr>
<td>HCA</td>
<td>High Court of Australia</td>
</tr>
<tr>
<td>Ipp Panel</td>
<td>Panel of Eminent Persons to Review the Law of Negligence consisting of Justice D Ipp, Professor P Cane, Associate Professor D Sheldon and Mr I MacIntosh</td>
</tr>
<tr>
<td>NADRAC</td>
<td>National Alternative Dispute Resolution Advisory Council</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NIIS</td>
<td>National Injury Insurance Scheme</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>PJ</td>
<td>Procedural Justice</td>
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<tr>
<td>RJ</td>
<td>Restorative Justice</td>
</tr>
<tr>
<td>TJ</td>
<td>Therapeutic Jurisprudence</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
</tr>
<tr>
<td>VCEC</td>
<td>Victorian Competition and Efficiency Commission</td>
</tr>
<tr>
<td>Wrongs Act</td>
<td><em>Wrongs Act 1958</em> (Vic)</td>
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</table>
ABSTRACT

In early 2000, Australia experienced a medical insurance ‘crisis’ due to a surge in medical negligence litigation and many publicised instances of hefty compensation payouts. Sustained critique of the compensation system prompted state and federal governments to commission an enquiry, known as the ‘Ipp Report’. Australian states reacted to the crisis by enacting legislative amendments in their respective civil liability legislation which are referred to as the ‘Ipp Reforms’. In Victoria reforms were made to the Wrongs Act 1958 (Vic) (‘Wrongs Act’), limiting entitlement to compensation in negligence disputes, introducing permanent injury thresholds, imposing caps on damages and implementing a statutory test of causation. The impact of the Ipp Reforms was drastic. Prominent Australian academics questioned whether the rights of plaintiffs with meritorious negligence claims were unfairly curtailed or denied altogether. For the purposes of this research, these are considered as the first tranche of medical negligence reforms under review.

A decade later, public debate about the compensation system led to the commissioning of a 2014 report by the Victorian Competition and Efficiency Commission. The Victorian government adopted many of the recommendations in the report through the 2015 amendments to the Wrongs Act. This second tranche of legislative amendments attempted to achieve a better balance between the need for affordable insurance premiums and the need to compensate the meritorious claims of individuals who have suffered loss or damage. This research demonstrates that medical negligence legal practitioners and judges perceive that current medical negligence injury thresholds are too high, and that compensation caps continue to be set too low, so that the current systems fails to meet the financial needs of victims.

The aim of this doctoral research was to gather reflections from senior tort lawyers, barristers and sitting judges about continuing challenges in both litigation and mediation of medical negligence and mental harm claims. Part One of this thesis explores the background of the initial insurance crisis, resultant legislative changes, the 2015 remedial amendments and the perceived effect of law reform on disputants’ rights. Part Two of this thesis explores how mediation operates in the shadow of the law, and particularly examines lawyers and parties’ emotional and non-legal needs in the mediation of medical negligence claims. The research seeks to establish the effects that the 2002-2003 law reforms have exerted on the litigation
and mediation of meritorious medical negligence claims from the perspective of practising medical negligence lawyers, and sitting judges with medical negligence experience. The research is grounded in interpretivist epistemology, and uses a doctrinal and qualitative methodological design. Research data was gathered through semi-structured interviews with 24 legal practitioners comprising senior tort lawyers, barristers and Victorian judges with medical negligence experience. The researcher used grounded theory as the theoretical framework to analyse the data.

Analysis of the data through the lens of corrective justice theory shows the research participants perceived that injury thresholds, caps on damages and the statutory principle of causation continue to present high hurdles in both progressing medical negligence and mental harm claims, and obtaining fair compensation. This finding supports the contention that the 2015 amendments to the Wrongs Act are inadequate to remedy the adverse effects of the 2002-2003 Ipp Reforms, and thus indicates that further reform is required to ensure the law achieves a more reasonable balance between the competing needs of claimants and insurers.

The findings indicate that consideration of emotion is an important but often neglected stage of medical negligence mediation. There was general acknowledgement from research participants that they neglected to exploit the unique opportunity that mediation offers individuals to express emotion in a way that assists emotional closure. The research participants endorsed the value of mediation, perceiving their role as advising on the law and settlement options. Some participants identified their role as a ‘translator’ of the legal system during negotiation in mediation, attempting to promote understanding of realistic parameters of settlement. As repeat players, the research participants demonstrated a strong tendency to shield their clients from the legal system, with the resultant effect of controlling and dominating the mediation process. Practitioner participants discouraged their clients from speaking in mediation and largely acted as spokesperson, although some clients expressed their wish to speak. These insights and perceptions about the culture in this area of legal practice prompt the question whether, in the area of medical negligence, it is advisable for lawyers to allow their clients the prospect of greater engagement in the legal process to facilitate emotional closure from the experience.

This research thesis breaks new ground as the first study in Victoria exploring the efficacy of the Victorian medical negligence compensation process, from the perspective of the legal
practitioner. This research significantly contributes to legal theory and also contributes to practice by making recommendations for law reform based on the perceptions gathered on contemporary challenges in the litigation and mediation of medical negligence and mental harm claims.
CHAPTER 1 – INTRODUCTION

1.1 RESEARCH BACKGROUND

Australian patients who become victims of medical negligence, such as misdiagnosis or surgery error, often sustain devastating injuries and rely on the legal system to obtain financial compensation to assist in managing life after injury. The medical practitioners occasioning the medical error are indemnified through insurance companies who manage the claims and provide compensation if damages are awarded. By 2002, myriad factors were impacting the high cost and availability of medical indemnity insurance. Australia found itself in an insurance ‘crisis’ due to a legal compensation system perceived as ‘out of control’.¹ Australia’s second largest insurance company, HIH Group, collapsed; Australia’s largest medical defence organisation, United Medical Protection, fell into liquidation;² substantial compensation payouts received highly publicised awards; and litigation surged due to the rise of ‘no-win, no-fee’ firms.³

In response, all Australian state and federal governments commissioned a report into the law of negligence, headed by the Hon. David Ipp and titled Review of the Law of Negligence Report⁴ (‘Ipp Report’) which was released in September 2002. The Ipp Panel was charged with reformulating the common law to limit liability and limit the quantum of damages in personal injury cases.⁵ The Ipp Report led to the ‘Ipp Reforms’, a suite of amendments to each state’s civil liability legislation. The focus of this empirical research is the state of Victoria, where amendments were made to the Wrongs Act 1958 (Vic) (‘Wrongs Act’) severely restricting amounts of compensation paid to victims of medical negligence, resulting in a legal compensation system which was not meeting the financial needs of medical negligence victims. This raises a fundamental question: what is the fairest regulatory

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⁴ Panel of Eminent Persons to Review the Law of Negligence, Review of the Law of Negligence Report, Second Report, Canberra, October 2002 (‘Ipp Report’), xiii. In this thesis reference is made to the panel as the ‘Ipp Panel’ and to the report as the Ipp Report, as the chair of the panel was the Honourable David Ipp.
⁵ Ipp Report, above n 4, 26.
framework that can be implemented to allow victims to pursue their rights? The balance between the needs of medical negligence victims and the cost of the compensation claims is a dilemma for the justice system, which requires exploration and ultimately, rectification.

Australian law aims to provide avenues of relief in circumstances where members of society have had their legal rights infringed, allowing individuals to seek redress through the courts, or alternative/appropriate dispute resolution (‘ADR’) options. In particular, the law of torts plays a key role in determining whether responsibility for an individual’s loss should be shifted to the tortfeasor who has committed the civil wrong. The tort of negligence allows a person who has suffered a loss, as a consequence of the tortfeasor’s failure to take reasonable care, to sue for compensation. To prove negligence, a plaintiff must prove three factors: the defendant owed them a duty of care; the defendant breached their duty; and the breach caused the harm. Causation, the third criterion, can be a high hurdle to successful attainment of compensation, as a plaintiff may be unable to satisfy a clear causal link between breach of the duty of due care and the injury sustained. Of the three elements, this thesis will focus on the element of causation as it can be a real barrier that prevents plaintiffs from recovering compensation in meritorious claims.

Medical negligence is a niche subset of the broader category of negligence, referring to negligence arising in the course of treatment by a doctor, nurse or other health care worker. There are two types of harm in medical negligence: physical and psychological/psychiatric (termed ‘mental harm’). Both types of harm may arise in the course of medical treatment. A

7 Dispute resolution processes other than trial were initially collectively referred to as ‘alternative dispute resolution’. However, in recent times a preference has emerged for ‘appropriate dispute resolution’ or simply ‘Dispute Resolution’ amongst commentators: see Michael King et al, Non-Adversarial Justice (Federation Press, 2nd ed, 2014) 96 and Laurence Boule and Rachael Field, Australian Dispute Resolution: Law and Practice (LexisNexis, 2017) 38-39.
10 For a comprehensive discussion on the principle of causation see Ian Freckelton and Danuta Mendelson (eds), Causation in Law and Medicine (Dartmouth Publishing Company, 2002).
medical practitioner will be held liable, but only if the plaintiff can satisfy (in court) that a breach of a duty of care occurred and that the breach has caused damage.\textsuperscript{13}

Plaintiffs in medical negligence, or mental harm cases, often suffer serious loss and subsequent disabilities which can impact their lives permanently. In the seminal case of \textit{Rogers v Whitaker},\textsuperscript{14} a patient who was already blind in one eye lost sight in her other eye as a result of the doctor’s failure to warn of risks associated with the medical procedure. A medical practitioner can be held liable for failure to warn of material risks,\textsuperscript{15} for negligent treatment (such as surgical errors)\textsuperscript{16} or for a delayed diagnosis or misdiagnosis.\textsuperscript{17} Medical practitioners can also be held liable in specific situations such as unwanted pregnancy (considered a separate category of medical negligence termed ‘wrongful birth’).\textsuperscript{18} Extant case law shows that no liability exists for ‘wrongful life’\textsuperscript{19} or for loss of a chance of a better outcome.\textsuperscript{20}

Claims for mental harm may also arise in the context of medical negligence, whether as a result of physical injury to the patient, or injury to a third party such as a child.\textsuperscript{21} The \textit{Wrongs Act} draws a distinction between ‘pure mental harm’ where the plaintiff has sustained psychological or psychiatric harm without physical injury and ‘consequential mental harm’ where the mental injury develops as a consequence of the physical injury.\textsuperscript{22} The Australian legal provisions depart from the British position where victims who have sustained mental harm are categorised as either a ‘primary victim’ or a ‘secondary victim’.\textsuperscript{23} In the United Kingdom (‘UK’) primary victims are individuals who have developed psychiatric conditions

\textsuperscript{13} For a comprehensive explanation of negligence in healthcare see Ben White, Fiona McDonald and Lindy Willmott, \textit{Health Law in Australia} (Lawbook Co, 2\textsuperscript{nd} ed, 2014) 259-334.
\textsuperscript{14} (1992) 175 CLR 479.
\textsuperscript{15} \textit{Rogers v Whitaker}(1992) 175 CLR 479; \textit{Hookey v Paterno} (2009) 22 VR 362. Special leave to the HCA was denied: see \textit{Hookey v Paterno} [2009] HCA Trans 226 (4 September 2009).
\textsuperscript{17} \textit{McKay v McPherson} [2010] VCC 585 (11 June 2010).
\textsuperscript{19} \textit{Harriton v Stephens} (2006) 226 CLR 52. ‘Wrongful life’ refers to legal action taken by a severely disabled child (or their parents) who sues a defendant (usually a medical practitioner) for failing to prevent the child’s birth.
\textsuperscript{20} \textit{Tabet v Gett} (2010) 240 CLR 537. An action for loss of chance in medical negligence arises where a plaintiff cannot establish that the defendant’s negligence caused their injury, so instead they contend the defendant’s negligence deprived them of the chance of a better outcome.
\textsuperscript{22} \textit{Wrongs Act 1958} (Vic) s 67.
\textsuperscript{23} \textit{Alcock v Chief Constable of South Yorkshire Police} [1992] 1 AC 310, 407.
associated with physical bodily harm, whereas secondary victims have sustained pure mental harm as a result of witnessing the death or injury of another individual.\textsuperscript{24}

In Australia, the legislation does not distinguish between primary and secondary victims. In Victoria, a duty of care is not owed for pure mental harm ‘unless the defendant foresaw or ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken.’\textsuperscript{25} Additional limits are imposed so that individuals are prevented from recovering damages for pure mental harm, unless the harm arose from a single shock, and the plaintiff either ‘witnessed, at the scene, the victim being killed, injured or put in danger’ or ‘the plaintiff is or was in a close relationship with the victim.’\textsuperscript{26} In the medical context, a claim for ‘pure mental harm’ can arise where a doctor’s negligent treatment to the patient causes a third party (such as a family member) to suffer psychiatric harm. For example, in \textit{Sorbello v South Western Sydney Local Health Network; Sultan v South Western Sydney Local Health Network} the parents of a child, who was injured due to oxygen deprivation at birth, sued the hospital for compensation for psychiatric injury sustained by them as a result of the physical injuries caused to the child.\textsuperscript{27}

The \textit{Wrongs Act} provisions also outline circumstances where damages may be sought for ‘consequential mental harm’. Damages cannot be recovered unless, ‘the defendant foresaw or ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken’.\textsuperscript{28} This section is worded with the same test outlined above, but applies to a different category of mental harm. In assessing the circumstances of the case, a court can take into consideration the physical injury to the plaintiff out of which the mental harm arose.’\textsuperscript{29} In this thesis, the use of the term mental harm is intended to encapsulate both pure mental harm and consequential mental harm which occurred as a result of medical injury.\textsuperscript{30}

\textsuperscript{24} \textit{Ibid.}
\textsuperscript{25} \textit{Wrongs Act 1958 (Vic) s 72.}
\textsuperscript{26} \textit{Ibid s 73(2).}
\textsuperscript{27} [2016] NSWSC 863 (24 June 2016).
\textsuperscript{28} \textit{Wrongs Act 1958 (Vic) s 74(1).}
\textsuperscript{29} \textit{Ibid s 74(2).}
\textsuperscript{30} On some occasions participants’ responses also referred to mental harm claims which were not limited to the medical context, particularly to emphasise the challenges of pursuing those claims in negligence more broadly.
Once a plaintiff has established the three elements of negligence in legal proceedings, the plaintiff must demonstrate that they have suffered an injury which satisfies specific statutory requirements to qualify for damages for economic and/or non-economic loss. The Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002 (Vic) introduced provisions limiting damages for economic loss to three times average weekly earnings and a cap on non-economic loss damages. Statutory thresholds were introduced in 2003 through the Wrongs and Limitations of Actions Acts (Insurance Reform) Act 2003 (Vic) and were designed to limit damages paid in personal injury claims. Prior to their introduction, no such thresholds existed under the common law.

Economic loss relates to the plaintiff’s lost income and ability to work. The maximum amount for loss of earnings is capped at three times the average weekly earnings. Plaintiffs can also make a claim for non-economic loss which encompasses pain and suffering, loss of amenities of life and loss of enjoyment of life, but only where the individual has sustained a permanent and ‘significant injury’. To qualify as a ‘significant injury’, the injury must be assessed by an independent medical practitioner using the American Medical Association’s Guides to the Evaluation of Permanent Impairment (5th edition) (‘AMA Guides’) at ‘more than 5 per cent’ impairment for physical injury, ‘equal to 5 per cent’ for spinal injuries, or ‘equal to 10 per cent’ for psychological injuries. Psychiatric injuries are assessed pursuant to the Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC).

If a plaintiff can demonstrate that a breach of duty has caused a ‘permanent injury’ which meets the prescribed threshold, that plaintiff is entitled to compensation. Unlike other jurisdictions such as New Zealand, Australia operates a fault-based tort compensation system, meaning plaintiffs are required to pursue legal action in the courts and satisfy the elements of negligence to attain damages. Successful plaintiffs are compensated by

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31 Wrongs Act 1958 (Vic) s 28F. As at November 2017, the Average Weekly Earnings are set at $1,628.10. Multiplied by three, this equates to $4,884.30.
32 Ibid s 28B.
33 Ibid s 28LF.
35 Wrongs Act 1958 (Vic) s 28LB defines the threshold level for significant injury assessment.
37 In contrast, a no-fault compensation would require an injured person to show they have sustained a ‘treatment injury’ and to apply to the Accident Compensation Corporation of New Zealand for financial compensation.
insurance companies, whose role is to indemnify medical practitioners. Medical indemnity is a framework to redress adverse healthcare outcomes arising from a breach of expected standards of care in medical treatment.\textsuperscript{38} Indemnification through insurance companies plays a critical role in medical negligence because once a claim is commenced, the insurer (or their legal representatives) manages the claim and finances compensation if damages are awarded. Australia’s fault-based tort system has been criticised by scholars as ‘slow, costly, inefficient, stressful and often inequitable and unpredictable’.\textsuperscript{39} Resolving disputes can be protracted and complex as litigation is known to be a key stressor for disputants,\textsuperscript{40} and inequities can arise where a claimant has sustained an injury, but is unable to satisfy the legal requirements for compensation.\textsuperscript{41}

1.1.1 THE FIRST TRANCHE OF REFORMS: THE 2002-2003 IPP REFORMS

Based on the recommendations contained in the Ipp Report, each Australian state government implemented law reforms in their respective civil liability legislation affecting medical negligence and mental harm claims. The recommendations adopted by the Australian state governments varied, with some states introducing statutory amendments to existing legislation and others retaining common law principles.\textsuperscript{42} Each state selected areas for reform arising out of the Ipp Report recommendations, hence the reforms across Australia vary significantly and the resultant changes are not uniform for each state.\textsuperscript{43} The Ipp Reforms affect all personal injury claims arising out of negligence by imposing statutory provisions for principles which were previously governed by the common law.\textsuperscript{44} These reforms created additional barriers for claims with a lower level of impairment, and they adversely impacted


\textsuperscript{41} Weisbrot and Breen, above n 39, 296.

\textsuperscript{42} For an overview of the civil liability regime in each Australian jurisdiction refer to Annexure 1 of this thesis.

\textsuperscript{43} A comprehensive explanation of the reforms implemented in the Australian states is outside of the scope of this thesis as the reforms varied significantly. For an overview see James J Spigelman, ‘Tort Law Reform: An Overview’ (2006) 14(1) \textit{Tort Law Review} 5.

\textsuperscript{44} For example, the case of \textit{Wyong Shire Council v Shirt} (1980) 146 CLR 40, 47-48 stood for the proposition that a foreseeable risk is not ‘far-fetched’ or ‘fanciful’. The equivalent test is now contained in s 48 of the \textit{Wrongs Act 1958} (Vic).
plaintiffs with severe injuries through the limited calculation of damages.\(^{45}\) A significant consequence of the reforms was to limit the liability of health professionals, by reducing the quantum of damages awarded by the courts.\(^{46}\)

Limitation of damages was achieved through the introduction of ‘permanent impairment thresholds’ that plaintiffs must satisfy via formal assessment by an independent medical practitioner. To recover damages for non-economic loss,\(^{47}\) a plaintiff must show they have a ‘significant injury’ that meets the prescribed threshold. At the time of introduction in 2003, the Victorian thresholds were set at ‘more than 5 per cent’ for a physical injury (including spinal injuries) and ‘more than 10 per cent’ for a psychiatric injury.\(^{48}\) Even when a plaintiff could satisfy the threshold hurdle, their award of damages was limited through the introduction of a cap on damages for non-economic loss. The Victorian cap was initially set at $371,380 with that figure to be indexed annually.\(^{49}\)

A significant change from the Ipp Reforms in Victoria was the alteration of the negligence criteria for the standard of care and breach of duty. These reforms relate to the second element of negligence and involve an assessment of whether a medical practitioner has breached their duty of care. Unlike the element of duty of care which involves a question of law, assessment of breach of duty is a question of fact, so each case will be determined based on individual circumstances. In the medical context, a doctor can breach their duty of care through failure to examine or adequately treat the patient, failure to diagnose or failure to warn a patient of material risks associated with treatment.\(^{50}\)

At common law, Mason CJ developed the legal test for the standard of care which must be owed to a person, which centred on a reasonable person’s response to a foreseeable risk:

A risk of injury which is quite unlikely to occur… may nevertheless be plainly foreseeable… when we speak of a risk of injury as being “foreseeable”… we are implicitly


\(^{47}\) Wrongs Act 1958 (Vic) s 28B.

\(^{48}\) Wrongs and Limitation of Actions Acts (Insurance Reform) Act 2003 (Vic) s 28LB.

\(^{49}\) Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002 (Vic) s 28G.

\(^{50}\) Sonia Allan and Meredith Blake, *The Patient and the Practitioner: Health Law and Ethics in Australia* (LexisNexis, 2014) 200.
asserting that the risk is not one that is far-fetched or fanciful … A risk which is not far-fetched or fanciful is real and therefore foreseeable.\(^{51}\)

Mason CJ’s judgment heavily influenced the legislative reforms relating to standard of care and breach of duty in negligence. Following the Ipp Reforms, the \textit{Wrongs Act} was amended so that the plaintiff must establish three matters in determining breach:

1. the risk was foreseeable;
2. the risk was not insignificant; and
3. that a reasonable person in the defendant’s position would have taken precautions against the risk of harm.\(^{52}\)

Notably, the \textit{Wrongs Act} departed from Mason CJ’s ‘far-fetched or fanciful’ requirement, and instead imposed a stricter test requiring risks be ‘not insignificant’, in response to the Ipp Panel’s concerns that the common law test was too easily satisfied.\(^{53}\) Once the reasonable foreseeability test is satisfied, the court is required to address the ‘calculus of negligence’. Four factors are used to assess whether a reasonable person ought to have taken precautions. These factors include: (1) probability of the risk materialising; (2) the likely seriousness of the harm; (3) the practicality or burden of taking precautions to avoid the harm; and (4) the social utility of the defendant’s conduct.\(^{54}\)

In relation to the liability of professionals (including medical professionals) the Victorian law-makers also introduced a requirement that the court must have regard to the standard of care that one should expect of professionals. In assessing whether the relevant standard of care has been met, the court may have regard to any special skills or qualifications the defendant possessed and the standard that can reasonably be expected of a person possessing such a skill.\(^{55}\) The legislation provides that:

a professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely

\(^{52}\) \textit{Wrongs Act 1958} (Vic) s 48(1).
\(^{54}\) \textit{Wrongs Act 1958} (Vic) s 48(2).
\(^{55}\) Ibid s 58.
accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances.\textsuperscript{56}

The ‘peer professional opinion’ provisions do not apply to liability arising in connection with the giving of (or the failure to give) a warning or information with respect to a risk of harm.\textsuperscript{57}

In this regard, the statutory requirements introduce a modified ‘Bolam rule’, which is a test used in the UK that states a defendant is not negligent if their practice complied with a reasonable body of opinion in the profession.\textsuperscript{58} The statutory Bolam rule applies to examination, diagnosis and treatment, but not the giving of a warning or information.\textsuperscript{59}

While the standard of care and breach of duty provisions were a key area of interest in Australia at the time of implementation, this thesis focuses on the reforms to causation, the third element of negligence.\textsuperscript{60} The Ipp Reforms created a two-part statutory test for causation, requiring a plaintiff to establish: negligence as a necessary condition of the occurrence of the harm (factual causation), and that the scope of the negligent person's liability extends to the harm which was caused (scope of liability).\textsuperscript{61} The causation element has been the subject of considerable academic commentary and thus is a critical focus of this thesis, reflective of this being a contested area of the law requiring law reform.

Concurrent with capping compensation damages for non-economic loss, the Ipp Reforms also limited defendants’ liability when plaintiffs pursued damages for mental harm. This was implemented by imposing a ‘normal fortitude’ requirement which plaintiffs must meet, meaning the psychiatric injury must be suffered by a person of normal fortitude in the circumstances.\textsuperscript{62} This increased the threshold to be satisfied,\textsuperscript{63} which further reduced the ability of plaintiffs to recover compensation. In addition, the plaintiff must possess a recognised psychiatric illness, as opposed to a recognisable illness, requiring the illness to be

\textsuperscript{56} Ibid s 59(1).
\textsuperscript{57} Ibid s 60.
\textsuperscript{58} The Bolam test derives from Bolam v Friern Hospital Management Committee [1957] 1 WLR 582. See also Carolyn Sapideen, ‘Bolam in Australia – More Bark than Bite?’ (2010) 33(2) UNSW Law Journal 386.
\textsuperscript{59} The statutory provisions preserve the principles in Rogers v Whitaker (1992) 175 CLR 479.
\textsuperscript{60} As seen in Chapter Five of this thesis, participants’ responses indicated that in their experience breach of duty and the standard of care of medical professionals was not a significant concern. Instead, participants’ responses indicated the element of causation presented as a problematic hurdle to the attainment of compensation.
\textsuperscript{61} Wrongs Act 1958 (Vic) s 51(1). See also Genna Angelowitsch, ‘Cause for Concern: The Link Between Breach and Injury’ (2014) 88(11) Law Institute Journal 44.
\textsuperscript{62} Wrongs Act 1958 (Vic) s 72.
formally recognised by an expert psychiatric body. Academic commentators propound that this definition is ‘backward-looking’ by implying a condition that the illness must have already been identified and classified by an authoritative body, rather than a forward-looking approach where an illness could be diagnosable by a body in the future.

1.1.2 THE EFFECTS OF THE IPP REFORMS

The effects of the IPP Reforms have prompted prominent academics and legal practitioners to question the coherency of the current tort regulatory framework. Advocates of the reforms argued the changes alleviated the ‘insurance crisis’, whereas opponents of the reforms questioned whether legislative intervention was genuinely required or if the response was an ‘instantaneous, unreasoned political reaction to popular outcry’. Both the driver of the reforms (the alleged crisis) and the manner in which the review was undertaken, were comprehensively criticised by distinguished commentators who declared that the two-month evaluation timeframe was too short, and that allegations of an ‘insurance crisis’ were public policy hype, utterly unsubstantiated by empirical evidence.

Academic and legal experts highlight the unreasonableness to the plaintiff in the post-Ipp framework. John Chu analysed the implications of the 2002-2003 tort reforms, asserting that the overall effect of the existing regime is ‘unfair’ for individuals because of the

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68 Underwood, above n 3, 39.
‘significant injury’ thresholds and the caps on damages.\textsuperscript{71} John North, former president of the Law Council of Australia, has stated that:

\begin{quote}
[T]he common law system provides proper compensation to people injured as a result of negligence by someone else... However, because of “tort reform” this elegantly simple principle has been hedged about with a forest of restrictions, many of which are simply arbitrary... A particularly ugly weed in this forest is thresholds on compensation for non-economic loss.\textsuperscript{72}
\end{quote}

Thresholds for non-economic loss have attracted thorny criticism. King presents three arguments to support the view that ‘significant injury’ thresholds restrict claimants with genuine injuries from accessing justice: first, the need for a permanent injury; second, the inability to consider subjective consequences of an injury on a person’s life; and third, the rigid structure of the AMA Guides in assessing a ‘significant injury’.\textsuperscript{73} The assessment of an injury, and subsequent conversion into a \textit{whole person impairment percentage} by an independent medical practitioner, in accordance with the AMA Guides, produces a ‘substantial gulf’ between the AMA impairment rating and the claimant’s disability.\textsuperscript{74} For example, a child who has sustained some permanent impairment in the use of their hand, coupled with permanent scarring would not meet the threshold, despite that injury being considered ‘significant’.\textsuperscript{75} An individual who has had surgical equipment, such as scissors, left inside their body due to a medical practitioner’s negligence would not satisfy the permanence requirement, thus would be ineligible for compensation as their injury is ‘transient’. An individual with permanent scarring, calculated at a 4, not 5, per cent whole person impairment would not qualify for compensation despite having a permanent disfigurement. These examples show that compensation thresholds for non-economic loss are less like North’s ‘ugly weeds’ and more like an impenetrable thicket, preventing meritorious claims from accessing a ‘just’ financial remedy.

The primary concern with the AMA Guides lies in the significant difference between one category of impairment and the next, as categories increase in 5 per cent increments. Following the 2003 amendments to the \textit{Wrongs Act} introducing thresholds, plaintiffs were

\begin{footnotesize}
\textsuperscript{71} Chu, above n 70, 168.
\textsuperscript{72} North, above n 70, 4.
\textsuperscript{73} King, above n 70, 26.
\textsuperscript{74} Law Institute of Victoria, Submission No 13 to Victorian Competition and Efficiency Commission, \textit{Inquiry into Aspects of the Wrongs Act 1958}, 12 September 2013, 6.
\textsuperscript{75} Ibid 7.
\end{footnotesize}
required to demonstrate a permanent impairment of ‘more than 5 per cent’ for spinal injuries. Therefore, a person with a spinal injury could be initially assessed as having an impairment of 5 per cent or less. If that person’s injury marginally worsens due to a nerve root compromise, the individual may still be prevented from obtaining compensation because the next category of impairment for spinal injuries is not 6, 7 or 8 per cent, but 10 per cent according to the AMA Guides. Such anomalies persisted between the introduction of the thresholds until the minor amendments in 2015 following the Victorian government review, set out below.

1.1.3 THE SECOND TRANCHE OF REFORMS: THE VCEC REPORT AND THE 2015 VICTORIAN TORT REFORMS

On 30 May 2013, the Victorian Competition and Efficiency Commission (VCEC) undertook an inquiry into aspects of the Wrongs Act responding to concerns that the law had imposed ‘unreasonable barriers’ and ‘limitations’ to legitimate personal injury claims. The scope of the inquiry was to make recommendations to address any anomalies, inequities or inconsistencies in the Wrongs Act relating to personal injury damages, without undermining the objectives of the major tort reforms from 2002 to 2003. VCEC released the final report, Adjusting the Balance: Inquiry into Aspects of the Wrongs Act 1958 (‘the VCEC Report’) on 26 February 2015. This report contained three overarching recommendations, many relevant to this thesis, including lowering the injury threshold for psychiatric and spinal injuries, and increasing the compensation cap for damages for non-economic loss.

On 18 November 2015, the Wrongs Act was again amended to enact many of the VCEC’s recommendations. The cap on non-economic loss was raised to $577,050 (to be indexed annually). The former cap, initially set at $371,380 in 2002, had increased annually so that at 1 July 2015 it had reached $518,300. In real terms, the 2015 cap increase to $577,050 resulted in only a minor elevation of $58,750. The injury threshold for psychiatric injury was lowered to 10 per cent, opposed to the previous requirement of ‘more than 10 per cent’. The injury threshold for spinal injury was also lowered to 5 per cent, opposed to the former ‘more

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76 Ibid.
78 Ibid 1.
79 Wrongs Amendment Act 2015 (Vic).
80 Wrongs Act 1958 (Vic) s 28G (as it then was).
than 5 per cent’. No recommendations regarding the principle of causation were made in the VCEC Report, so the law in this area remains unchanged. The 2015 reforms raise important questions about whether the amendments are sufficient to address the ‘harshness’ of the existing legislation and whether the removal of certain restrictions will increase litigation, which may reignite fear of another insurance ‘crisis’.

The ability to seek redress against wrongs, through litigation and ADR avenues, is a fundamental aspect of tort law. This tension begs the question: what is the fairest regulatory framework that can be implemented to allow victims to pursue their rights? The 2015 reforms to the Wrongs Act were an attempt to achieve a better balance, however the amendments have not addressed the perceived unfairness to claimants. The next section of this chapter will discuss the theoretical framework underpinning this research, focusing on corrective justice theory, economic efficiency and regulatory coherence.

1.2 THEORETICAL FRAMEWORK

An analysis of legal theory may support the legislative regulation of tort law in Australian society. This section will discuss the theoretical position that provides the best basis for coherent legislative regulation of the tort of negligence. For instance, apportioning liability in negligence may be seen as the core of the purpose of the law and the concept of justice. From a corrective justice perspective, the law’s purpose in the context of tort law is to correct wrongdoing by holding a defendant liable for his harmful conduct. However, achieving justice often needs to be balanced with practical considerations such as the economic welfare of society. This section focuses on three theories particularly relevant to negligence: corrective justice theory; economic efficiency theory; and ensuring coherent regulation.

In King v Philcox, the High Court of Australia restricted the plaintiff’s ability to claim damages for sustaining psychiatric injury in the form of pure mental harm in the aftermath of an accident. Justice Keane articulated the policy reasons behind the restrictions, stating:

Legislative measures which deny the remedy of damages in certain cases of negligently inflicted personal injury are now familiar measures, taken in the public interest to preserve the general

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availability of the remedy by ensuring the viability and affordability of arrangements to meet the costs involved.  

Justice Keane’s comments point to the ongoing tension in medical negligence law. The ability to access compensation for negligence claims is well established at common law, but the need to balance this principle with compensation affordability is said to be in the public interest, to ensure the ongoing availability of indemnity insurance. This friction is reflected in the principles of corrective justice theory and economic efficiency theory, which aid in comprehending the development of current tort principles. In negligence, awards of damages arguably have a corrective purpose as they are designed to ‘put something right that has gone wrong’.  

This infers that any wrong should be remedied in the form of ‘just compensation’. However, plaintiffs who do not satisfy permanent impairment thresholds or whose loss exceeds the maximum caps on damages are unable to access corrective justice. The purpose then becomes to ‘partially put something right that has absolutely gone wrong’, which opposes the concept of general negligence.

Throughout this thesis, corrective justice theory is adopted as the theoretical construct for understanding tort principles and analysing qualitative interview data. Contemporary theorist Ernest Weinrib defines corrective justice as a bilateral relationship, where each of the two parties adopts an active or passive pole of the same injustice.  

Corrective justice theorist Allan Beever describes this relationship as ‘interpersonal justice’, if one person wrongs the other by infringing on their legal rights, there is an obligation to restore the equality of the parties. In this way, Beever posits that the law of negligence is best understood in terms of principles of morality.  

In contrast, economic efficiency theorists are concerned with the distribution of wealth in society. The focus for economic theorists is not restoring justice between a wrongdoer and a

83 King v Philcox (2015) 255 CLR 304, 326 [42].  
84 Mendelson, above n 81, 314.  
victim, but in how resources can be optimally allocated to serve society’s economic wellbeing. Economic efficiency theory may best explain the rationale between the Ipp Reforms, which unraveled because the ‘efficiency’ of resource allocation usurped the notion of a just outcome.

1.2.1 CORRECTIVE JUSTICE THEORY

The theoretical framework that supports the legislative regulation of tort law in a fault-based system is corrective justice. Corrective justice is centred on the premise that if an individual causes harm to another, there is an obligation to repair the loss. The theory has its origin in Aristotle, who distinguished between ‘corrective justice’ and ‘distributive justice’. Aristotle envisaged two parties starting in a position of equality. If one party was to disrupt that equality, corrective justice demands restoration by deducting something from the party who disturbed the equality and returning it to the other disrupted party. In other words, if one person causes another to be injured through negligence, this person has made a gain through the other person’s loss. Corrective justice requires the negligent person to repair the injured person’s loss, which is achieved through compensation. Corrective justice can be contrasted with distributive justice, which is concerned with the equal distribution of goods and wealth in society. Distributive justice addresses justice across a community based on a criterion of merit, requiring a broad institution to implement appropriate distribution across the community. A compensation scheme that distributes resources from a pool provided by contributors which distributes these resources according to some set criteria, is an example of distributive justice.

To Aristotle as well as to contemporary theorist Ernest Weinrib, corrective justice is considered an alternative to distributive justice, which is dependent on a transaction between the affected parties. Distributive justice has been likened to ‘legislative justice’ involving the creation of statute law that distributes benefits and burdens through the regulation of

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90 Michael DA Freeman, Lloyd’s Introduction to Jurisprudence (Thomson Reuters, 9th ed, 2014) 481.
Corrective justice is more akin to ‘judicial justice’ where judges have the power to correct wrongs through the imposition of remedies. In contrast, Wright contends that corrective and distributive justice are compatible, allowing a plaintiff to be fully compensated by shifting the loss from the plaintiff to the members of society who should properly bear the burden.

The imposition of tort liability arguably has its roots in the notion of justice. This is because a fundamental premise of tort law remedies is to effect justice between the parties. Corrective justice theory provides that a tortfeasor has an obligation to compensate his victim for harm suffered. Accordingly, corrective justice theory takes into account the moral aspects of tort law. It can be contrasted with distributive justice that arguably fails to create an appropriate lens through which tort law can be viewed. This is because the role of courts in torts disputes is not to distribute resources in society, but rather, to adjudicate disputes and award remedies individually.

According to the corrective justice theory, the purpose of negligence law should be to ensure tortfeasors redress wrongs they have committed. The law should be able to facilitate this by enabling aggrieved individuals to commence negligence actions and by providing a variety of dispute resolution avenues to enable the recovery of remedies. Under this view, the aim of negligence law should not be to concern itself with distributive justice for the entire society. Rather, its sole objective should be to effect justice between the tortfeasor and the aggrieved party.

A modern pioneer of corrective justice is American philosophy professor Jules Coleman who has written extensively on the interrelation of tort law and corrective justice. Coleman explores whether tort practices can be understood as expressing an ideal of justice. In Coleman’s view corrective justice specifies grounds for recovery and liability, but it does not

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96 Mendelson, above n 81, 313.
97 Ibid 314.
99 Mendelson, above n 81, 313.
101 Weinrib, above n 94, 403.
102 Freeman, above n 90, 524.
provide a mode of rectification. For instance, Coleman ponders who ought to bear the cost if a defendant is held liable for damages: should it be the particular defendant, a class of defendants or those best able to reduce the risk of injury at the lowest marginal cost? Coleman asserts that the fairest and most effective compensation scheme is one where victims draw payment from a fund stocked by potential injurers, in other words a no-fault scheme. Coleman outlines three categories of interrelation between justification and compensation: (1) where the defendant only owes compensation to the victim if the loss is caused by the defendant’s unjustifiable or unreasonable conduct (2) where the victim suffers loss as a result of justifiable conduct, but recovery of compensation is not barred and (3) the defendant’s conduct is justifiable only if they pay compensation for the losses they occasion. Coleman contends that the first two categories involve the principle of corrective justice. Coleman concludes that corrective justice does not provide a full explanation of tort law, especially in circumstances where tort law is unable to provide a remedy for every wrongdoing, but that corrective justice is important in understanding tort law.

Contemporary tort scholars support the application of corrective justice in negligence. For instance, Gemma Turton contends that corrective justice is the preferred foundation for negligence law. In her view, the dualistic form of corrective justice correlates with negligence liability because an injustice can only be corrected when the wrongdoer repairs the injured person’s loss. Turton further elaborates that causation is an integral aspect of corrective justice because the very essence of corrective justice theory is concerned with justice in interactions between people. This is supported by Weinrib who states, ‘[t]he requirement of factual causation establishes the indispensable nexus between the parties by relating their rights to a transaction in which one has directly impinged upon the other.’ Causation is therefore a central part of negligence.

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104 Ibid 358.
105 Ibid 352.
106 Ibid 355.
107 Ibid 379.
108 Ibid 379.
110 Ibid 9.
111 Ibid 20.
Torts academic Sharon Erbacher adopts a corrective justice framework for analysing principles of negligence and illegality.\textsuperscript{113} Erbacher argues that the doctrine of illegality in negligence, despite being traditionally justified through public policy frameworks, can be understood in a corrective justice framework.\textsuperscript{114} Building on the work of scholars such as Ernest Weinrib, Allan Beever and Robert Stevens, Erbacher argues that corrective justice is an appropriate theoretical framework for understanding illegal negligent acts because previous reliance on public policy has led to the development of an uncertain and unsatisfactory illegality doctrine.\textsuperscript{115} According to Erbacher, corrective justice provides a principled framework for deciding future cases in a consistent and systematic manner.\textsuperscript{116}

Applying corrective justice theory to a medical negligence context, the law should enable those who have suffered harm to seek compensation from the medical practitioners responsible. This view does not require consideration of the needs of the entire community, but rather, it is about effecting justice between a medical practitioner and patient. However, one cannot disregard limits on the financial resources required to effect justice, which means there will ultimately be some legitimate constraints on the ability to compensate all injured persons. Corrective justice theory thus presents deficiencies that economic efficiency theory seeks to remedy. However in practice a balance must be sought between the roles and needs of plaintiffs and of defendants in society.

1.2.2 ECONOMIC EFFICIENCY THEORY

Whilst corrective justice philosophers are concerned with notions of justice and morality, economists on the other hand contend that tort law can most adequately be explained through an economic analysis. A contemporary advocate of an economic efficiency approach, US judge Richard Posner, contends that, ‘the common law is best explained as if the judges were trying to maximize economic welfare’.\textsuperscript{117} Economic theory is concerned with the distribution of wealth in society and according to its tenets, judges should decide cases with the aim of maximising society’s total wealth.\textsuperscript{118} In other words, justice is equated to wealth maximisation.

\begin{footnotesize}
\begin{enumerate}
  \item Ibid 8-9.
  \item Ibid 21-22.
  \item Ibid 9.
  \item Posner, above n 88, 4.
  \item Freeman, above n 90, 520.
\end{enumerate}
\end{footnotesize}
Economic theory is normative, because it focuses on how the law ought to be. In a negligence context, economists are concerned with the imposition of liability rules that promote and encourage economic efficiency. Posner contends that, ‘[t]he common law method is to allocate responsibilities between people engaged in interacting activities in such a way as to maximize the joint value, or, what amounts to the same thing, minimize the joint cost of the activities’.\(^{119}\) Therefore, according to economists, the role of tort law is simply costs allocation. Tort law should be aimed at minimising the cost of accidents and reducing the cost of avoiding them.\(^{120}\) Hence, if the cost of taking care to avoid injury is less than the cost of compensating for an injury sustained, people should be encouraged to take action to avoid the risk of injury. Tort law consists of a set of liability rules that determine the circumstances in which a person is required to compensate another. These rules govern the distribution of losses generated by human conduct. Assuming that human beings are rational utility maximisers, legal economists assert that human beings will make choices that maximise their welfare, which in turn leads to an allocation of resources that maximises society’s wealth.\(^{121}\)

Economic efficiency theory assists with an analysis of the Ipp Reforms. If the cost of personal injury compensation payouts grow too high (and this is implied in the claim that high costs resulted in an insurance ‘crisis’), it follows there is a need to reduce compensation payouts and consequently increase society’s wealth. One of the criticisms of this pursuit of economic efficiency is that it leads to inequality. Coleman contends that it causes the wealthy to gain more rights and increase their wealth while the poor become worse off.\(^{122}\) In a medical negligence context, the wealth of insurance companies, hospitals and medical practitioners increases, while the rights of injured individuals to access compensation decreases. A problem with such an approach is that it focuses on a theoretical ideal regarding the regulatory framework, which does not necessarily translate well to tort law regulation which is set in motion after a wrong has been committed.\(^{123}\) On the other hand, effective tort regulation can steer behaviour and deter wrongs. While economic efficiency theory creates an

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ideological framework within which tort law may operate, corrective justice theory appears to be the better fit in substance form because it operates after the wrong has occurred, to compel the wrongdoer to correct the wrongdoing. As Keating states, ‘[t]he success of corrective justice as a theory of tort is the flip side of the failure of economic analysis. The basic structural features and main concepts of tort law embody the principle of corrective justice’. 124

Mendelson contends that the Australian judiciary has tended to apply principles of economic efficiency theory in case law, with judges imposing liability based on social, moral, political and economic considerations.125 Yet, Mendelson acknowledges that the tort reform legislation has strongly been influenced by principles of corrective justice, which she asserts forces judges to concentrate on a ‘very intricate analysis of facts’ of a case, particularly with regard to breach of duty and causation principles, when determining how to apportion liability.126 Arguably, such an analysis requires judges to have regard to the social facts of the case. Kylie Burns argues it has long been accepted that in negligence cases judges refer to policy consequences of tort liability within their reasoning, including effects on insurance.127 Burns argues that corrective justice theory and rights-based theories of tort law do not adequately account for judicial use of social facts in tort cases.128 Burns contends that such considerations must be taken into consideration when formulating an accurate theoretical account of judicial reasoning in negligence cases,129 given that empirical evidence shows judges do use social facts in judicial decision-making.130

1.2.3 COHERENCE AND REGULATION

Commissioning an inquiry into personal injury compensation suggests the Victorian government was concerned that the effects of the 2002-2003 reforms were too harsh. The 2015 amendments attempted to address the injustice caused by the original reforms, but their enactment raises questions about whether the current regulatory approach is adequate.

124 Ibid.
125 Mendelson, above n 81, 457-458.
126 Ibid 458.
128 Ibid 77.
129 Ibid 104.
Regulatory coherence is a theory of law that provides a framework for analysis and evaluation of existing regulatory frameworks.\textsuperscript{131} It examines how political and social considerations influence the design and implementation of regulation.\textsuperscript{132} It is premised on the concept that incoherent regulatory frameworks are ineffective and fail to achieve their intended objectives.\textsuperscript{135} Accordingly, the concept of regulatory coherence provides an evaluative tool to assess the operation and consequences of a regulatory framework.\textsuperscript{134} Applied to the area of tort law and the dilemma of recompense for those who suffer damage due to medical negligence, this framework allows critique of the Ipp law reforms and the 2015 reforms, to determine whether the legislature has struck the right balance between corrective justice and economic efficiency in order to achieve regulatory coherence.

1.3 MEDICAL NEGLIGENCE AND MEDIATION

Forms of ADR, such as mediation, are prevalent in the resolution of civil disputes, and are an increasing part of court mandated, case management processes. Mediation involves the intervention of a trained and impartial third party whose role is to assist the parties in dispute to achieve a voluntary agreement.\textsuperscript{135} Mediation offers myriad advantages over litigation as the traditional vehicle for adversarial dispute resolution: it can be quicker, more cost effective and produce confidential settlements which may assist to preserve the parties’ existing relationship.\textsuperscript{136} Mediation is increasingly being used as part of the litigation process, either as a mandatory pre-action protocol or through court referral during proceedings.\textsuperscript{137} In this thesis the acronym ADR refers to ‘alternative or appropriate dispute resolution’, which encapsulates a range of dispute resolution processes including negotiation, mediation, conciliation and arbitration.\textsuperscript{138} The term ‘dispute resolution’ refers to parties’ engagement in a consensual

\textsuperscript{132} Ibid.
\textsuperscript{133} Ibid 393.
\textsuperscript{134} Ibid 397.
\textsuperscript{135} Tania Sourdin, Alternative Dispute Resolution (Thomson Reuters, 5th ed, 2016) 76.
\textsuperscript{137} Mandatory pre-action protocols are a series of procedural pre-requisites that must be satisfied prior to commencing litigation. For example, the Civil Dispute Resolution Act 2011 (Cth) introduced pre-litigation procedures in federal civil litigation.
\textsuperscript{138} NADRAC, Dispute Resolution Terms: The Use of Terms in (Alternative) Dispute Resolution (Australian Government, 2003) 4.
resolution process. Finally, the National Mediator Accreditation Standards definition of ‘mediation’ is used.139

In Victorian civil proceedings, legislation imposes an overarching purpose to ‘facilitate the just, efficient, timely and cost-effective resolution of the real issues in dispute’,140 which can be realised by an ADR process either agreed to by the parties, or ordered by the court. This obliges all litigants, including legal practitioners, in medical negligence disputes to attempt some form of ADR prior to trial.141 Given that the shadow of the law informs dispute resolution avenues, it is imperative to explore whether the Ipp Reforms have had any impact on the mediation of medical negligence disputes.

The second part of this thesis focuses on how reforms to the Wrongs Act have impacted upon mediation practice, which contributes to research concerning the lawyer’s role in court-connected mediation and how lawyers frame their practice.142 The manner in which lawyers construct their role can influence settlement and client satisfaction,143 particularly as dispute resolution of medical negligence and mental harm claims can occur in an emotionally charged environment, where claimants have sustained devastating injuries, and there is a loss of trust in the medical practitioner. Emotion is a key aspect of conflict and an integral part of dispute resolution,144 so addressing emotion may be integral in medical negligence disputes involving heightened levels of emotion. Extant literature highlights the benefits of using mediation as a dispute resolution process in emotionally-charged disputes.145 It is therefore

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139 Mediator Standards Board, National Mediation Accreditation Standards (2015) 9 <https://msb.org.au/themes/msb/assets/documents/national-mediator-accrediation-system.pdf>. The definition of ‘mediation’ includes a process that promotes the self-determination of participants and in which participants, with the support of a mediator: (a) communicate with each other, exchange information and seek understanding; (b) identify, clarify and explore interests, issues and underlying needs; (c) consider their alternatives; (d) generate and evaluate options; (e) negotiate with each other; and (f) reach and make their own decisions.

140 Civil Procedure Act 2010 (Vic) s 7.

141 The Medical List in the County Court of Victoria hears the majority of medical negligence proceedings and requires that all proceedings be subject to mediation prior to trial.


143 Ibid 765.


apposite to explore the role emotion plays in medical negligence cases where mediation is used. This research will explore whether emotion is an integral factor to resolution from the perspective of lawyers, and whether parties are able to express their emotions in the mediation process.

1.4 RESEARCH MOTIVATION AND SCOPE

The Ipp Reforms have been criticised by prominent members of the legal profession as being driven by external economic pressures, and for being hastily implemented.\(^{146}\) Given the objective of the Ipp Reforms was to reduce the compensation payable to plaintiffs in personal injury claims,\(^{147}\) nearly two decades later it is timely to explore whether these reforms have been effective. Further, all Victorian plaintiffs who instigate medical negligence proceedings will at some stage face a court-connected ADR process, typically mediation.\(^{148}\) Therefore this research needs to address how the current laws have affected mediation in medical negligence disputes. The VCEC Report and subsequent reforms underscore the ongoing problems plaintiffs endure in securing compensation in meritorious medical negligence and mental harm claims. This persistent problem provided a unique opportunity to explore the legal challenges faced in the litigation and mediation of such claims, through the perspective of practising medical negligence lawyers.

As the literature review chapter of this thesis makes clear, there is no existing empirical study on the effects of the Ipp Reforms on medical negligence litigation and mediation in Victoria. Internationally, a Canadian interpretive study undertaken by Tamara Relis canvassed the different perceptions of professional, legal and lay actors in the litigation and mediation process of medical injury claims.\(^{149}\) Whilst Relis’ research was conducted on a larger scale than this project, her findings provide meaningful data with which to compare the different perceptions of legal and lay actors involved in tort disputes, particularly as Victoria and

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\(^{146}\) Mendelson, above n 66, 494; Butler, above n 64, 121.

\(^{147}\) Ipp Report, above n 4, 26 provides that the prime task of the Panel, as stated by the Terms of Reference, is ‘to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death’.


\(^{149}\) Tamara Relis, Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties (Cambridge University Press, 2009).
Canada are both common law jurisdictions. Relis’ research aids in identifying problems with the regulatory framework governing the litigation and mediation of these disputes.

1.4.1 SCOPE OF RESEARCH

The scope of this research was limited to analysing the medical negligence compensation system in the Victorian jurisdiction. Further, this study was confined to court-connected mediation of medical negligence disputes. Wider issues regarding resolution of healthcare disputes in hospitals were not explored for the purposes of this doctoral research project.

1.5 RESEARCH OBJECTIVES AND QUESTIONS

The aim of this research thesis is to critically evaluate whether the 2002-2003 and 2015 amendments to the Wrongs Act, continue to present unreasonably high hurdles for plaintiffs to obtain financial compensation in medical negligence and mental harm disputes.

The four research objectives for this thesis are:

1. to gather qualitative data about the perceptions from lawyers practising in the field of medical negligence, and sitting judges with medical negligence experience;
2. to explore what effects the Ipp Reforms have had on the litigation and mediation of meritorious medical negligence claims from the perspective of lawyers and judges;
3. to explore what effects the 2015 reforms have had on the litigation and mediation of medical negligence, and to ascertain whether further reform is required; and
4. to analyse the perceptions derived from the qualitative data and generate theory to understand the phenomenon under investigation.

This research into medical negligence disputes in Victoria is warranted, because it will address the following two research questions:

1. Have the 2002-2003 amendments to the Wrongs Act, resulting from the Ipp Reforms, had any effect on the litigation and mediation of meritorious medical negligence claims?
2. What impact has the 2015 amendments to the Wrongs Act had, and likely to have, on the litigation and mediation of medical negligence disputes?
These research questions are explored through qualitative interviews with practising lawyers representing plaintiffs and defendants in medical negligence, as well as barristers and sitting judges with medical negligence experience. All participants are experts in this field, able to provide insight and offer reflections on the challenges experienced post the 2002-2003 and 2015 reforms, as they are deeply involved in the legal processes of compensation. As experts, the participants are well-positioned to identify any need for further reform. The lawyers engaged in mediation in medical negligence possess a rich source of experience to understand what typically occurs in negotiations and settlements related to medical negligence, and thus are expertly placed to inform the researcher about practices during the mediation of medical negligence disputes.

1.6 RESEARCH DESIGN

This research is embedded into an interpretivist epistemology, utilising a qualitative methodological design. Interpretivist research is concerned with assessing qualitative data relating to the gathering of thoughts, feelings and ideas.\textsuperscript{150} As such, interpretivism is an ideal construct to underpin this study, given the research involves gathering subjective sources of data including thoughts, feelings, beliefs and perceptions concerning medical negligence compensation processes. The research data was gathered through semi-structured interviews with 24 research participants: 11 medical negligence lawyers from plaintiff and defendant law firms in Victoria, 10 barristers and three judges with medical negligence litigation experience. The participants were purposively selected based on the length of their medical negligence experience, and invited by email to participate in the research.\textsuperscript{151} The participants provided commentary on their perceptions of legal issues impacting the attainment of compensation in medical negligence cases, following the Ipp Reforms and subsequent 2015 amendments. Further, the participants’ breadth of legal experience assisted in articulating the need for further legislative overhaul.

Consistent with the epistemological approach, grounded theory was adopted as the research methodology. Grounded theory is an inductive framework, used when the researcher seeks to

\textsuperscript{150} Christina Quinlan, \textit{Business Research Methods} (Cengage Learning, 2011) 105.
\textsuperscript{151} Ibid 213. Participants were selected using purposive sampling, meaning that they were selected based on certain characteristics such as the length of experience in medical negligence. This was important given participants needed to have experience with the state of legislation prior to and following the Ipp Reforms. An internet search was conducted to locate the participants. Subsequently the snowball sampling method was used where participants already interviewed recommended other participants for the study.
create a theory from data or when researching a matter where little is already known.\textsuperscript{152} Grounded theory is useful in explaining the phenomenon being studied, which in this instance are the high hurdles to compensation presented by the 2002-2003 and 2015 amendments to the \textit{Wrongs Act}. Grounded theory was selected as the preferred research methodology to justify the research method and undertake data analysis. The use of grounded theory as a research methodology can be contrasted with corrective justice theory and economic efficiency theory, which was used as the conceptual framework through which the analysis of the data occurred. Grounded theory was used to extract themes (incorporating access to justice, unfairness, emotion and the role of lawyers) and to formulate a theoretical framework underpinning the concepts (corrective justice), in order to comprehend the responses that emerged from the data. The use of grounded theory assisted in formulating the conclusion that the present legal framework governing personal injury is incompatible with principles of corrective justice, necessitating further reform. While qualitative research is not usually affiliated with numerical representation of the data, some scholars accept that use of numbers in qualitative research is a legitimate and valuable method of presenting data.\textsuperscript{153} Therefore, in some sections of this thesis, numerical indicators are used to offer greater clarity and illustrate the analysis of the data.

\section*{1.7 RESEARCH CONTRIBUTIONS}

The aim of this thesis was to make an original contribution to the field of medical negligence research and practice in Victoria, which has already been achieved. This study contributes to the existing body of knowledge, by exploring the impact of the 2002-2003 and 2015 reforms on the ability of medical negligence plaintiffs to recover compensation. This doctoral research is noteworthy because it is path-breaking: it represents the first study investigating the impact of the Victorian Ipp Reforms on medical negligence parties, from the perspective of legal actors. The informed perceptions and reflections of the research participants enable critical evaluation of the reforms, and facilitate consideration of their efficacy in addressing the issue of personal injury compensation since the alleged ‘crisis’.

\textsuperscript{152} Ibid 183-184. See also Melanie Birks and Jane Mills, \textit{Grounded Theory: A Practical Guide} (SAGE Publications, 2\textsuperscript{nd} ed, 2015).

Although a plethora of academic literature has focused on the negative impacts of the Ipp Reforms, no systematic empirical study in this subject area has been undertaken within the Victorian jurisdiction. The Ipp Reforms can be viewed as reactive and it is argued the reforms were introduced so that the government could be seen to be responding to the much-hyped, but largely unsubstantiated insurance crisis.\(^{154}\) For instance, esteemed legal academic Professor Harold Luntz has made reference to a ‘supposed insurance crisis’\(^ {155}\) and an ‘alleged public liability and medical indemnity crisis’\(^ {156}\) in his work in this area.

This research recommends enhancements to the current regulatory framework, including amending the existing fault-based system to reduce barriers to recovery of compensation. Alternatively, the study explores the feasibility of introducing a no-fault system of compensation, modelled on the current New Zealand system.

Also, this doctoral research significantly contributes to knowledge of mediation practice (in medical negligence) by exploring the role of lawyers in conducting mediation of such disputes, including the extent that expression of emotion plays in addressing personal injury disputes. Mediation operates in the shadow of the law, and encompasses corrective justice through a quicker and less expensive method of dispute resolution. This doctoral research has found that the legal actors in the mediation of personal injury disputes do not use mediation to its fullest potential to facilitate the expression of emotion by their clients. These research findings provide a platform to explore themes regarding the culture of lawyers and adversarialism.

Finally, recommendations are made to reform mediation practice in medical negligence disputes through: (1) the introduction of pre-action protocols; (2) imposition of a mandatory requirement for doctors to attend mediation; (3) introduction of ‘medical negligence restorative conferences’, a process similar to restorative justice conferencing but within medical negligence disputes, where plaintiffs can confront doctors; and (4) use of legal education as a catalyst for shifting the practice of lawyers towards non-adversarialism in mediation within the Victorian jurisdiction. These findings and recommendations may be generalised to the practice of medical negligence compensation in other Australian states.

\(^{154}\) Luntz, above n 69, 836.


\(^{156}\) Luntz, above n 69, 836.
1.8 STRUCTURE OF THIS THESIS

This thesis is divided into seven chapters. Chapter 1 has outlined the background to the research, including objectives, research questions and research design. Principles of corrective justice, economic efficiency and regulatory coherence are used as the conceptual basis for this research, as they assist to explicate the underlying reasoning for the development of key aspects of negligence principles. The chapter also indicates the research contributions and provides an outline of the thesis structure.

Chapter 2 contains a comprehensive literature review relating to the Ipp Reforms, including its background, an overview of the key amendments, and the legal community’s response to the two tranches of reforms. The impact of the Ipp Reforms and the 2015 remedial reforms on medical negligence and mental harm claims is explored with a focus on the continuing challenges presented by these reforms including thresholds, caps on damages and the statutory principle of causation.

Chapter 3 contains a literature review of the history of mediation, and the significance of court-connected mediation to the resolution of medical negligence disputes. It explores the role of lawyers in mediation, including their ability to influence settlement and achieve client satisfaction. The role of emotion is identified in the mediation literature as the opportunity to explore underlying interests and concerns of parties through a discourse that allows for expression of emotions, such as anger. Litigating in medical negligence can be stressful. Expression of emotion may contribute to the successful settlement of a dispute, and to generating greater levels of procedural satisfaction for the disputants. Empirical studies focusing on mediation in medical negligence are explored to demonstrate that no systematic empirical study of lawyers’ perceptions of mediation in medical negligence disputes in Victoria has ever been undertaken. Finally, legal culture and the adversarialism of the legal profession are explored, alongside the potential of legal education as a catalyst for meaningful reform.

Chapter 4 outlines the epistemological and methodological framework. It outlines the organisation of the study, method of data collection and addresses ethical issues. This study has adopted grounded theory as the method of analysing the interview data to extract themes.
The method of analysis through open, axial and selective coding is explained, and the limitations of the research are presented.

Chapter 5 contains the first part of the findings of this study, focused on the continuing challenges which arise in medical negligence and mental harm claims. Analysis of the responses shows that the majority of participants thought that significant injury thresholds, caps on damages and causation pose high hurdles in progressing medical negligence and mental harm claims. Some research participants raised concerns that the law discriminates between physical and psychiatric injuries, reinforcing the historic distinction between the two, by imposing more onerous requirements to demonstrate existence of mental harm. When questioned about causation, most participants expressed the view that causation was the greatest issue for litigants in medical negligence proceedings. Participants articulated numerous benefits of no-fault schemes, including those mirrored under the Victorian transport and workplace accident schemes, such as the quicker resolution of claims and certainty of compensation without the need to establish negligence in court. Consequently, this chapter briefly discusses potential law reform and contemplates the feasibility of adopting New Zealand’s no-fault statutory scheme in Australia.

Chapter 6 contains the second part of the findings of this study, relating to the mediation of medical negligence disputes. Research participants endorsed the value of mediation as a relatively quick, informal opportunity for dispute resolution. With regard to the examination of emotion which is a focus of this project, analysis of the data shows that participants broadly considered that emotion can be an important aspect of medical negligence mediation. Participant attitudes to emotion were confined to ‘avoidance’ of addressing it during mediation, rather than engaging with the parties’ experience. Participants mostly viewed mediation as beneficial to their client, by providing the opportunity to avoid the emotional cost of pursuing a negligence claim. Research participants did not exploit the prospects that mediation presents for parties to express emotion in a way that assists both victim and medical practitioner to obtain emotional closure or procedural satisfaction.

In addition, the dominant role of lawyers in the mediation of medical negligence disputes emerged as a major theme. Analysis of the data shows that participants unquestionably valued mediation in the context of medical negligence disputes. Research subjects reflected on the benefits of mediation as an informal option in case management. Some lawyers
specifically referred to the *Civil Procedure Act 2010* (Vic) as promoting mediation. Participants valued mediation as a way for clients to avoid the stress of court, and viewed their role as advising on the law and settlement options. Some participants commented on their role as a ‘translator’ of the legal system during negotiation in mediation, describing their efforts to promote understanding of realistic parameters for settlement. As experienced legal practitioners, the lawyers acted to shield their clients from the legal system, thus appearing to dominate the process. Further, the lawyer participants discouraged their clients from speaking, or even being present at mediation, largely choosing to act as spokespeople even though many identified that some clients expressed their wish to be more involved in the dispute resolution process.

Chapter 7 summarises the findings in this study, concluding that the 2015 legislative changes are inadequate to remedy the adverse effects of the Ipp Reforms. Further law reform is required. This conclusion is based on the legal challenges raised by the participants, including the causation hurdle, injury thresholds and caps on compensation. The existing National Disability Insurance Scheme (NDIS) and the proposed National Injury Insurance Scheme (NIIS) are discussed, together with the strengths and weaknesses of no-fault schemes for medical treatment injury. The mediation findings are also discussed, particularly focusing on the role of emotion and adversarialism of lawyers in medical negligence. Recommendations for reform are made, including the need for more restorative forms of dispute resolution. This chapter contains the theoretical and practical implications of the research, recommendations, limitations of the study, and the need for future research. The findings of this doctoral study should be used to assist policy makers when considering future law reform to principles of negligence, and could be applied to jurisdictions other than Victoria: both within and outside Australia.
CHAPTER 2 – THRESHOLDS, CAPS AND CAUSATION IN MEDICAL NEGLIGENCE AND MENTAL HARM PROCEEDINGS

2.1 INTRODUCTION

In the last two decades, Australian jurisdictions have experienced significant legislative reform in tort law. Contemporary principles regarding liability in negligence were substantially altered at the beginning of the twentieth century and the effects of these reforms continue to play a role in the operation of the current compensation system. The central themes of this thesis circle around three restrictions emanating from the civil liability reforms: permanent injury thresholds, caps on damages and the statutory principle of causation. Following the implementation of the reforms, legal commentators argued that the restrictions emanating from the civil liability reforms prevent plaintiffs with meritorious negligence claims from recovering compensation. It is imperative to explore the background to the civil liability reforms, the legal community’s response to the reforms, and the effects on the compensation system because the perceived restrictiveness and unfairness of the reforms was a crucial emergent theme in the data gathered for this study.

At the beginning of the twenty-first century, the increasing cost and decreasing availability of medical indemnity insurance was attributed to substantial insurance payouts in the preceding decade and a perception that damages awarded by courts were too high,¹ as well as to the collapse of several large medical insurance providers. These factors contributed to a perceived ‘insurance crisis’ in Australia.² Legislative intervention was called for, especially in light of the common perception that the law of negligence was ‘unclear and unpredictable’, that ‘it has become too easy for plaintiffs in personal injury cases to establish liability for negligence’ and ‘damages awards in personal injuries cases have been too high’.³ As a consequence, the Commonwealth, state and territory governments agreed to a joint review of

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the tort liability system with the objective of reducing the quantum of damages payable in personal injury claims.\textsuperscript{4} The review was chaired by the Honourable David Ipp and resulted in a report titled \textit{Review of the Law of Negligence Report} (‘Ipp Report’). Based on the recommendations contained in the Ipp Report, the Victorian government implemented law reforms, predominantly affecting public liability and professional responsibility negligence claims.\textsuperscript{5}

It is outside the scope of this thesis to canvass the entire breadth of the 2002-2003 reforms, therefore only the amendments that have had a significant impact on medical negligence and mental harm claims are addressed. Three vital changes were implemented. These were the need to satisfy permanent injury impairment thresholds, the introduction of caps on damages for non-economic loss, and the introduction of a statutory test of causation. Recovery of compensation for non-economic loss is precluded unless a plaintiff can demonstrate that they have sustained a ‘significant injury’ assessed at ‘more than 5 per cent’ whole person impairment for physical injuries, ‘equal to 5 per cent’ for spinal injuries and ‘equal to 10 per cent’ for psychiatric injuries.\textsuperscript{6} While the threshold does not affect recovery of economic loss, it does adversely affect members of the community (such as children, non-working parents and the elderly) who are not earning a high income and rely on non-economic loss compensation. If a plaintiff does satisfy the significant injury thresholds, the sum of damages they receive is capped at a figure indexed annually. In 2015, the base cap figure was increased to $577,050.\textsuperscript{7}

The element of causation is an integral, but particularly problematic, aspect of a negligence action. This is because in order to recover damages a plaintiff must prove the defendant owes them a duty of care, the defendant has breached that duty of care, and the defendant’s negligent act has \textit{caused} the plaintiff’s harm or loss. Proving this causative link is often


\textsuperscript{5} \textit{Wrongs and Other Acts (Law of Negligence) Act 2003} (Vic).

\textsuperscript{6} Section 28LE of the \textit{Wrongs Act 1958} (Vic) provides that a person is not entitled to recover damages for non-economic loss unless the person injured has suffered significant injury. A ‘significant injury’ is defined in s 28LF of the \textit{Wrongs Act 1958} (Vic) as the degree of impairment of the whole person resulting from the injury has been assessed by an approved medical practitioner as satisfying the threshold level. Section 28LB gives a definition of ‘threshold level’.

\textsuperscript{7} \textit{Wrongs Act 1958} (Vic) s 28G.
complicated in cases involving indirect harm or unintentional conduct. The Ipp Reforms introduced a two-part causation test into s 51 of the Wrongs Act, altering but not eliminating the common law principles that had developed over previous decades. The causation tests remain problematical and difficult to apply in the medical negligence (including mental harm) context and arguably constitute an unfair restriction of patients’ rights to compensation. This is because the statutory test is poorly defined, leading to uncertainty and unpredictability in application.

This chapter begins with the background to the Ipp Reforms and a brief outline of the Ipp Reforms relating to this thesis, followed by a critical analysis of the literature relating to those legislative amendments. Next, the chapter contains a doctrinal analysis of the principle of causation, through an analysis of legislation and case law in the medical negligence and mental harm context. This is followed by an examination of how the principle of causation has been applied by superior courts in Australia subsequent to the amendments. Then the chapter outlines a summary of the VCEC’s report and the 2015 reforms affecting injury thresholds and caps to damages, while identifying the failure of Victorian government to address the contentious issue of causation in these reforms.

2.2 BACKGROUND TO THE IPP REFORMS

By early 2002, the availability of medical insurance was affected by the collapse of some of Australia’s largest insurance companies, United Medical Protection and HIH Group. High compensation payouts in the preceding decade were blamed for an alleged ‘insurance crisis’ motivating the review of the law of negligence and reforms to tort law. The motivation behind the reforms and the manner in which the review was undertaken were criticised by distinguished commentators, who contended that the timeframe for the review (two months) was too short and the allegations of an ‘insurance crisis’ were unsubstantiated by empirical

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11 See for instance Simpson v Diamond [2001] NSWSC 925 (5 November 2001) where the plaintiff was awarded $14,202,042 in damages for cerebral palsy caused by the defendant medical practitioner. The amount was reduced on appeal to $10,998,692 however the doctor’s insurance company, United Medical Protection Ltd went into liquidation.
In response to the alleged ‘insurance crisis’, the states and the federal government commissioned a review of the law of negligence, chaired by Justice David Ipp (‘Ipp Panel’). The Ipp Report was released in September 2002 and contained 61 recommendations.

One challenge faced by the Ipp Panel was to create recommendations aimed to reduce uncertainty in the law. This was in response to submissions from community groups who stated their perception that ‘the net of responsibility for the consequences of negligence is being cast too widely’. In other words, courts were deemed to be too easily imposing liability for consequences that were only remotely connected to a defendant’s conduct. The Ipp Panel’s recommendations for the adoption of a statutory causation test to limit the scope of responsibility were subsequently implemented through legislative reform and form a critical part of this thesis.

Another challenge faced by the Ipp Panel was to develop and evaluate proposals to limit the quantum of damages, in response to the perception that damages awards in personal injury claims were too high. This was reflected in the views of Senator Helen Coonan, a proponent of the reforms, who alleged the increase in insurance premiums and collapse of insurance companies such as HIH Insurance were ‘due in large part to the operation of the legal system’ and that personal injury law was providing, ‘very generous compensation to a very small proportion of the population at considerable expense to the rest of the community’. The Ipp Panel’s objective to limit damages awards is reflected in the recommendations regarding injury thresholds (limiting who has access to compensation payments) and caps on non-economic loss damages (limiting how much compensation is paid).

The Ipp Report recommendations spanned a wide range of tort issues. Firstly, the Ipp Panel recommended that a national response to tort reform be enacted in a single statute in each
jurisdiction. Amongst the recommendations was the adoption of a ‘Bolam’ standard of care for medical practitioners, a recommendation that duties of medical practitioners to inform patients should be legislatively stated, and insertion of statutory provisions about recreational services warning of obvious risks, emergency services and time limitations for bringing claims. With regard to negligence, the Ipp Panel recommended that principles regarding foreseeability, standard of care, causation and remoteness, be legislatively stated. Defences of contributory negligence and voluntary assumption of risk were extended, common law principles relating to recovery for mental harm were altered, and liability of public authorities was limited. Various recommendations were made regarding entitlement to claim for damages, including the introduction of permanent impairment thresholds and caps on damages.

Based on the recommendations contained in this report, each state government implemented law reforms affecting medical negligence and mental harm claims (Ipp Reforms). The Ipp Reforms were executed in two waves: one wave in 2002 predominantly affected public liability claims, whilst the second wave in 2003 affected time limitations and the law of negligence more broadly. The Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002 (Vic) introduced provisions regarding intoxication and illegality, apologies, good Samaritans and volunteer liability. Most notably, this amending Act inserted a number of provisions regarding personal injury damages, including limiting damages for economic loss to three times average weekly earnings and a cap on damages for non-economic loss. The Wrongs and Other Acts (Law of Negligence) Act 2003 (Vic) implemented amendments to duty and standard of care, causation and mental harm, and liability of public authorities.

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18 Ipp Report, above n 4, 35 (Recommendation 1).
19 Ibid 41-42 (Recommendation 3). The Bolam test stems from the English case Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 and provides a medical practitioner is not negligent if they acted pursuant to opinion widely held by the medical profession.
20 Ipp Report, above n 4, 45-53 (Recommendations 5-7).
21 Ibid 62-64 (Recommendation 11).
22 Ibid 67-68 (Recommendation 14).
23 Ibid 69-70 (Recommendation 16).
24 Ibid 85-99 (Recommendations 23-26).
26 Ibid 121-130 (Recommendations 30-32).
27 Ibid 135-149 (Recommendations 33-38).
29 Ibid 181-227 (Recommendations 45-61).
Finally, the *Wrongs and Limitations of Actions Acts (Insurance Reform) Act 2003* (Vic) implemented significant injury thresholds, rules regarding proportionate liability, and time limitation periods.

### 2.2.1 OVERVIEW OF THE KEY AMENDMENTS

It is outside the scope of this thesis to address all of the recommendations made in the Ipp Report in detail. The recommendations most relevant in the current context relate to causation, injury thresholds and caps on damages, as well as the legislative provisions relating to mental harm. Amongst the Ipp Panel’s recommendations was the endorsement of caps on damages, to limit the maximum amount of compensation payments a court could award. The Ipp Panel recommended a cap of $250,000 for general damages (non-economic loss), encompassing payments relating to loss of expectation of life, loss of amenity and pain and suffering.\(^{32}\) Subsequently, the Victorian government introduced a slightly more generous cap of $371,380 (to be indexed annually) for non-economic loss into the *Wrongs Act*.\(^{33}\)

Another recommendation made by the Ipp Panel was the introduction of a permanent impairment threshold, outlining the minimum injury percentage a plaintiff was required to satisfy in order to recover compensation, a threshold set at 15 per cent impairment of a most extreme case.\(^{34}\) The Victorian government implemented ‘significant injury’ thresholds, requiring plaintiffs to satisfy their injury exceeded a ‘more than 5 per cent’ permanent impairment requirement for physical and spinal injuries, and a ‘more than 10 per cent’ impairment for psychiatric injuries.\(^{35}\)

The ability to claim compensation for mental harm claims was also affected by the Ipp Reforms. The reforms limited insurer liability for mental harm claims by tightening the ability of plaintiffs to recover compensation through the imposition of a ‘normal fortitude’ requirement, increasing the threshold to be satisfied.\(^{36}\) In addition, a requirement that the plaintiff have a *recognised* psychiatric illness (as opposed to recognisable) was introduced.

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33. This was introduced into the *Wrongs Act 1958* (Vic) s 28G (as it then was). For a discussion on the effect of the damages limitation see John Chu, ‘Analysis and Evaluation of Victorian Reform in General Damages for Personal Injury under the Tort of Negligence’ (2007) 10(2) *Deakin Law Review* 12.
This requirement imposes a condition that the illness must be formally recognised by an expert psychiatric body.\textsuperscript{37} 

A further recommendation particularly relevant to this thesis was the adoption of a two-part statutory test of causation.\textsuperscript{38} The legislative test for causation was inserted into s 51 of the \textit{Wrongs Act} and requires that the negligence must be a necessary condition of the occurrence of the harm (factual causation) and that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (scope of liability).\textsuperscript{39} A comprehensive analysis of the thresholds, caps on damages, mental harm provisions and the principle of causation are contained in this chapter.

\subsection*{2.2.2 RESPONSE TO THE IPP REFORMS}

The composition of the Ipp Panel, preparation of the Ipp Report and the subsequent law reform process were questioned by many lawyers, judges and legal academics.\textsuperscript{40} The central criticisms related to the main driver of the reforms being lobby groups, the existence of an insurance crisis that could not be empirically substantiated, the lack of transparency of the reform process, and finally, the effects the reforms have had on plaintiffs’ rights.

The first issue of concern was the driver of the legislative reforms, with many commentators contending the reforms were driven by insurance lobby groups to decrease insurance payouts rather than to alleviate an actual crisis. Justice Peter Underwood was critical of the reforms for this very reason, stating that the demand for legislative reform was driven not by principle but rather by the need to reduce insurance premiums.\textsuperscript{41} Likewise Judge Tom Wodak of the County Court of Victoria labelled the perceived insurance ‘crisis’ motivating the reforms a

\begin{footnotesize}
\begin{enumerate}
\item \textit{Ipp Report}, above n 4, 11-12.
\item \textit{Wrongs Act} 1958 (Vic) s 51(1). See also Genna Angelowitsch, ‘Cause for Concern: The Link Between Breach and Injury’ (2014) 88(11) \textit{Law Institute Journal} 44.
\item See Skene and Luntz, above n 2; Underwood, above n 2; Mendelson, above n 3. For instance, in Joachim Dietrich, ‘Liability for Personal Injuries Arising from Recreational Services: The Interaction of Contract, Tort, State Legislation and the Trade Practices Act and the Resultant Mess’ (2003) 11(3) \textit{Torts Law Journal} 1, 18 Dietrich notes that ‘in my view, the process was always going to be flawed. This is because the process by which the Ipp Report’s conclusions and recommendations were reached was fundamentally compromised from the outset.’ See also Rob Davis, ‘The Tort Reform Crisis’ (2002) 25(3) \textit{University of New South Wales Law Journal} 865 who described the review as ‘flawed’.
\item Underwood, above n 2, 41.
\end{enumerate}
\end{footnotesize}
‘myth’, explaining that a surge in cases prior to the implementation of the reforms was simply plaintiffs’ haste to bring their case to court so as to avoid the new laws. Chu identified five drivers behind the alleged crisis, contending the reform was driven by community attitude, common law developments of negligence, the downturn in the insurance industry cycle, the emergence of specialist plaintiff law firms offering ‘no win no fee’ services, and class actions. Chu asserts that the criticisms against the reforms can be grouped into the areas of premise, objective, rationale, process and outcome.

The Ipp Panel was not permitted to challenge the premise that negligence law was ‘unpredictable’ or that recovering damages was ‘too easy’ and the simple objective was to limit the quantum of awards for damages. Davis contends the reforms arose out of insurers’ public campaign for tort reform which was ‘big on rhetoric but scant on facts’ and that the terms of reference denied the Ipp Panel the ability to ascertain the true cause of insurance premium increases. From a national report on litigation trends during the period 1995 to 2005, Professor Wright concluded there was no empirical basis to substantiate a crisis stating, ‘[t]here is little or no evidence of a sustained, significant increasing trend in claims prior to the Ipp Review’.

It was also suggested that if there were a genuine need to prevent a surge in insurance premiums, a solution could have been achieved through a more transparent reform process. Danuta Mendelson critiqued the reform process, stating that ‘[t]he process of reform has been hasty, and some of the profound legal and social implications of the legislation appear not to have been fully thought through’. Joachim Dietrich noted, ‘In my view, the process was always going to be flawed. This is because the process by which the Ipp Report’s conclusions and recommendations were reached was fundamentally compromised from the outset.’ The composition of the Ipp Panel was also questioned, given that law reform bodies are typically

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44 Chu, above n 33, 135.
45 Davis, above n 40, 865.
47 Mendelson, above n 3, 494.
48 Dietrich, above n 40, 18.
staffed by lawyers. The Ipp Panel consisted of two lawyers, with the other two members from a local authority and the medical profession which were key stakeholder groups.49

Loane Skene and Harold Luntz argued that the outcome of the report was practically given to the Ipp Panel. Skene and Luntz state, ‘[t]he terms of reference themselves made it clear that the assumptions contained in [its] preamble were unchallengeable and that the panel had in effect to devise ways of limiting liability and damages, but within the law of negligence’.50 It was contended that the Ipp Report was prepared and its recommendations implemented within a relatively short period, considering that the common law principles governing this area of law were developed over hundreds of years and had been functioning quite well. The Honourable Ian Callinan, former Justice of the High Court of Australia, echoed this sentiment:

Both the common law, and insurance business and practice, are the products of hundreds of years of evolutionary development. It seems rather unlikely that everything that has so evolved is wrong and should be discarded. When loud voices clamour for radical change it is usually a time for patience and caution.51

Des Butler argued, ‘The panel’s task was made difficult by the imposition of a ridiculously short timeframe for reporting, […] less than two months, […] and an entire absence of empirical evidence from the insurance industry substantiating any assertion that the industry was in crisis.’52 In summary, the views of esteemed legal scholars indicate that some of the basic assumptions underpinning the reforms were questionable.

One effect of the reforms is arguably an excessive curtailment of the rights of injured plaintiffs. In attempting to reduce insurance premiums, the legislature limited plaintiffs’ rights to meritorious claims leading to potentially unfair results. The then Chief Justice of the New South Wales Court of Appeal, James Spigelman has publicly criticised the effect of the legislative reforms on plaintiffs’ rights to seek compensation.53 Peter Cashman highlighted that the reforms have led to unfair consequences:

49 Cane, above n 12, 669.
50 Skene and Luntz, above n 2, 346.
52 Butler, above n 37, 121.
The abolishment or curtailment of the rights of innocent victims of injury negligently inflicted by others is neither fair nor a solution to the problem. Particularly unfair is the attempt by some sections of the media, aided and abetted by an army of lobbyists and public relations consultants engaged by the insurance industry, to blame plaintiffs and their lawyers. The real causes of the medical indemnity crisis are apparent to those with an interest in the reality rather than the rhetoric. The truth is that the current crisis has primarily arisen out of a variety of complex commercial and economic factors.54

Following the reforms, Chu evaluated Victorian provisions for compensating non-economic loss due to negligence and found the overall effect of the existing regime unfair for individuals.55

One aspect of negligence the Ipp Reforms intended to adjust was a plaintiff-centred shift in personal responsibility. Keeler asserts that an influential body of legal opinion had become critical of the common law, arguing that the standard of care imposed on defendants was too stringent and that levels of care imposed on plaintiffs for their own safety was too low.56 Yet, Stewart and Stuhmcke contend that since the 1990s tort scholars have observed a shift in focus of the common law towards personal responsibility.57 Through a doctrinal analysis of High Court negligence cases over an eleven-year period between 2000 and 2010, the authors found that parties who had suffered loss or damage were successful in 25 cases, compared with defendants who were successful in 53 cases.58 Given the commencement of actions before the implementation of the Ipp Reforms, only three of the cases were substantially affected by the civil liability reforms.59 The low levels of plaintiff success rates can be attributed to a change of judicial composition of the High Court bench.60 A comparable study by Professor Harold Luntz of decisions between 1987 and 1999 showed a 71% success rate...

55 Chu, above n 33, 168.
58 Stewart and Stuhmcke, above n 57, 594.
59 Ibid 591.
for plaintiffs in 56 appeals.\textsuperscript{61} Stewart and Stuhmcke assert their research confirms the views of tort law scholars that the common law had imposed greater personal responsibility on plaintiffs,\textsuperscript{62} and that the tort reform legislation was unnecessary.\textsuperscript{63} McDonald argues that by trying to impose greater personal responsibility, the legislature has permitted ‘complete exculpation of negligent defendants in some cases, thus undoing the advances in apportionment of responsibility that had been achieved by earlier legislation’.\textsuperscript{64}

Despite being enacted more than a decade ago, a recent Victorian government report has recognised that the Ipp Reforms continue to cause ongoing problems to ‘legitimate claims’ by imposing stringent limitations leading to denial of claims, as well as dealing with plaintiffs inconsistently due to anomalies in the implementation of the reforms.\textsuperscript{65} For instance, one anomaly is the manner in which impairment assessment is conducted under the relevant medical guides for spinal injury and psychiatric claims. An injury must be assessed at 10 per cent or more (psychiatric injury), 5 per cent or more (spinal injuries), or more than 5 per cent (injuries other than psychiatric or spinal injuries) to qualify for non-economic loss damages. The injury is assessed and converted into a whole person impairment pursuant to the American Medical Association’s Guides to the Evaluation of Permanent Impairment (5\textsuperscript{th} ed) (‘AMA Guides’) for physical injuries and the Guide to the Evaluation of Psychiatric Impairment for Clinicians (‘GEPIC’) for psychological or psychiatric injuries. These tools separate impairment percentages into categories or ‘classes’. For example, an impairment of ‘more than 5 per cent’ for spinal injuries, prior to the 2015 remedial reforms, would have to satisfy an impairment threshold of 10 per cent, rather than 6 per cent, because the threshold categories increase in multiples of five. In relation to psychiatric impairment, ‘Class Two’ of GEPIC refers to impairment assessed at between 10 to 20 per cent, so that claimants with a 10 per cent impairment were excluded from that category because they needed to satisfy a more than 10 per cent impairment.\textsuperscript{66}

\textsuperscript{62} Stewart and Stuhmcke, above n 57, 612.
\textsuperscript{63} Ibid 591-592.
\textsuperscript{65} VCEC Report, above n 1, 1.
The 2015 reforms have remedied the anomalies in relation to spinal and psychiatric injuries by reducing the spinal injury threshold to ‘5 per cent or more’ and the psychiatric injury threshold to ‘10 per cent or more’. Claimants who have a physical injury, other than a spinal injury, are still required to satisfy a threshold of ‘more than 5 per cent’. Criticisms of the Ipp Reforms centred on the thresholds and caps being too restrictive and adversely impacting legitimate claims, with some commentators questioning whether the provisions conflict with notions of justice.

A second anomaly is the fact that similar injuries can produce different damages awards across the three personal injury regimes in Victoria, namely the Wrongs Act 1958 (Vic), the Accident Compensation Act 1985 (Vic) and the Transport Accident Act 1986 (Vic). For instance, assessment of injury under the AMA Guides pursuant to the Wrongs Act regime has been criticised for focusing heavily on objective assessment criteria and thus failing to take into consideration the subjective impact of an injury on a claimant’s life. This issue is addressed by the transport accident and workplace accident statutory scheme through the use of a ‘narrative test’, which allows a subjective assessment of the impact of an injury on an injured person’s life.

There are a number of concerns around the Ipp Report legislative changes that are surfacing not only in medical negligence but also in public liability claims which have a similar trajectory to the reform outcomes. For example, Bell-James and Barker have recently argued regarding public liability claims, that the legal community and policy makers must consider whether the Ipp Reforms were flawed and question whether a reversion to the common law approaches would be an appropriate solution. Apart from the threshold restrictions and limits placed on damages for non-economic loss in Victoria, problems also persist with the statutory principle of causation. As this is a common law principle with a lengthy judicial history, it warrants the more comprehensive discussion in section 2.3 of this chapter.

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67 *Wrongs Act 1958* (Vic) s 28LB.
2.3 CAUSATION AND MEDICAL NEGLIGENCE

Causation is a complex legal principle that is an essential component in establishing negligence. As His Honour Justice Spigelman opined, ‘Nothing is more calculated to excite a common lawyer, or exasperate the uninitiated, than a discussion on the subject of causation’.\(^{71}\) The term *causation* concerns a consequential relationship between two occurrences.\(^{72}\) The main causal question that courts are concerned with is whether an action has caused a specific harm, that question being relevant both to liability and to its extent.\(^{73}\) The principle of causation has been described as ‘esoteric’ and ‘poorly defined’.\(^{74}\) It is therefore unsurprising that there is no universal definition that the courts have accepted. However, Mason CJ in *March v E & MH Stramare Pty Ltd*\(^ {75}\) held that ‘[g]enerally speaking, …causal connection is established if it appears that the plaintiff would not have sustained his or her injuries had the defendant not been negligent’.\(^ {76}\)

At common law, judges adopted the ‘but for’ test to aid in satisfying the causation requirement.\(^ {77}\) The ‘but for’ test requires the court to enquire: would the plaintiff have sustained harm or damage but for the defendant’s negligence? For instance, in *Barnett v Chelsea and Kensington Hospital Management Committee*\(^ {78}\) a hospital doctor was not found to be negligent despite refusing to examine and admit to hospital a person who had been vomiting after drinking tea. The patient subsequently died five hours later of arsenic poisoning. Causation was not satisfied because the patient would likely have died of poisoning even if he had been admitted to the hospital, as it was unlikely an antidote would have been administered in time.\(^ {79}\) The ‘but for’ test has been criticised for its ‘seductive simplicity’,\(^ {80}\) with potential to lead to a limited application. This is because the test requires a court to essentially question whether the plaintiff’s injuries would have been sustained but for the defendant’s negligence, the response requiring only a yes or no answer. This simplicity led the High Court of Australia (HCA) to reject the ‘but for’ test as the sole determining

\(^{71}\) Spigelman, above n 12, 298.
\(^{72}\) Mendelson, above n 8, 453.
\(^{74}\) Mirko Bagaric and Sharon Erbacher, above n 9, 759.
\(^{75}\) (1991) 171 CLR 506.
\(^{76}\) Ibid 514.
\(^{78}\) [1969] 1 QB 428.
factor proving causation in *March v E & MH Stramare Pty Ltd*.\(^{81}\) Mason CJ noted that the ‘but for’ test may cause difficulties in circumstances where there are two or more acts sufficient to cause injury to the plaintiff.\(^{82}\) The High Court expanded the test to include a ‘common sense’ approach to determine if, as a matter of common sense, the negligent act should be regarded as the cause of the injury.

One of the effects of the Ipp Reforms was the introduction of a statutory test of causation in 2003.\(^{83}\) The legislative test for causation is contained in s 51(1) of the *Wrongs Act* and requires that the plaintiff satisfy that negligence was a necessary condition of the occurrence of the harm (factual causation) and that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (scope of liability).\(^{84}\) The first stage of analysis requires the plaintiff to establish that ‘but for’ the defendant’s negligence, the plaintiff would not have sustained harm. In cases where there is an evidentiary gap and it is impossible to prove causation (for instance where multiple potential causes of the harm exist) the legislation includes a ‘material contribution’ test. This allows the court to make a normative judgment about whether liability should be imposed in the circumstances.\(^{85}\) In other words, a court can make a finding of negligence without a clear causal link between fault and harm.\(^{86}\) The second stage of analysis requires the court to determine the extent of the defendant’s liability in the circumstances.\(^{87}\) Essentially this obliges the court to decide whether it is fair or ‘right’ that the defendant bear the loss.\(^{88}\) Problems with the statutory test of causation are discussed in detail below.

### 2.3.1 PROBLEMS WITH CAUSATION

When the Ipp Reforms were implemented, the law regarding causation in negligence was not codified. Accordingly, the legislative provisions are subject to judicial interpretation and

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\(^{81}\) (1991) 171 CLR 506.

\(^{82}\) Ibid 516.


\(^{84}\) Most of the Australian states contain similar provisions: *Civil Liability Act 2002* (NSW) s 5D; *Civil Law (Wrongs Act)* 2002 (ACT) s 45; *Civil Liability Act 2003* (Qld) s 11; *Civil Liability Act 1936* (SA) s 34; *Civil Liability Act 2003* (Tas) s 13; *Civil Liability Act 2002* (WA) s 5C. The *Personal Injuries (Liabilities and Damages) Act 2003* (NT) does not contain an equivalent provision.

\(^{85}\) See for instance *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32; *Amaca Pty Ltd v Ellis* (2010) 240 CLR 111; *Amaca Pty Ltd v Booth* (2011) 246 CLR 36.

\(^{86}\) Mendelson, above n 3, 503.

\(^{87}\) *Paul v Cooke* (2013) 85 NSWLR 167 (19 September 2013); *Wallace v Kam* (2013) 250 CLR 375.

\(^{88}\) Skene and Luntz, above n 2, 354.
expansion, increasing the uncertainty surrounding the principle. McDonald highlights the confusion in interpreting the statutory provisions by reference to the factual causation and scope of liability provisions. In order to explain ‘scope of liability’, the Ipp Report stated the term covered concepts such as ‘real cause’, ‘effective cause’, ‘remoteness of damage’ and ‘foreseeability’. That definition in the Ipp Report conflicts with established common law principles that use terms such as the ‘reasonable foreseeability’ test to assess duty of care, breach of duty and remoteness of damage. Similarly, the Ipp Report affiliated the ‘scope of liability’ element with notions of common sense, yet at common law, common sense was affiliated with factual causation. McDonald argues that this allows for the construction that the statutory changes intended to alter common sense considerations of the broader ‘scope of liability’ element.

Susan Bartie contends that the common law approach allowed courts to mask or avoid the delivery of clear reasons with respect to causation and that the reforms would eliminate some of the uncertainty. Bartie discusses the influence of Jane Stapleton’s scholarly work on the development of causation principles, given Stapleton’s work was the only academic publication considered by the Ipp Panel. Stapleton contends that the common law principles did not adequately address the considerations of causation and remoteness, and that a two-stage enquiry is not only preferable in addressing the surrounding normative issues but would encourage clearer judgments. Bartie asserts that the Ipp Reforms were intended to extend the causation and remoteness inquiries, and that judicial interpretation consistent with Stapelton’s work would expand the ‘scope of liability’ enquiry.

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89 Subsequent to the reforms, several High Court cases have interpreted the provisions relating to causation, including Adeels Palace Pty Ltd v Moubarak (2009) 239 CLR 420; CAL No 14 Pty Ltd v Motor Accidents Insurance Board (2009) 239 CLR 390 and Amaca Pty Ltd v Ellis (2010) 240 CLR 111.


91 Ipp Report, above n 4, 117.

92 Sydney Water Corporation v Turano & Anor (2009) 239 CLR 51, 70 [45] per French CJ, Gummow, Hayne, Crennan and Bell JJ: ‘Reasonable foreseeability of the class of injury is an essential condition of the existence of a legal obligation to take care for the benefit of another. The concept is relevant at each of the three, related, stages of the analysis of liability in negligence: the existence and scope of a duty of care, breach of the duty, and remoteness of damage.’

93 Ibid.


95 Ipp Report, above n 4, 109 provides ‘The Panel’s consideration of and recommendations about causation have been greatly assisted by the work of Jane Stapleton’. See Jane Stapleton, ‘Cause-In-Fact and the Scope of Liability for Consequences’ (2003) 119 (July) Law Quarterly Review 388.

96 Stapleton, above n 95, 411-12.

97 Bartie, above n 94, 436.
The operation of both the factual causation and scope of liability principles have been subject to criticisms by legal commentators. Bagaric and Erbacher argue that, ‘causation is a poorly defined legal concept, leading to a large degree of uncertainty and unpredictability regarding the operation of the principle’. Due to the difficulty of using the ‘but for’ test as a sole test of causation, the courts must rely on the scope of liability test which lacks precision and clarity. Bagaric and Erbacher are critical of the scope of liability test:

It is not defined with any degree of precision but rather focuses on “appropriateness” which is a normative concept that incorporates undefined policy considerations. It confers a broad judicial discretion to determine causation in individual cases by reference to idiosyncratic notions of “policy” and “justice”. It is no more transparent or principled than the common sense approach.

Manning identifies three difficulties with causation. The first is that the plaintiff’s adverse outcome may be as a result of a naturally worsening health condition rather than the breach of the practitioner’s duty of care. The second problem is that it may be impossible to prove the cause of an injury (as in mesothelioma cases) due to limits in the current state of medical science. The third issue relates to the ‘but for’ test being problematic in circumstances where there are several possible causes of an injury. In relation to the material contribution test and cases with evidential gaps, Mendelson suggests that the legislative amendments have made it easier for plaintiffs to bridge the causal ‘evidential gap’. But in doing so, the legislature has not succeeded in achieving clarity with the test because of the substantial discretion vested in the judiciary to decide causation principles on policy grounds rather than legal principle. Arguably, to vest judges with this task blurs the functions of the executive and the judiciary.

The causation element can be particularly problematic in ‘failure to warn’ cases, which are a specific niche of medical negligence, involving a failure of a medical practitioner to warn the

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98 Bagaric and Erbacher, above n 9, 772.
99 Ibid 765.
101 Ibid 340.
102 Mendelson, above n 3, 509.
103 Ibid.
patient of a material risk associated with a procedure or medication. In order to succeed, a plaintiff is required to satisfy an objective test (that a reasonable person in the plaintiff’s position would want to know the information) and a subjective test (that the plaintiff himself or herself would want to know of the risk). Skene and Luntz highlight that the Wrongs Act is at odds with the equivalent legislation of many other Australian states in failure to warn cases. It neglects to codify the subjective test at common law about what the plaintiff would have done if warned of the risk. Four other jurisdictions make statements by the plaintiffs about what they would have done inadmissible, except to the extent that the statement is against the plaintiff’s interest.

This lack of codification and uniformity means that the element of causation is governed by a broad two-part statutory test combined with common law principles, which contributes to uncertainty. This is supported by Davies and Malkin who note that the wide-ranging reforms in 2003 not only altered entitlement to damages (by placing a cap on non-economic loss) but also ‘affect[ed] basic common law doctrine, modifying or even eliminating judicial discretion that had hitherto determined when liability should be imposed’. Davies and Malkin further comment that ‘…these changes do not tame the common law’s harshness. Instead, in some respects, they add to its severity, at least from the vantage point of injured persons who are dependent on tort for compensation.’ This issue will be explored through a discussion of medical negligence and mental harm case law both prior and subsequent to the Ipp Reforms. The cases have been included to illustrate the development and operation of common law principles in medical negligence and mental harm claims prior to the reforms, as well as the interpretation and application of legislative provisions after the Ipp Reforms.

2.3.2 ROGERS V WHITAKER

Rogers v Whitaker (Rogers) is a landmark decision which concerns negligence proceedings against an ophthalmologist for failure to disclose an inherent risk associated with a medical

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104 See for instance Rogers v Whitaker (1992) 175 CLR 479.
106 Skene and Luntz, above n 2, 356.
107 See Civil Liability Act 2002 (NSW) s 5D(3); Civil Liability Act 2003 (Qld) s 11(3); Civil Liability Act 2003 (Tas) s 13(3) and Civil Liability Act 2002 (WA) s 5C(3). See also Tina Cockburn and Bill Madden, ‘Proof of Causation in Informed Consent Cases: Establishing What the Plaintiff Would Have Done’ (2010) 18(2) Journal of Law and Medicine 320.
108 Davies and Malkin, above n 80, 45.
109 Ibid.
110 (1992) 175 CLR 479.
procedure. The patient, Maree Whitaker, was effectively blind in her right eye and consulted Dr Christopher Rogers, an ophthalmic surgeon, to undergo an operation to improve the sight in that eye. Following the operation, Mrs Whitaker’s eyesight in her right eye did not improve. Instead she developed sympathetic ophthalmia, an inflammation in her left eye, leading to loss of sight in that eye.\textsuperscript{111} The issue on appeal in the High Court was whether Dr Rogers was negligent for failing to warn of a risk associated with the medical treatment, in this particular instance a one in 14,000 risk of the patient developing sympathetic ophthalmia. The High Court decided that Dr Rogers was negligent for failing to warn Mrs Whitaker of the risk.

The significance of the Rogers decision is that it permitted actions in negligence against medical practitioners in ‘failure to warn’ situations and simultaneously highlighted the legal consequences for medical practitioners for such a failure. The policy behind the imposition of the duty of care in Rogers centred on the autonomy of adult patients who have the right to be properly informed of all risks associated with undergoing a medical procedure in order to decide whether to undertake that procedure.\textsuperscript{112} This policy was balanced with practical considerations requiring medical practitioners to adhere to onerous disclosure thresholds.\textsuperscript{113} Ultimately, the Rogers decision privileged patient autonomy and placed the onus on medical practitioners to provide comprehensive disclosure.\textsuperscript{114} Whilst the judgment was not contingent on causation, the case is vital in establishing the rights of patients in failure to warn medical negligence cases.

2.3.3 CHAPPEL V HART

The High Court in Rogers focused largely on issues of medical practitioners’ duty of care and the materiality of the risk in question. Even when both of these factors have been satisfied a patient must then establish causation. Whilst the Rogers judgment did not contain much guidance on rules with respect to causation, a short time later the High Court was faced with

\textsuperscript{111} Ibid 479-481.
\textsuperscript{112} Rogers v Whitaker (1992) 175 CLR 479, 489-491.
\textsuperscript{114} For commentary on the decision and its impact on the medical profession see James Cockayne, ‘Rogers v Whitaker: Still Crazy After All These Years?’ (2007) 36(1) Health Information Management Journal 30. For information and medical practice see John Devereux, Australian Medical Law (Routledge, 3\textsuperscript{rd} ed, 2007) 313-559.
another medical negligence case which provided an opportunity for further articulation of the principles relating to causation.

In *Chappel v Hart*\(^{115}\) Mrs Hart underwent an operation to remove a pharyngeal pouch in her oesophagus. The procedure was performed by ear, nose and throat specialist Dr Chappel. Mrs Hart enquired about the risks associated with the operation, particularly on her vocal cords, indicating her specific concern that she did not wish to end up with a voice resembling that of Neville Wran, former Premier of New South Wales, whose distinctively croaky voice was due to vocal cord damage caused by a throat infection.\(^ {116}\) Dr Chappel warned Mrs Hart of the risk of perforation, but not of an infection occurring which could affect her voice.\(^ {117}\) Mrs Hart contended that if she had been informed of the risk, she would not have proceeded with the operation, but rather, would have engaged the most experienced surgeon to conduct the procedure. The question on appeal concerned principles of causation.\(^ {118}\) Counsel for Dr Chappel submitted that there was no causal connection between Dr Chappel’s failure to warn of the risks and the injury suffered by Mrs Hart. Dr Chappel’s argument was further premised on the basis that Mrs Hart’s claim was based on a *loss of a chance* to have the surgery performed by a more experienced surgeon as opposed to the physical injury she sustained.\(^ {119}\)

Mrs Hart was successful in a split High Court decision, the court finding Dr Chappel negligent for failing to disclose the risk a punctured oesophagus would have on Mrs Hart’s vocal cords. The decision was controversial, particularly because of the consequences to the medical community at large in that Mrs Hart asserted an entitlement to an extremely high level of information and disclosure from her medical practitioner. Causation was established because of Mrs Hart’s evidence that had she known of the risks she would not have undertaken the procedure and instead would have consulted a more experienced surgeon. Justice Kirby delved into a detailed discussion about the principles of causation in this case. His Honour stressed the complexity of causation stating, ‘[e]stablishing a causal connection between medical negligence and the damage alleged is often the most difficult task for a plaintiff in medical malpractice litigation’.\(^ {120}\)

\(^{116}\) Ibid 266.
\(^{117}\) Ibid 233.
\(^{118}\) Ibid 254.
\(^{119}\) Ibid 237.
\(^{120}\) Ibid 264.
His Honour accepted that the ‘but for’ test remains a relevant but not exclusive criterion for establishing causation. Further, the High Court in *Chappel* confirmed that the test for causation is subjective. To satisfy the test, one must enquire what the particular patient would have done if informed of the material risk associated with the procedure. If the patient would have proceeded with the procedure then the medical practitioner cannot be said to have caused the injury to the patient. This creates evidential problems insofar as the subjective test is concerned, because plaintiffs are likely to give self-serving testimony in order to satisfy the test. There were several notable aspects of this case, including the endorsement of a subjective test of causation by the High Court of Australia and the endorsement of a reversed onus of proof of causation onto the defendant if the plaintiff satisfied a prima facie causation. The judgment is also significant for its emphasis on patient autonomy as a policy consideration.

2.3.4 ROSENBERG V PERCIVAL

With the *Rogers* decision having opened doors for plaintiffs in medical negligence cases, numerous cases were subsequently heard involving negligent failure to warn of risks. In 2001 the High Court in *Rosenberg v Percival* was once again faced with a medical negligence action which raised issues regarding whether a medical practitioner’s failure to warn caused the patient’s injury. In this instance, however, principles of causation presented an obstacle to the plaintiff’s likelihood of succeeding. The patient underwent elective surgery to her jaw to correct a dental condition. Prior to the surgery the dental surgeon, Dr Rosenberg, warned the patient of general risks associated with the procedure but did not warn her of the particular risk of temporomandibular joint disorder. The patient developed the disorder and sued Dr Rosenberg claiming that if she had been informed of the risk she would not have elected to undergo the procedure. Ultimately all five judges unanimously decided against the patient because she was not able to establish causation in the particular circumstances.

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121 Ibid 269.
122 Ibid 272.
123 Addison, above n 113, 1.
125 Ibid.
The High Court was required to address two issues in the appeal. The first issue was whether the doctor was in breach of his duty of care towards the patient. The second issue was if there was a breach, whether the breach caused the patient’s injuries.\textsuperscript{128} The Court established that the test for causation in circumstances where there is a failure to warn a patient of risks is subjective, requiring the Court to ask whether if warned of the risks this particular patient would have undertaken the surgery.\textsuperscript{129} Justice Gummow addressed the question of causation stating that the process involved two levels of inquiry: the first requires the risk to be related physically to the injury and the second requires a causal connection between the material risk and the injury.\textsuperscript{130} His Honour highlighted that in failure to warn cases there can never be a negligent physical act which truly causes an injury but rather that the legal concept of causation is more concerned with attributing responsibility in such instances.\textsuperscript{131}

Ultimately the plaintiff failed because she was unable to satisfy causation on the evidence provided to the court. Whilst the plaintiff testified that she would not have undergone the surgery had she been informed of all of the risks, such a statement is subjective and can often be self-serving. Chief Justice Gleeson warned of the ‘prism of hindsight’ stating that ‘[r]ecent judgements in this Court have drawn attention to the danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated’.\textsuperscript{132} To overcome this, the Court suggested a number of objective factors be considered such as the need for the procedure, knowledge of treatment options and the plaintiff’s questioning of the risk.\textsuperscript{133} The decision is significant because it highlights that courts must carefully examine the needs of a reasonable patient, as well as the needs of the particular patient in the circumstances. Further, the case emphasises a patient must demonstrate that the failure to warn has genuinely altered the course of treatment such that the patient would not have undergone the treatment if warned of the risks, rather than the patient simply ‘reciting the formula’.\textsuperscript{134}

\begin{flushright}
\textsuperscript{128} Ibid.
\textsuperscript{129} Ibid 443.
\textsuperscript{130} Ibid 460.
\textsuperscript{131} Ibid 460.
\textsuperscript{132} Ibid 441.
\textsuperscript{133} Ibid 442 (Gleeson CJ); 446 (McHugh J); 455 and 459 (Kirby J); See also Mendelson, above n 8, 518.
\textsuperscript{134} Ian Freckelton, ‘Editorial: Rogers v Whitaker Reconsidered’ (2001) 9(1) Journal of Law and Medicine 5, 11. The article discusses the Rogers v Whitaker and Rosenberg v Percival decisions and concludes these judgments consolidate Australia’s distinctive emphasis upon patients’ entitlements to information to enable them to make informed decisions regarding their health.
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2.3.5 ANALYSIS OF CASE LAW BETWEEN 1992 AND 2002

The *Rogers* decision extended the rights of patients to sue their medical practitioners not only for medical negligence resulting in physical injuries but also for failure to warn of risks associated with medical procedures. Thomas Addison has conducted an analysis of case law between 1992 and 2002 to determine whether it has become easier or more difficult for patients to succeed in negligence claims for failure to warn.\(^{135}\) Addison examined 57 cases decided after *Rogers* and observed that in only seven cases the risk of harm was held not to be material.\(^{136}\) Addison concludes however that in light of decisions such as *Rosenberg* the pendulum has swung in favour of medical practitioners in that it is becoming more challenging for patients to establish negligence in failure to warn cases. This is largely due to causation being difficult to establish, and now courts tend to place more emphasis on an objective test evaluating how a reasonable person would have acted regarding the procedure if a warning had been given.\(^{137}\)

Arguably, the *Rosenberg* decision appeared to be the beginning of a change in medical litigation trends at common law. It provided the High Court with an opportunity to review the state of the law and address whether the burden placed on medical practitioners was too high. Justice Kirby in *Rosenberg* took the opportunity to highlight the practical considerations raised in response to the *Rogers* decision which centre mainly on whether it is unreasonable to expect medical practitioners to communicate to patients every single risk associated with a procedure.\(^{138}\) Ultimately his Honour noted that the practical considerations do not affect the legal principle established in *Rogers*. Case law relating to medical negligence and mental harm claims following the Ipp Reforms is outlined in section 2.5 below.

2.4 LEGAL CHALLENGES IN MENTAL HARM

Pure mental harm (sometimes referred to as psychiatric harm or nervous shock) is a niche of negligence where the plaintiff suffers no physical injury, but is left with purely psychological injuries as a result of the defendant’s negligence.\(^{139}\) Historically, legal principles regarding psychological injury were slower to develop than those regarding physical injuries, with

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\(^{135}\) Addison, above n 113, 1.  
\(^{136}\) Ibid 17.  
\(^{137}\) Ibid 29.  
courts reluctant to recognise such an action.\textsuperscript{140} The law of mental harm has been described as ‘marching with medicine but in the rear and limping a little’\textsuperscript{141} and the remedies developing ‘slowly, cautious step by cautious step’\textsuperscript{142} and these metaphors reflect the reality of the slow-moving development of the law of mental harm.

In Australia, the ability to claim compensation for mental harm was initially limited by English authority.\textsuperscript{143} In Victorian Railway Commissioners \textit{v} Coultas\textsuperscript{144} a couple travelling in a horse-drawn carriage passed a set of railway tracks, and the woman feared their cart would be struck by the train. The Privy Council held the woman’s mental harm was too remote from the incident. Subsequently, the High Court adopted a similar restrictive approach in Chester \textit{v} Council of Municipality of Waverley\textsuperscript{145} where a mother suffered nervous shock upon seeing her child’s body lifted out of a trench. The defendant council had failed to erect a fence around the trench. The High Court held that the plaintiff could not recover damages as the harm was unforeseeable, given the plaintiff did not directly perceive the incident causing death.

It was not until 1970 that the High Court allowed damages to be recovered for nervous shock.\textsuperscript{146} In Mount Isa Mines \textit{Ltd} \textit{v} Pusey\textsuperscript{147} the respondent witnessed two co-workers who were burned in an electric accident and later developed a form of schizophrenia. The respondent did not directly witness the traumatic incident nor did he know the victims involved. In finding in favour of the respondent, the High Court determined the case on principles of foreseeability, holding it was not necessary to foresee the precise injury, but rather merely the class of injury.\textsuperscript{148}

A significant turning point in the field of mental harm occurred in 1984 in Jaensch \textit{v} Coffey\textsuperscript{149} when a wife suffered nervous shock as a result of witnessing her husband in hospital following a car accident where the husband had sustained serious injuries. Despite

\begin{thebibliography}{9}
\bibitem{140} Bernadette Richards and Melissa De Zwart, \textit{Tort Law Principles} (Lawbook Co, 2\textsuperscript{nd} ed, 2017) 238.
\bibitem{141} Mount Isa Mines \textit{Ltd} \textit{v} Pusey (1970) 125 CLR 383 at 395, per Windeyer J.
\bibitem{142} Ibid 403.
\bibitem{143} Victorian Railway Commissioners \textit{v} Coultas (1888) 13 AC 222.
\bibitem{144} Ibid.
\bibitem{145} (1939) 62 CLR 1.
\bibitem{146} Mount Isa Mines \textit{Ltd} \textit{v} Pusey (1970) 125 CLR 383.
\bibitem{147} Ibid.
\bibitem{148} Ibid 390.
\bibitem{149} (1984) 155 CLR 549.
\end{thebibliography}
the wife not being present at the scene of the accident the High Court permitted recovery on the basis that she had witnessed the aftermath of the incident. In order to establish causation, the plaintiff was required to prove they had suffered a single shock (a subjective test) but this was qualified by an objective requirement that a reasonable person of normal fortitude would also have suffered a shock. Following this decision, mental harm principles remained relatively stable, with courts requiring plaintiffs to demonstrate a sudden sensory perception of the accident or its aftermath.

The legal principles established in *Jaensch* were reviewed almost two decades later when the High Court simultaneously heard two nervous shock cases. In *Tame v New South Wales*\(^\text{150}\) Mrs Tame claimed she suffered a nervous shock upon being told that a police officer had negligently recorded her blood alcohol result so that it was the same as that of another driver, when in fact Mrs Tame’s blood alcohol reading was zero. *Annetts v Australian Stations Pty Ltd*\(^\text{151}\) involved a boy who was employed as a jackaroo in a remote part of Australia. The boy’s parents were reassured by the boy’s employer that he would be safe, but instead he was sent to work in an even more remote area where he died. The boy’s parents suffered nervous shock upon being told of the boy’s death. Given neither of the factual circumstances fell into the nervous shock categories of direct sensory perception or witnessing the aftermath of an accident, the cases provided the High Court with an opportunity to review mental harm principles.

The control mechanisms prior to *Tame* and *Annetts* consisted of the need for a recognisable psychiatric illness, the need for reasonable foreseeability, a requirement that the plaintiff be of normal fortitude and the controls of direct perception and sudden shock.\(^\text{152}\) The first control of the plaintiff needing to establish that he or she is suffering from a recognisable psychiatric illness remained unaltered so as to distinguish and prevent plaintiffs seeking damages for pure ‘emotional distress’.\(^\text{153}\) The requirement that the plaintiff be a person of normal fortitude was rejected by the High Court as being a ‘separate and definitive test of liability disqualifying a plaintiff with a particular susceptibility to nervous shock from


\(^{151}\) (2002) 211 CLR 317.


\(^{153}\) Ibid 66.
In addition, the control of direct perception was strictly rejected with the Court being persuaded by the ‘anomalous, illogical and unjust results ensuing from their application’. The need for sudden shock was also discarded, with the focus being on the illness rather than the manner in which the illness was sustained.

The High Court held the test of ‘reasonable foreseeability’ as central to determination of whether a duty of care is owed and lowered the requirements of ‘normal fortitude’ and ‘sudden shock’ from prerequisites to mere considerations. Ultimately the High Court decided Mrs Tame’s psychological injury from a clerical error was not reasonably foreseeable. The Annetts’ appeal was allowed. The High Court’s decision was significant because it widened the scope of liability and made it easier for plaintiffs to seek compensation for mental harm sustained as a result of the defendant’s negligence. This decision was ‘greeted with some alarm’ by policy makers given the decision was handed down at the time of an alleged insurance crisis. Subsequently in Gifford v Strang Patrick Stevedoring three children claimed to have suffered a psychiatric injury after learning of their father’s death. The father had been crushed by a forklift at work. In finding the employer did owe a duty of care to the children, the High Court clarified that reasonable foreseeability was not the only criterion for determination of mental harm following Tame and Annetts and that the other restrictions continued to apply.

2.4.1 PROBLEMS WITH LEGISLATIVE AMENDMENTS IN MENTAL HARM CLAIMS

As part of the Terms of Reference, the Ipp Panel was required to inquire into the application, effectiveness and operation of common law principles applied in negligence to limit liability including the formulation of duties and standards of care such as in claims for mental harm. In relation to mental harm claims, the Ipp Report contained the following recommendations:

(a) The plaintiff’s mental harm must consist of a recognised psychiatric illness;

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154 Ibid 67.
155 Ibid 68.
156 Ibid 69.
160 Ipp Report, above n 4, 135.
(b) No duty of care is owed unless the defendant foresaw that a person of normal fortitude might suffer a recognised psychiatric illness.

(c) Various matters be taken into account such as whether the mental harm was sustained through a sudden shock or whether the plaintiff was at the scene where the shocking events occurred.\textsuperscript{161}

This recommendation is reflected in s 72 of the \textit{Wrongs Act} which addresses circumstances where a duty of care is owed in mental harm cases. In order to succeed, a plaintiff must satisfy the court that due to the defendant’s failure to take care, it was reasonably foreseeable that a personal of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness.\textsuperscript{162} Section 72(2) of the Wrongs Act provides that the “circumstances of the case” include the following:

(a) whether or not the mental harm was suffered as the result of a sudden shock;
(b) the plaintiff witnessed, at the scene, a person being killed, injured or put in danger;
(c) the nature of the relationship between the plaintiff and any person killed, injured or put in danger; and
\begin{itemize}
\item[(d)] whether or not there was a pre-existing relationship between the plaintiff and the defendant.\textsuperscript{163}
\end{itemize}

Similarly to Victoria, legislation in New South Wales, South Australia, the ACT, Western Australia and Tasmania imposes ‘normal fortitude’ and ‘recognised psychiatric illness’ requirements.\textsuperscript{164} In contrast to Victoria, the common law continues to govern mental harm principles in Queensland and the Northern Territory.

Section 73 of the \textit{Wrongs Act} imposes a limitation by providing that a plaintiff is not entitled to recover for pure mental harm (as opposed to consequential mental harm) unless the plaintiff witnessed the scene where the victim was being killed, injured or put in danger, or the plaintiff is or was in a close relationship with the victim.\textsuperscript{165} Section 74 imposes a further limitation, in relation to recovery for consequential mental harm. The plaintiff cannot claim

\begin{itemize}
\item[(b)] Ibid 144 (Recommendation 34).
\item[(c)] Wrongs Act 1958 (Vic) s 72.
\item[(d)] Ibid ss 72(2)(a)-(d).
\item[(e)] Civil Liability Act 2002 (NSW) s 32; Civil Liability Act 1936 (SA) s 33; Civil Liability Act 2002 (WA) s 5S; Civil Liability Act 2002 (Tas) s 34; Civil Law (Wrongs) Act 2002 (ACT) s 34.
\item[(f)] Wrongs Act 1958 (Vic) s 73(2).
\end{itemize}
compensation unless the defendant foresaw that a person of normal fortitude might suffer the harm, or the defendant knew that the plaintiff was a person of less than normal fortitude.\textsuperscript{166}

The statutory provisions relating to mental harm are problematic for several reasons. The first is the imposition of the ‘normal fortitude’ requirement (an objective test) that increases the threshold that has to be satisfied. This is a departure from the common law position in \textit{Tame} and \textit{Annetts} where the High Court had reduced the ‘normal fortitude’ rule as a consideration not a prerequisite. A further problem is the use of the term ‘\textit{recognised} psychiatric illness’ which seems to impose a higher threshold than the common law term ‘\textit{recognisable} psychiatric illness’. The term ‘recognised’ seems to impose a requirement that the illness be formally recognised by psychiatric experts compared with a situation where a plaintiff suffers a psychiatric condition (which may indeed exist) but may not have a recognised name.\textsuperscript{167} Further, the legislation addresses the principle of breach of duty but does not give any guidance as to interpretation and application of principles of causation in the context of mental harm. Mendelson comments on this issue:

\begin{quote}
It is unfortunate that statutory provisions relating to recovery of damages for negligently occasioned mental harm, while focusing on the duty of care and thresholds to recovery of damages, fail to explicitly instruct the courts that establishing breach of duty and causation are also essential elements of liability.\textsuperscript{168}
\end{quote}

The consequence in having this gap is that neither the common law nor the statutory provisions govern this area of law in its entirety. It has the potential to lead to inconsistent application of the law and to an increase in complexity in negligence cases for pure mental harm.

The restrictions imposed on mental harm claims, that is ‘normal fortitude’, ‘recognised psychiatric illness’ and the need to satisfy a significant injury threshold of ‘10 per cent or more’ which is double that of physical injury, illustrate the law’s discriminatory treatment of psychological injuries. The stringent requirements recommended by the Ipp Panel have been widely adopted in legislative provisions and reflect the longstanding suspicion with which the law treats psychological injury. Victoria, New South Wales, South Australia, Western

\textsuperscript{166} Ibid s 74(1).
\textsuperscript{167} Butler, above n 37, 123.
\textsuperscript{168} Mendelson, n 36, 176-177.
Australia, Tasmania and the Australian Capital Territory have provisions outlining circumstances where a duty of care is owed, requiring the plaintiff be of ‘normal fortitude’ and that the plaintiff must sustain a ‘recognised psychiatric illness’.\textsuperscript{169} In Queensland and the Northern Territory, common law principles apply. A comparison of mental harm provisions in the Australian jurisdictions is contained in Appendix 6.

The Ipp Panel acknowledged the law has made it more difficult for plaintiffs in mental harm claims: firstly, that psychiatric injury is difficult to diagnose objectively; secondly, that it may be difficult to foresee the number of people who suffer mental harm (as opposed to physical harm) from one single act of negligence and thirdly, due to resource limitations it is deemed more important to compensate people for physical rather than psychological injury.\textsuperscript{170} Forster and Engel are critical that the effects of the Ipp Reforms seem to have magnified the distinction between physical and mental harm.\textsuperscript{171} They highlight that the impact and costs of mental injuries on society are significant, particularly given that treatment of mental injuries can be long-term and often requires ongoing use of medication and professional assistance.\textsuperscript{172} The impact of mental harm can be debilitating for an aggrieved individual and also more widely for society.\textsuperscript{173} Forster and Engel contend that mental injuries are costly to society, both directly through ongoing need for professional consultation and medication, and indirectly through reduced employment prospects for sufferers.\textsuperscript{174} These problems highlight the need to revisit this issue by the legislature to achieve an ‘effective compensatory framework [that] could reduce the direct and indirect impacts and costs of mental injury’.\textsuperscript{175}

\subsection*{2.5 CASE LAW SUBSEQUENT TO LEGISLATIVE INTERVENTION}

Assessing case law trends in the post-Ipp era demonstrates how the amendments stemming from these reforms have impacted upon litigation of medical negligence and mental harm claims. In 2006, the Law Council of Australia commissioned a report on the litigation trends

\begin{flushleft}
\textsuperscript{169} Wrongs Act 1958 (Vic) ss 72-75; Civil Liability Act 2002 (NSW) ss 27-33; Civil Liability Act 1936 (SA) ss 33, 53; Civil Law (Wrongs) Act 2002 (ACT) ss 33-35; Civil Liability Act 2002 (WA) ss 5S-5T; Civil Liability Act 2002 (Tas) ss 31-34.
\textsuperscript{170} Ipp Report, above n 4, 135.
\textsuperscript{171} Forster and Engel, above n 37, 608.
\textsuperscript{172} Ibid 607.
\textsuperscript{173} Ibid 606.
\textsuperscript{174} Ibid 607-608.
\textsuperscript{175} Ibid 608.
\end{flushleft}
before and after the Ipp Reforms.176 In a report on national litigation trends during the period 1995 to 2005, Professor Wright concluded that ‘data indicates in most jurisdictions that there has been an appreciable (in some States, dramatic) decline in litigation since the implementation of the Ipp Review-inspired reforms’.177 The Victorian trends show a ‘dramatic’ decline with Victoria being the lowest claiming state.178 Several appellate court decisions are drawn upon to illustrate the ongoing issues affecting medical negligence and mental harm claims following the Ipp Reforms.

2.5.1 WALLACE V KAM

In 2013, the High Court was faced with a medical negligence case for failure to warn. In Wallace v Kam179 the patient consulted Dr Kam (a neurosurgeon) with respect to a lumbar spine condition. The patient underwent surgery which held two risks: the first risk involved nerve damage as a result of lying down on the operating table for an extended period of time and the second risk was permanent paralysis due to damage to the spinal nerve. The first risk, the less catastrophic of the two, eventuated. Mr Wallace initiated negligence proceedings against Dr Kam for failure to warn him of both risks. Mr Wallace was unsuccessful at trial and in his appeal to the New South Wales Court of Appeal. His appeal to the High Court was also dismissed. The High Court considered principles of causation under s 5D of the Civil Liability Act 2002 (NSW) which is essentially a replica of s 51 of the Wrongs Act. The High Court focused on the scope of liability element, deciding it would not be appropriate to find Kam negligent in circumstances where if Mr Wallace had been warned of the risk he would have been prepared to accept that risk.180 The decision in Wallace has been described by Thomas Faunce as continuing a judicial trend to ‘go cool’ on patients’ rights in medical negligence cases.181

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177 Wright, above n 46, 246.
178 Ibid 255.
179 (2013) 250 CLR 375.
2.5.2 ODISHO V BONNAZI

Following the 2013 Wallace decision, the Victorian Court of Appeal was faced with a failure to warn case in 2014. The appellant in Odisho v Bonazzi\textsuperscript{182} suffered from abnormally heavy bleeding and was prescribed tranexamic acid for this condition by specialist gynaecologist Marcia Bonazzi. As a result of a side effect of the tranexamic acid the appellant developed multiple pulmonary emboli which involve a blockage of blood vessels. The appellant’s counsel argued Dr Bonazzi failed to warn her of the risk of developing the pulmonary emboli. The Victorian Court of Appeal dismissed Ms Odisho’s appeal. The court specifically addressed principles of causation under the Wrongs Act. In this regard the court was not satisfied that even if warned of the risk, Ms Odisho would have declined the treatment. An application for special leave to the High Court on the point of causation was dismissed on 15 October 2014.\textsuperscript{183} The case demonstrates that causation can be an unjust obstacle in circumstances where the plaintiff can satisfy a breach of duty of care but is unable to satisfy the subjective test that she would have been deterred from taking the medication based on the warning.

2.5.3 OVERVIEW OF RECENT CASES

In King v Western Sydney Local Health Network\textsuperscript{184} the plaintiff, a pregnant woman, attended hospital where doctors were informed that the woman’s daughter had been diagnosed with chickenpox. Doctors decided not to administer a vaccine to the plaintiff, who subsequently contracted chickenpox, a virus that can inhibit foetal development. The plaintiff’s baby was born with Congenital Varicella Syndrome. The plaintiff claimed that had she been given the vaccine at her initial hospital attendance, she would not have contracted chickenpox and thus the injuries sustained by the baby would have been prevented. The plaintiff was unsuccessful at both the trial and on appeal, due to being unable to satisfy factual causation. The Court of Appeal found that the plaintiff was only able to satisfy a possible material increase in risk, which was insufficient to satisfy the threshold on the balance of probabilities.

The Court of Appeal considered the application of the ‘but for’ test in Carangelo v State of New South Wales.\textsuperscript{185} The case concerned an action for mental harm by a police officer,
alleging he had suffered psychiatric injury in the course of his employment. Specifically, the appellant claimed the failure to offer pastoral care and support, and/or to recommend him to a private psychiatrist caused the injury. The Court of Appeal considered the Ipp Report recommendations regarding causation, including factual causation, increased risks, material contribution and the scope for application of the exceptional case provision.\textsuperscript{186} The court highlighted the limitations of the ‘but for’ test where there is more than one sufficient condition to the occurrence of the plaintiff’s injuries.\textsuperscript{187} Ultimately, the court found that the evidence did not support a finding of a connection between the failure to offer psychiatric support and the psychiatric injury.\textsuperscript{188} The court further held that the circumstances of this case did not constitute an ‘exceptional case’ to which the material contribution test could apply.\textsuperscript{189}

The scope of liability element has also been judicially considered by the NSW Court of Appeal, in \textit{Paul v Cooke},\textsuperscript{190} a case involving a failure to diagnose an aneurysm on the appellant’s computerised tomography (CT) scan in 2003. The appellant underwent surgery in 2006 where the aneurysm burst during the operation. The appellant was unsuccessful because the court found it was not appropriate to extend liability to Dr Cooke for risks inherent in the condition rather than in the delay of diagnosis. In other words, Dr Cooke’s negligence changed the timing of the surgery but did not affect the inherent risk associated with it. This case is an example where a plaintiff can satisfy that a medical practitioner has breached a duty of care, but that breach has not caused the injury. An appeal for special leave to the HCA on the issue of causation was denied.\textsuperscript{191}

Apart from causation, the legislative provisions relating to mental harm have also been subjected to judicial interpretation. For instance, in \textit{King v Philcox}\textsuperscript{192} the plaintiff was the brother of a victim killed in a motor vehicle collision. The plaintiff drove past the scene several times without realising the victim was his brother. He subsequently realised he had driven past the location of the accident whilst his brother was trapped inside a vehicle. The plaintiff developed a major depressive disorder. On appeal, the HCA set aside an award of

\textsuperscript{186} Carangelo v State of New South Wales [2016] NSWCA 126 (27 May 2016), [63]-[74] (Emmett AJA).
\textsuperscript{187} Ibid [74].
\textsuperscript{188} Ibid [94].
\textsuperscript{189} Ibid [95].
\textsuperscript{190} (2013) 85 NSWLR 167.
\textsuperscript{191} Paul v Cooke [2014] HCATrans 25 (14 February 2014).
\textsuperscript{192} (2015) 255 CLR 304.
damages awarded by the Full Court of the Supreme Court of South Australia and held that the plaintiff was not entitled to recover damages because he was not at the scene of the accident when the death occurred within the meaning of s 53(1)(a) of the Civil Liability Act 1936 (SA). The wording of the South Australian provision is similar to s 72 of the Wrongs Act, so that the High Court's decision would apply to cases decided under Victorian legislation. However, the High Court acknowledged the difference in the wording between the South Australian provision and the NSW provision which requires the plaintiff to be 'present at the scene of the accident when the accident occurred'. Given the similarities between the NSW and Victorian provisions, there is also scope for Victorian cases to distinguish this decision when interpreting mental harm provisions.

A NSW decision demonstrates how the thresholds on non-economic loss have impacted upon recovery of compensation in medical negligence and mental harm claims. In Sorbello v South Western Sydney Local Health Network; Sultan v South Western Sydney Local Health Network the plaintiffs were parents of a child born with a severe intellectual disability due to oxygen deprivation at birth. The hospital conceded elements of duty, breach and causation so those elements were not in issue; however, an issue relevant to this thesis was the quantum of damage. Schmidt J assessed non-economic loss for the mother at 35 per cent of the maximum cap whereas the father was assessed at 20 per cent. This case serves to highlight the problems with the cap on non-economic loss damages, and shows the maximum cap is only likely to be received in cases where plaintiffs have sustained a significant injury of the most serious kind.

These cases illustrate that appellate courts' interpretation of the statutory test of causation was presenting as a barrier to plaintiffs, particularly in circumstances where plaintiffs are able to satisfy a breach of duty of care but fail at the causal hurdle. The cases also highlight problems with mental harm provisions and caps on damages. It is therefore important to identify a coherent legal response to the regulation of personal injury and this is explored through the lens of corrective justice theory in this chapter.

194 See the Civil Liability Act 2002 (NSW) s 30 and Wrongs Act 1958 (Vic) s 73.
196 Ibid [117] (Schmidt J).
197 Ibid [189] (Schmidt J).
2.6 2015 LEGISLATIVE REFORMS

On 30 May 2013, VCEC undertook an enquiry into aspects of the Wrongs Act in response to the concern that the law had imposed ‘unreasonable barriers’ and ‘limitations’ to legitimate personal injury claims.\(^{198}\) The scope of the enquiry was to identify and make recommendations to address any anomalies, inequities or inconsistencies in the Act relating to personal injury damages, without undermining the objectives of major tort reforms in 2002 and 2003.\(^{199}\) This included addressing limits placed on damages for economic and non-economic loss, impairment thresholds imposed in relation to damages for non-economic loss, discount rates for lump sum damages for future economic loss and limitations on damages for gratuitous attendant care.\(^{200}\)

VCEC consulted numerous stakeholders who identified factors that led to people missing out on ‘fair’ compensation for economic and non-economic losses or produced inconsistencies in outcomes for similarly injured parties under the Victorian compensation regimes.\(^{201}\) The Law Institute of Victoria highlighted the unfairness to VCEC with an example of a boy who was denied compensation for non-economic loss because the Medical Panel assessed the boy’s injury at less than 5 per cent, despite the injury requiring surgery and a lengthy recovery time.\(^{202}\) The terms of reference specifically excluded VCEC from revisiting the underlying objectives of the previous tort law reforms or from assessing their overall impact on the effectiveness of the reforms, their impact on economic efficiency, or their impact on equity or fairness.\(^{203}\) While implicitly acknowledging the problems presented by the Ipp Reforms, the legislature nevertheless directed VCEC to steer clear of re-opening the debate relating to the previous decade’s reforms.

VCEC’s report contained three overarching recommendations: (1) a decrease in significant injury thresholds and an increase in the maximum amount of damages to address anomalies, inequities and inconsistencies in the limitations on damages for personal injury or death; (2) the introduction of prescribed forms to reduce transaction costs and improve equity; and (3)

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\(^{198}\) *VCEC Report*, above n 1, vii - viii.
\(^{199}\) Ibid 1.
\(^{200}\) Ibid xxiv. VCEC was also directed to enquire and make recommendations into possible reforms for liability regarding aircraft.
\(^{201}\) Ibid xxv.
\(^{202}\) Ibid xxvi.
\(^{203}\) Ibid 2.
that section 31 of the Wrongs Act 1958 (Vic) be amended to allow for recovery of damages for mental harm caused by an aircraft accident only in circumstances where personal or property damage is also caused by the aircraft.\textsuperscript{204} The first of these overarching recommendations (Recommendation 7.1) is most relevant to this thesis. In this regard, VCEC recommended that the Victorian government amend the Wrongs Act to allow for a more generous impairment threshold for damages for non-economic loss to 10 per cent or greater for psychiatric injuries, and 5 per cent or greater for spinal injuries, and to increase the maximum amount of damages that may be awarded to a claimant.\textsuperscript{205}

VCEC recommended a ‘modest’ reform package, balancing the need to address anomalies, inconsistencies and inequities but without adversely increasing the cost of insurance. In relation to non-economic loss, VCEC made the following recommendations:\textsuperscript{206}
\begin{itemize}
\item a reduction of the impairment threshold for spinal and psychiatric injuries;
\item an increase to the maximum cap on non-economic loss damages;
\item the cap on economic loss to apply to pre- and post-injury earnings;
\item in claims for loss of expectation of financial support, deductions for the deceased person’s expenses are to be made before applying the cap on economic loss;
\item a limited entitlement for loss of capacity to care for others;
\item the impairment assessment for spinal injuries take into account the claimant’s post-surgery condition (rather than pre-surgery);
\item common law claims arising from the use of a motor vehicle are subject to the Wrongs Act limitations.
\end{itemize}

On 18 November 2015, amendments were made to the Wrongs Act.\textsuperscript{207} The amendments were in response to VCEC’s 2014 Final Report titled Adjusting the Balance: Inquiry into Aspects of the Wrongs Act 1958 (‘VCEC Report’).\textsuperscript{208} The purpose of the changes was to make damages more accessible by lowering the impairment threshold for psychiatric and spinal injuries, and by increasing the damages cap for non-economic loss. The Wrongs Amendment Act 2015 (Vic) implemented the majority of the changes recommended by VCEC.\textsuperscript{209} The

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\item \textsuperscript{204} Ibid xxxiii-xxxiv.
\item \textsuperscript{205} Ibid xxxiii.
\item \textsuperscript{206} Ibid at xxx.
\item \textsuperscript{207} Wrongs Amendment Act 2015 (Vic).
\item \textsuperscript{208} VCEC Report, above n 1, vii - viii.
\item \textsuperscript{209} Wrongs Amendment Act 2015 (Vic) s 1. The purpose of the amending act was to effect five changes: (1) An increase in injury threshold levels; (2) An increase in the non-economic loss damages cap; (3) An
Victorian Government did not adopt the recommendation to make common law motor vehicle claims subject to the limitations in the *Wrongs Act 1958* (Vic) nor the recommendation to assess degree of impairment for spinal injuries based on the claimant’s post-surgery condition. The amended provisions commenced operation on 19 November 2015.

One of the key amendments was an alteration to s 28LB of the *Wrongs Act* decreasing the impairment threshold level.\textsuperscript{210} The section reads as follows:

\begin{quote}
threshold level means –
(a) in the case of injury (other than psychiatric injury or spinal injury), impairment of more than 5 per cent;
(b) in the case of psychiatric injury, impairment of 10 per cent or more;
(c) in the case of spinal injury, impairment of 5 per cent or more.
\end{quote}

The threshold for spinal injuries was reduced from ‘more than 5 per cent’ to ‘5 per cent or more’. The change with respect to spinal injuries has potential to have significant impact because of the way an injury is assessed pursuant to the AMA Guides. All other physical injuries continue to be assessed at more than 5 per cent whole person impairment.\textsuperscript{211} A similar amendment was made to the threshold for psychiatric injury, reducing it from ‘more than 10 per cent’ to ‘10 per cent or more’.\textsuperscript{212} However, the change to psychiatric injury may not have such a significant impact given it applies only to primary psychiatric injury, such as nervous shock. VCEC acknowledged this amendment would apply in limited cases.\textsuperscript{213}

A separate amendment increased the non-economic damages cap from $371,380 to $577,050, with that figure indexed annually.\textsuperscript{214} This is an increase of approximately $60,000, given the indexed figure was $518,300 as at 1 July 2015. This amendment is likely to only impact serious physical injuries at the higher end of the limit such as paraplegia, quadriplegia and severe cognitive impairment. The Act also amended the calculation of the cap on economic

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{210}]Ibid s 11.
\item[\textsuperscript{211}]Ibid.
\item[\textsuperscript{212}]Ibid. Psychiatric impairment is measured using the Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC).
\item[\textsuperscript{213}]VCEC Report, above n 1, 129.
\item[\textsuperscript{214}]Wrongs Amendment Act 2015 (Vic) s 6.
\end{itemize}
\end{footnotesize}
loss, altering it to three times the average weekly earnings and removing the requirement to ‘disregard’ earnings above the cap of three times average weekly earnings.  

VCEC considered the introduction of a ‘narrative test’ to assist claimants whose claims might otherwise fall below the threshold. The narrative test is used under the Accident Compensation Act 1985 (Vic) and Transport Accident Act 1986 (Vic), and allows a subjective assessment of the impact an injury has had on a plaintiff. For instance, it enables assessment of the long-term effects on a person’s quality of life, including occupational, financial, social, domestic and psychological effects. VCEC rejected the narrative test due to a risk that over time it may result in plaintiffs receiving compensation for unmeritorious claims. VCEC did not provide evidence of extensive consideration of this reform proposal, save for consideration of submissions from three stakeholders, nor did VCEC provide comprehensive reasons for rejecting the proposal. The essence of the rejection was premised on three factors: first, existing chapters of the AMA Guides already include an allowance for pain; second, if the narrative test was implemented, it could lead to adverse effects on insurance premiums with the increase of compensation and third, it could lead to increased court and administrative costs. Ultimately, the reforms recommended by VCEC to increase impairment thresholds by one per cent were conservative in order to avoid adversely impacting on costs.

The 2015 reforms raise important questions about whether the amendments are sufficient to address the ‘harshness’ of the existing legislation or whether the removal of certain restrictions will increase litigation to the point that insurance companies will again complain of an unfair financial burden. Despite the remedial nature of the 2015 amendments, the imposition of permanent injury thresholds and caps on non-economic loss damages are excessively restrictive to the detriment of injured persons dependent on the legal system for compensation. It is important to recognise that keeping insurance premiums low is necessary to allow various stakeholders to obtain affordable insurance, however restricting compensation harshly can also have undesirable financial consequences by placing a

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215 Ibid s 5.
216 Ibid 36.
217 Ibid 50.
218 Ibid 51.
financial burden on the welfare system to assist the injured who are unable to recover compensation. Some commentators have argued that locking out a portion of claimants because they do not satisfy thresholds may also be contrary to human rights provisions. The Charter of Human Rights and Responsibilities Act 2006 (Vic) provides for the equal protection of the law without discrimination giving rise to an argument that the current Wrongs Act provisions are discriminatory against claimants who rely on non-economic damages. Further, the thresholds are restrictive in excluding claimants who fail to meet the permanent injury thresholds, even by a small margin. In circumstances where the imposition of thresholds and caps is potentially discriminatory, it is relevant to consider compensation alternatives such as a no-fault scheme that allows claimants to be compensated equally.

2.7 COMPENSATION ALTERNATIVES – NO-FAULT SCHEME

Given the challenges that continue to exist in medical negligence and mental harm litigation, an alternative means of compensating victims including the no-fault statutory scheme in New Zealand (NZ) is worthy of consideration. Introduced in 1972, the no-fault scheme provides compensation to those harmed by accidents without the need to pursue fault-based litigation. In this regard it is similar to the no-fault transport accident and workplace schemes already operating in Victoria. The scheme is administered by the Accident Compensation Corporation under the Injury Prevention, Rehabilitation and Compensation Act 2001 (NZ). Funding is drawn from various sources including employees, the New Zealand Government, and taxes on petrol and vehicle registrations. In order to receive compensation for medical negligence, an injured person must show they have suffered a ‘treatment injury’. A treatment injury is defined as a personal injury suffered by a person seeking or receiving treatment from a health professional, caused by treatment and is not a

222 King, above n 68, 26.
223 Charter of Human Rights and Responsibilities Act 2006 (Vic) s 8(3).
225 See for instance Accident Compensation Act 1985 (Vic) and Transport Accident Act 1986 (Vic).
226 Accident Compensation Corporation, How ACC We’re Funded: The Five ACC accounts <http://www.acc.co.nz/about-acc/overview-of-acc/how-were-funded/ABA00010>.
necessary part or ordinary consequence of the treatment.\textsuperscript{228} The NZ legislation also requires proof of causation between treatment and injury, stating that treatment injury does not include ‘personal injury that is wholly or substantially caused by a person’s underlying health condition’.\textsuperscript{229} However, the courts have allowed drawing an inference of a causal nexus between treatment and injury, even if not medically proven.\textsuperscript{230}

The benefits of NZ’s no-fault scheme have prompted commentators to question whether Australia should adopt a similar system. Weisbrot and Breen are critical of the present Australian fault-based tort system which is ‘slow, costly, inefficient, stressful and often inequitable and unpredictable means of assisting people harmed through medical care.’\textsuperscript{231} They argue that the Productivity Commission should conduct an enquiry into the merits of moving to a no-fault scheme for all medical injuries.\textsuperscript{232} Some of the benefits of a no-fault system include more predictable care and support, more consistent coverage of all injured people regardless of the particular circumstances of the injury and a more efficient system.\textsuperscript{233} Criticisms of the no-fault system centre on the fact that compensation can be lower than under a fault-based scheme and thus claimants may be financially worse off under a no-fault system. In addition, there are compelling arguments around the potential costs of a no-fault scheme given the likely rise in the number of claimants who would receive compensation and the issue of who will pay for this increase.\textsuperscript{234} Yet the recent introduction of the National Disability Insurance Scheme (NDIS) in Australia provides a useful guide on adoption of a no-fault scheme, without excessive cost to the community. The NDIS is funded through government revenue (including a diversion of all usual disability services funding to the NDIS) and an increase to the Medicare levy.\textsuperscript{235}

\begin{footnotes}
\item[228] Accident Compensation Act 2001 (NZ) s 32(1).
\item[229] Ibid s 32(2)(a). The New Zealand Court of Appeal in Accident Compensation Corporation v Ambros [2008] 1 NZLR 340 rejected the option of permitting a reversal of the legal onus of proof of causation.
\item[230] See Brash v Accident Compensation Corporation [2013] NZACCC 23 where the court drew an inference of a causal nexus between treatment (neck manipulation by a chiropractor) and injury (stroke).
\item[232] Ibid 296.
\item[233] Ibid 297.
\item[234] Ibid 297.
\end{footnotes}
Insofar as mental harm is concerned, the NZ scheme permits recovery of compensation only if the mental injury is suffered as a consequence of physical injury. The plaintiff also has to show the mental injury (arising from the physical injury) was a clinically significant behavioural, cognitive or psychological dysfunction. The restrictions under the scheme are analogous to recovery for ‘consequential mental harm’ and the need for the injury to be a ‘recognised psychiatric illness’ under Australian law. The NZ scheme excludes recovery for pure mental harm without accompanying physical injury. Plaintiffs are also unable to claim compensation in ‘secondary victim’ circumstances, such as witnessing harm to others. Thwaites posits that seeking compensation at common law is particularly difficult for secondary victim claimants. Therefore, despite the advantages of the NZ scheme, it does not entirely eliminate the disparity between physical and psychological injuries.

The obvious benefit under the NZ scheme is that plaintiffs have the entitlement to basic compensation not only for their physical injuries but also for psychological injuries in limited circumstances. Additionally, the no fault scheme means an applicant need not litigate, thus saving them the stress of a trial. This may be particularly important for those suffering a mental health illness as the experience of litigation can be distressing and may mean a litigant is revictimised by the experience of court. For instance, a longitudinal study of 332 Australian hospital patients examined whether claiming for compensation after injury is associated with poor health outcomes. The study found that stress associated with the claims process following injury is linked to long-term disability. A separate aspect of the same study examined claimant experiences in compensation processes, and found that claims processes are the primary facilitators of access to justice for injured persons. Further, tools for assessing compensation sums such as the AMA Guides were intended to foster accuracy, predictability and consistency of decision-making, yet claimants perceive such tools to be

236 Accident Compensation Act 2001 (NZ) s 26(1)(c). In addition, there are two special cases providing compensation for mental injury caused by criminal acts (s 21) and claimants who suffer mental injury in a work-related sudden event or incident (s 21B).

237 Accident Compensation Act 2001 (NZ) s 27.


239 Karin Huffer, Overcoming the Devastation of Legal Abuse Syndrome (Karin Huffer, 1995).


241 Ibid 1000-1005. The study consisted of data gathered from four hospitals in Victorian, New South Wales and South Australia between April 2004 and February 2006.

The findings of this study support the premise that administrative systems in personal injury should strive to grant claimants access to compensation in a straightforward manner, without being overly complex, time-consuming and confusing. Given the advantages of no fault schemes, there is potential to explore whether litigation avoidance and a simpler claims process assist claimants to experience a more ‘just’ resolution of their claim, and further, it may assist with the development and evaluation of a more adequate claims system in Victoria.

2.8 CONCLUSION

This chapter has amalgamated tort law literature and a doctrinal analysis of legislation and case law on the topic of medical negligence and mental harm claims, to explain the development of the law in this area and to highlight the level of concern that these tort policy reforms have merited. The analysis has shown that many legal academics are of the view that the Ipp Reforms were hastily implemented without proper empirical underpinning or community consultation. The Ipp Reforms have impacted upon the ability of plaintiffs to succeed in meritorious negligence proceedings by placing restrictions such as permanent injury thresholds, caps on damages and the statutory causation test. The 2015 reforms by the Victorian legislature were indicative of a need to reform the area of personal injury compensation, yet the reforms were relatively conservative. Case law demonstrates ongoing restrictions in compensating claimants in medical negligence and mental harm claims, supporting the researcher’s decision to undertake qualitative research on this topic and to interview lawyers and judges with medical negligence experience to gather their views on the challenges presented by the current legislative framework. Further, given that all claims brought by injured individuals in Victorian courts will be subjected to ADR processes prior to trial, the next chapter will comprehensively explore the use of mediation in medical negligence disputes.

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243 Ibid 652.
CHAPTER 3 – MEDIATION OF MEDICAL NEGLIGENCE AND MENTAL HARM DISPUTES

3.1 INTRODUCTION

Over the past few decades in Australia and internationally, the legal practice landscape has changed considerably with the increase of dispute resolution avenues other than litigation. In Australia this increase is evident in many legal fields and dispute types, including family, government and civil disputes.¹ In medical negligence, ADR is deeply entrenched within the dispute resolution culture, with court practice directions encouraging parties to resolve their disputes without the need for trial.² The privileging of ADR as the primary method of dispute resolution is apparent in legislation which imposes an overarching purpose for a ‘just, efficient, timely and cost-effective resolution of the real issues in dispute’.³ Likewise, judicial officers are now expressly empowered to use ADR as a case management tool to encourage efficient resolution of disputes.⁴ Proponents advocate for increased use of ADR because it offers a speedier, cost effective and less adversarial method of dispute resolution than traditional adversarial avenues. Despite the benefits, some scholars question whether ADR poses a threat to the adversarial system, particularly to the doctrine of precedent, and whether mandatory imposition threatens the voluntary nature of parties’ participation in ADR.⁵ Notwithstanding such criticisms, recent government reports have further endorsed the trajectory of increased use of ADR in Australia.⁶

Alternative avenues of dispute resolution, such as mediation, are an integral part of medical negligence disputes. Medical negligence disputes often involve a medical error that entails a

¹ Farm debt, franchising, family law and retail lease disputes are require mandatory pre-litigation ADR: Family Law Act 1975 (Cth), s 60I and 79(9); Retail Leases Act 2003 (Vic) s 87; Farm Debt Mediation Act 2011 (Vic). In a government context, ADR is used by the Dispute Settlement Centre of Victoria, Consumer Affairs Victoria and the Victorian Ombudsman.
² County Court of Victoria, Practice Note: Common Law Division – Medical List No 1 of 2015, 24 July 2015, [66].
³ Civil Procedure Act 2010 (Vic) s 7(1).
⁴ Ibid s 66(1).
breach of trust between a doctor and a patient, frequently giving rise to an emotionally heated dispute. Less adversarial arenas are therefore more appropriate forums for the resolution of medical negligence disputes, allowing for an explanation, an expression of regret, sympathy or emotional closure.\(^7\) Given that the shadow of the law influences the choice and use of dispute resolution avenues,\(^8\) it is important to explore whether the Ipp Reforms have had any impact on the mediation of medical negligence disputes and whether any challenges occur in practice.

This chapter explores the role of lawyers in influencing the mediation process, as well as highlighting the potential benefits of addressing emotion in medical negligence disputes. This chapter will first define mediation, describe its historical development in Australia and explore its importance as a dispute resolution mechanism. This is followed by a discussion of the current use of court-connected mediation as a tool for resolving disputes prior to trial, as well as a focus on the role of lawyers, and an exploration of the potential to address emotion in the mediation process. Next the discussion centres on the use of mediation in medical negligence and mental harm disputes, and outlines previous empirical studies in this context. Finally, the chapter addresses the role of legal education in shifting the adversarial culture of the legal profession to ensure lawyers’ improved engagement with mediation. This literature review chapter contributes to the overall research aim by providing a theoretical frame of reference against which to conduct qualitative interviews about mediation practice in medical negligence.

### 3.2 WHAT IS MEDIATION?

Mediation can be described as a system of negotiation or decision-making where parties are assisted to reach agreement with the assistance of a neutral third party.\(^9\) The Mediator Standards Boards offers the following definition of mediation in the National Mediator Accreditation Standards:

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Mediation is a process that promotes the self-determination of participants and in which participants, with the support of a mediator: (a) communicate with each other, exchange information and seek understanding (b) identify, clarify and explore interests, issues and underlying needs (c) consider their alternatives (d) generate and evaluate options (e) negotiate with each other; and (f) reach and make their own decisions. A mediator does not evaluate or advise on the merits of, or determine the outcome of, disputes.\textsuperscript{10}

The process of the traditional model of mediation involves the identification of issues in dispute (including parties’ underlying needs, goals, wants and desires), developing options and aiming to reach an agreement.\textsuperscript{11} Mediation can be used to define problems, settle or manage disputes, negotiate contracts, create policy or prevent future conflicts.\textsuperscript{12} Advantages of mediation are said to include that the process is flexible, informal, emphasises a ‘win-win’ solution for all parties and provides parties with a higher degree of control over the process.\textsuperscript{13} The premise of a ‘win-win’ negotiation rejects adversarialism and positional bargaining, and instead encourages both parties to negotiate to achieve an outcome that satisfies their individual interests as well those of the other party.\textsuperscript{14}

Four models of mediation have been identified over time in the mediation field reflecting the evolution of mediation practice. These models can be referred to as the settlement, transformative, evaluative and facilitative models.\textsuperscript{15} Settlement mediation focuses on incremental bargaining, often reaching a mid-point compromise between parties.\textsuperscript{16} Transformative mediation moves away from a purely settlement focus to conflict privileging party clarity and strength in decision-making through recognition and empathy.\textsuperscript{17} Evaluative mediation will often include an advisory role for the mediator with the aim of reaching a settlement according to parties’ legal rights and entitlements.\textsuperscript{18} Facilitative mediation focuses on addressing parties’ underlying needs and interests and achieving collaborative problem

\textsuperscript{11} David Spencer and Samantha Hardy, Dispute Resolution in Australia: Cases, Commentary and Materials (Thomson Reuters, 3\textsuperscript{rd} ed, 2014) 136.
\textsuperscript{12} Boulle, above n 9, 30 – 34.
\textsuperscript{13} Peter Condliffe, Conflict Management: A Practical Guide (LexisNexis, 5\textsuperscript{th} ed, 2016) 300.
\textsuperscript{15} Boulle, above n 9, 43.
\textsuperscript{16} Ibid 44.
\textsuperscript{17} Ibid.
\textsuperscript{18} Ibid.
solving.\textsuperscript{19} Spencer and Hardy argue that the facilitative model of mediation is the most commonly used model in Australia, although they acknowledge that in court-connected contexts settlement or evaluative models are common.\textsuperscript{20} Despite the existence of several models of mediation, a common factor is the fact that solutions to a dispute must be by agreement\textsuperscript{21} as there is no judge to be the decision-maker.\textsuperscript{22}

Within the mediation process, lawyers will frequently undertake negotiation over the subject matter of the dispute, and the approaches they can adopt vary. There are two widely accepted negotiation models: the first is ‘zero-sum negotiation’ which can also be referred to as positional or distributive negotiation and the second is the integrative problem-solving model.\textsuperscript{23} Zero-sum negotiation focuses on a distributive approach where what is achieved by one party is gained at the expense of the other. It is accepted in disputes where other matters, such as parties’ desire for an ongoing relationship, are not critical.\textsuperscript{24} Zero-sum negotiation involves lawyers using tactics and arguments over the law and evidence to persuade the opposition of the merits of their case.\textsuperscript{25} In contrast, the problem-solving approach recognises that individuals have a variety of needs and interests (including economic, social, psychological, moral and communal), thus takes into account needs and objectives in reaching a creative solution.\textsuperscript{26} Engaging in problem-solving approaches is challenging for repeat players (such as insurers, governments and lawyers) who tend to adopt positional bargaining, as a lack of time and resources force leave little time to explore needs, interests and collaborative solutions.\textsuperscript{27} Yet, Boulle and Field recognise that problem-solving negotiation is an aspiration for many negotiators, as it is the model on which mediation theory and standards are premised.\textsuperscript{28}

\textsuperscript{19} Ibid.
\textsuperscript{20} Spencer and Hardy, above n 11, 146.
\textsuperscript{21} Adele Carr, ‘Broadening the Traditional Use of Mediation to Resolve Interlocutory Issues Arising in Matters Before the Courts’ (2016) 27(1) Australasian Dispute Resolution Journal 10, 11.
\textsuperscript{22} Ibid 11.
\textsuperscript{23} Laurence Boulle and Rachael Field, Australian Dispute Resolution: Law and Practice (LexisNexis, 2017) 221.
\textsuperscript{24} Ibid 221-222.
\textsuperscript{25} Ibid 222.
\textsuperscript{26} Ibid 223.
\textsuperscript{27} Ibid 223.
\textsuperscript{28} Ibid 225.
3.3 THE HISTORY OF MEDIATION IN AUSTRALIA

Indigenous communities in Australia have used a range of dispute resolution processes for thousands of years. Following settlement in Australia, the English legal system was influential in the development and use of non-litigious forms of dispute management. In Australia, the modern ADR movement can be traced back to the 1980s in New South Wales and Victoria. It began with a Community Justice Centre Pilot Project providing community-based mediation services in New South Wales in 1980, and was followed by the establishment of four Neighbourhood Mediation Centres by the Legal Aid Commission in 1987 in Victoria. The 1980s saw expansion of ADR in other Australian states, with further growth in the 1990s with the legislative introduction of mediation into a range of dispute categories such as farm debt, native title and workplace relations. In 1995 the Commonwealth Attorney-General created the National Alternative Dispute Resolution Advisory Council (NADRAC) for the promotion of ADR. In 2006, reforms were introduced to the Family Law Act 1975 (Cth) requiring parties to a parenting dispute to attend compulsory mediation prior to issuing a formal application to the Family Court, evidencing a gradual but important move towards mandatory mediation. In September 2017, it was announced by the Attorney General that a comprehensive review of Family Law would be undertaken and this review is likely to include more initiatives relating to ADR.

The rise in ADR may be attributed to a number of problems experienced with the adversarial legal system, including excessive cost and delay. In the adversarial system of justice, parties

29 Condliffe, above n 13, 128.
30 Ibid.
31 Ibid.
32 Ibid.
34 Ibid.
35 Condliffe, above n 13, 129-130.
36 Ibid 130.
37 Ibid 131.
are antagonists and the judge is an impartial umpire who remains largely passive, albeit responsible for making the ultimate binding decision.\textsuperscript{40} One problem with the adversarial system that was recognised in the 1990s was that it encouraged an arena of conflict and resulted in a system that was too expensive and too slow in delivering justice to the parties.\textsuperscript{41} Influential writer Carrie Menkel-Meadow is critical of the adversarial system and the binary solutions it produces. In a postmodernist critique, Menkel-Meadow argues that court-derived outcomes or solutions produced in the shadow of the law produce ‘win-loss’ outcomes that oversimplify human problems.\textsuperscript{42} She contends that avenues of problem-solving which are capable of meeting the needs and interests of the parties, such as ADR, can produce fairer outcomes.\textsuperscript{43}

Mediation offers many benefits when compared to litigation: it reduces costs, alleviates pressure on court resources, maintains amicable relations between parties, and increases the possibility of early dispute resolution.\textsuperscript{44} Prompted by major legislative reform in the UK, Australian government inquiries were conducted with a view to improving the justice system at a federal and state level.\textsuperscript{45} In 2010 significant legislative reforms were made to the Victorian \textit{Civil Procedure Act 2010} (Vic) with the introduction of an overarching purpose to facilitate a ‘just, efficient, timely and cost-effective resolution of the real issues in dispute’.\textsuperscript{46} In practice this is implemented through court-connected mediation, where judges are expressly empowered to give directions or orders to conduct and manage court proceedings in accordance with the overarching purpose.\textsuperscript{47} Judges can encourage parties to use appropriate dispute resolution avenues to attempt to resolve a dispute.\textsuperscript{48} This is just one example of policy promoting ADR and more detailed examples in recent government reports are discussed below.

\textsuperscript{40} Michael Legg, \textit{Case Management and Complex Civil Litigation} (Federation Press, 2011) 2.
\textsuperscript{43} Ibid 12.
\textsuperscript{46} \textit{Civil Procedure Act 2010} (Vic) s 7(1).
\textsuperscript{47} Ibid s 47.
\textsuperscript{48} Ibid s 47(2)(d)(iii).
3.3.1 POLICY PROMOTING ADR

The release of the Australian Government Productivity Commission’s *Access to Justice Arrangements* report in December 2014 has endorsed the trajectory of embedding ADR in the civil litigation process.\(^{49}\) Most noteworthy is the recommendation that ADR should be used as the default dispute resolution mechanism.\(^{50}\) The Productivity Commission acknowledged that ADR is increasingly used by courts and tribunals as an alternative to formal hearings. The report outlined many benefits of ADR, including the possibility for parties to achieve an overall result that is more satisfactory than litigation, retention of control by parties in the dispute resolution process, and significant cost and time savings.\(^{51}\) Further, ADR encourages early settlement, minimises the overall time the dispute is before the courts, is more informal than litigation and can be more culturally appropriate.\(^{52}\)

The Productivity Commission identified certain types of disputes where there is potential to target and increase the use of ADR, including prior to approaching a court, prior to the court hearing if the parties are already engaged in the litigation process, as well as in government disputes and in private disputes (particularly for small businesses).\(^{53}\) In dispute types where ADR processes have been demonstrated to be efficient and effective, the report recommended that ADR should be employed as the default mechanism in the first instance.\(^{54}\) The Productivity Commission further recommended that courts should undertake and evaluate pilots for dispute types that are not currently referred to ADR. In addition, recommendations sought to encourage greater use of ADR by governments,\(^{55}\) as well as identifying the importance of education and the promotion of information about ADR.\(^{56}\)

In August 2016, the Victorian Government’s *Access to Justice Review* report further endorsed the use of ADR in the Victorian jurisdiction.\(^{57}\) The review was commissioned in 2015 to expand on the Productivity Commission’s *Access to Justice Arrangements* report by


\(^{50}\) Ibid 294.

\(^{51}\) Ibid 286.

\(^{52}\) Ibid 286.

\(^{53}\) Ibid 290.

\(^{54}\) Ibid 294.

\(^{55}\) Ibid 295-298.

\(^{56}\) Ibid 304.

addressing the cost of legal services, access to information and litigants’ ability to secure legal representation. One requirement stipulated an examination of whether and how ADR mechanisms could be expanded in Victoria.\textsuperscript{58} The review acknowledged that ADR was used widely throughout Victoria, in private settings as well as by government departments, courts, the Victorian Civil and Administrative Tribunal (VCAT), independent statutory bodies and industry bodies.\textsuperscript{59} The review highlighted ADR had the capacity to increase access to justice for the public by providing a quicker and cheaper process and more satisfactory outcomes for the parties.\textsuperscript{60}

A particular focus was the role of apologies which can provide a meaningful means of redress and reduce the desire to litigate.\textsuperscript{61} Submissions to the review highlighted the reluctance of government agencies to offer apologies because of lack of protection from consequences that might flow if the apology was used in future litigation.\textsuperscript{62} In a negligence context for example, s 14J of the \textit{Wrongs Act} applies in limited circumstances involving death or injury and does not prevent an apology from being adduced into evidence.\textsuperscript{63} The Victorian provisions only cover expression of sorrow, regret or sympathy and not an acknowledgement of fault, unlike the NSW civil liability legislation which protects an apology that includes or implies an admission of fault.\textsuperscript{64}

Despite many benefits, the review identified circumstances where ADR may be inappropriate, such as where engaging in the process would cause delay, disempower the parties, create additional legal costs or prematurely end disputes where public adjudication is warranted.\textsuperscript{65} The report further identified the need to protect vulnerable and disadvantaged people, as in family law disputes where one party has been subjected to domestic violence by the opposing party. Nevertheless the review endorsed increased use of ADR and indicated there were opportunities for further expansion as a primary dispute resolution mechanism. For instance, the review recommended that VCAT partner with the Dispute Settlement

\textsuperscript{58} Ibid 195.
\textsuperscript{59} Ibid 197.
\textsuperscript{60} Ibid 195.
\textsuperscript{61} Ibid 209.
\textsuperscript{62} Ibid 210.
\textsuperscript{63} Ibid 210.
\textsuperscript{64} \textit{Civil Liability Act} 2002 (NSW) Part 10.
Centre of Victoria to expand ADR services. The review also recommended increased use of ADR by government, including a public ministerial commitment to ADR, the creation of a culture of good dispute resolution, a stronger expectation of ADR in government Model Litigant Guidelines and the establishment of a community of practice to encourage sharing of knowledge and ideas about good dispute resolution. Particularly relevant to the subject matter of this thesis, the review recommended amendments to the Wrongs Act to broaden protection given to apologies in circumstances beyond those involving death or serious injury, so that an apology does not constitute an admission of liability and is not subsequently admissible in court as evidence of fault or liability. Further, the review recommended that public bodies develop policies around the making of apologies. The recommendations regarding apologies are consistent with views of scholars who have advocated for the legislative recognition of apologies as a genuine reflection of their significance in society.

Commentators have also acknowledged the important role that mediation has as a forum to facilitate the expression of apologies.

### 3.4 THE IMPORTANCE OF MEDIATION IN DISPUTE RESOLUTION

The principles and procedures of mediation have often been compared with the traditional model of litigation to highlight their advantages as an alternative avenue of dispute resolution. Mediation is capable of addressing many of the shortcomings of litigation: the adversarial nature of the trial process, prohibitive expense, delay and lack of party participation and control. Litigation can be a long and costly process, and other ADR avenues such as arbitration involve similar drawbacks. In contrast, mediation is less expensive, can be organised quickly and sessions can last as little as a few hours.

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66 Ibid 236 (Recommendation 4.3).
67 Ibid 240 (Recommendation 4.4).
68 Ibid 240 (Recommendation 4.4).
71 Bouillé, above n 9, 141.
73 Ibid.
in other forms of dispute resolution such as arbitration.\textsuperscript{74} Section 2 of the National Mediator Accreditation System (NMAS) defines mediation as follows:

\begin{quote}
\begin{itemize}
\item[(a)] communicate with each other, exchange information and seek understanding;
\item[(b)] identify, clarify and explore interests, issues and underlying needs;
\item[(c)] consider their alternatives;
\item[(d)] generate and evaluate options;
\item[(e)] negotiate with each other;
\item[(f)] reach and make their own decisions.
\end{itemize}
\end{quote}

As indicated in the NMAS definition, a vital aspect of mediation is self-determination, described as the value that grounds every model of mediation and is fundamental to any mediation process.\textsuperscript{75} In mediation the parties have control over the decision-making process and can contribute to the overall outcome. The prospect of self-determination can also encourage parties to communicate in a meaningful way.\textsuperscript{76}

Mediation offers the benefit of privacy which is not afforded in public court proceedings.\textsuperscript{77} In medical negligence proceedings the reputations of doctors and hospitals are often at stake which creates a desire to avoid publicity. Similarly, plaintiffs may wish to keep details of their claims confidential. The benefit of privacy is also present in unassisted negotiations between parties and their lawyers.\textsuperscript{78} However, the disadvantage of private negotiations is that there is no independent third party to assist the parties to reach an agreement. Lawyer negotiators tend to adopt a positional bargaining approach which can focus too heavily on legal rights and duties rather than non-legal objectives. The use of a mediator can assist in the facilitation of negotiation guidelines, create an environment of trust and provide problem-solving techniques.\textsuperscript{79} When collated, all of these strengths indicate that mediation can be a helpful process as a pre-action dispute resolution tool to prevent proceedings being initiated. Accordingly, the next section will address the advantages and disadvantages of using mediation in a court-connected context.

\begin{footnotes}
\item[74] Ibid 94.
\item[77] Menkel-Meadow, Porter Love and Kupfer Schneider, above n 72, 94.
\item[78] Boulle, above n 9, 142.
\item[79] Nadja Alexander, Jill Howieson and Kenneth Fox, \textit{Negotiation: Strategy, Style Skills} (LexisNexis, 3\textsuperscript{rd} ed, 2015).
\item[80] Boulle, above n 9, 147.
\end{footnotes}
3.5 THE USE OF COURT-CONNECTED MEDIATION

Court-connected mediation refers to the situation where parties are encouraged or ordered by a judge to undertake mediation before a trained mediator prior to a matter proceeding to trial.\textsuperscript{81} Court-connected mediation can be voluntary or ordered by a judge pursuant to legislation, regulation or court practice notes.\textsuperscript{82} Spencer and Hardy contend that mediation can be ‘connected’ to a court in various ways: it can be recommended or required prior to the filing of proceedings or prior to the matter being listed for trial; it can be conducted internally within the court system by a judicial officer or externally through referral to a mediator; and it can also be conducted by judges in the hearing room.\textsuperscript{83} Sourdin describes Victoria as having the oldest and most well developed court-connected ADR programs of the Australian states.\textsuperscript{84} For instance, the Supreme Court of Victoria places great importance on the use of mediation prior to trial so that, save for exceptional circumstances, no case will proceed to trial without at least one attempt at mediation.\textsuperscript{85} Similarly, the Medical List in the County Court of Victoria, which hears the majority of medical negligence proceedings, requires that all proceedings be subject to mediation prior to trial.\textsuperscript{86} John Arthur acknowledges that both federal and state legislation increasingly provide for ADR to be used by courts, tribunals and other agencies.\textsuperscript{87}

The evolution of mandatory or court-connected mediation, particularly through pre-action procedures, is evident in Australia and internationally. At the federal level, compulsory pre-action ADR operates in family law where parties are required to make a genuine effort to resolve their dispute at family dispute resolution (most often mediation) and obtain a certificate prior to instigating court proceedings.\textsuperscript{88} In civil disputes, parties must file a ‘genuine steps’ statement to indicate that genuine steps have been made to attempt to resolve a dispute.\textsuperscript{89} Federal Court judges are also empowered to refer proceedings to ADR.\textsuperscript{90}

\begin{thebibliography}{99}
\bibitem{81} Ibid 560.
\bibitem{82} Krista Mahoney, ‘Mandatory Mediation: A Positive Development In Most Cases’ (2014) 25(2) \emph{Australasian Dispute Resolution Journal} 120.
\bibitem{83} Spencer and Hardy, above n 11, 173.
\bibitem{84} Sourdin, above n 9, 307.
\bibitem{85} Ibid 263.
\bibitem{86} County Court of Victoria, \emph{Practice Note: Common Law Division – Medical List No 1 of 2015}, 24 July 2015, [66].
\bibitem{87} John K Arthur, ‘Statutory Requirements to Attend or Use ADR: Victoria’ (2014) 1(1) \emph{Australian Alternative Dispute Resolution Bulletin} 12, 14.
\bibitem{88} \emph{Family Law Act 1975} (Cth) s 60I(7). This requirement is subject to exceptions, including family violence.
\bibitem{89} \emph{Civil Dispute Resolution Act 2011} (Cth) s 6. Pursuant to s 4(1)(d) an ADR process can constitute a genuine step to resolve the dispute.
\bibitem{90} Ibid 263.
\end{thebibliography}
Victorian state government has been more reluctant to adopt legislation analogous to the federal compulsory pre-action ADR rules. For example, mandatory pre-action protocols introduced in 2010 by the Victorian Labor government were promptly overturned by a subsequent Liberal government. Yet, the Victorian transport accident scheme has implemented pre-action dispute resolution protocols which encourage the use of ADR as the primary dispute resolution mechanism. South Australia has also recently shown an inclination towards adopting pre-action ADR with the introduction of the Supreme Court Fast Track Rules 2014 (SA). Particularly prevalent in construction and medical negligence disputes, the rules require parties to attempt to resolve their dispute before commencing proceedings, including exchanging information and attending ADR.

Research emanating from the construction industry in Scotland has found the mediation process does not assist parties to resolve a dispute if they are too deeply entrenched in their positions, indicating that attempts at mediation early in the dispute may be more beneficial. Despite many benefits, commentators caution that pre-action protocols can have disadvantages, including front-loading of costs for parties and an increase in ‘satellite’ litigation where parties litigate over compliance with pre-action protocols. However, provided safeguards are implemented to allow exceptions to the pre-action protocols in certain circumstances, commentators accept pre-action protocols hold many advantages for parties and court systems.

International jurisdictions have also initiated pre-action requirements. For example, in the UK the Woolf reforms to civil procedure introduced pre-action protocols requiring early exchange of information with a view to a speedier resolution. In personal injury cases, the plaintiff is required to provide a letter outlining a factual summary, the nature of injuries and

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90 Federal Court of Australia Act 1976 (Cth) s 53A; Federal Court Rules 2011 (Cth), r 28.01
93 Andrew Agapiou and Bryan Clark, ‘Scottish Construction Lawyers and Mediation: An Investigation into Attitudes and Experiences’ (2011) 3(2) International Journal of Law in the Built Environment 159, 167.
95 Ibid 57.
the loss incurred.96 Taking a different approach to Australia and the UK, pre-action mediation has been implemented contractually in the US through the Florida Patient Safety and Pre-Suit Mediation Program.97 Introduced in 2008, the program requires patients to contractually agree to pre-suit mediation before receiving medical care, obliging them to mediate before commencing court proceedings.98 While the methods across jurisdictions vary, all initiatives demonstrate an increasing trend towards the imposition of pre-action protocols or mandatory court-connected ADR avenues.

The merits of mandatory mediation have been extensively discussed.99 Notwithstanding the benefits of mediation, and ADR more generally, some scholars have questioned whether the lines between adversarial and non-adversarial processes are becoming blurred, contending it is risky for ADR to assume all the functions of a court.100 This caution is in response to mandatory mediation which risks creating conflict in six ways.101 Firstly, mediation privileges party autonomy and the right to voluntarily participate in the process. By imposing mediation as a mandatory dispute resolution process, parties’ empowerment and self-determination are necessarily diminished.102 Secondly, use of mediation in inappropriate circumstances may be detrimental where there is domestic violence or a power imbalance between the parties.103 For instance, Field has highlighted the need to adopt specific strategies to protect the interests and safety of victims of domestic violence in mediation.104 Thirdly, problems of confidentiality and court resources can arise where a judge has been involved in mediation but must then be recused from subsequent proceedings if the mediation is unsuccessful.105 Fourthly, private ADR processes are said to threaten the doctrine of precedent by undermining the value of the common law justice system.106 Fifthly, user

98 Ibid 3.
100 Baron, Corbin and Gutman, above n 5, 283.
101 Ibid 293.
102 Ibid.
103 Ibid 293-294.
105 Baron, Corbin and Gutman, above n 5, 294.
106 Ibid 294.
satisfaction may be affected in mediation which uses an informal and flexible procedure and where participants are focused on obtaining procedural fairness.\textsuperscript{107} For example, researchers have found that collaborative approaches and informality can jeopardise procedural fairness in child protection cases where there is a need to prioritise children’s safety and rights.\textsuperscript{108} Finally, mediation arguably does not provide procedural justice because it denies participants the right to have their case decided pursuant to established legal precedent and does not provide avenues of appeal.\textsuperscript{109} Baron, Corbin and Gutman contend that a tension is evident between ADR and adversarial processes, but achieving a balance between the two is important and depends upon the roles, responsibilities and expertise of the legal actors involved.\textsuperscript{110}

In the UK, Professor Dame Hazel Genn is a vocal opponent against the imposition of mandatory mediation at the expense of the civil litigation system. While Genn accepts the general benefits of mediation, she bases her criticisms on three grounds.\textsuperscript{111} Firstly, Genn accepts that mediation can be beneficial but only when the parties have voluntarily agreed to participate in the process.\textsuperscript{112} Secondly, Genn views the civil litigation system as a necessary backdrop against which mediation occurs because in her view it is the threat of litigation which motivates parties to negotiate.\textsuperscript{113} Thirdly, Genn questions whether mediation has strengths in its own right or whether the promotion of mediation is simply due to its advantages when compared to the disadvantages of the litigation process.\textsuperscript{114}

Frequently, mediation is presented as a quicker, cheaper and less stressful dispute resolution process than trial so it is touted as the preferred method of resolving disputes.\textsuperscript{115} However, Genn cautions that the growing preference for private avenues of dispute resolution over public processes is not without challenges.\textsuperscript{116} For example, a rise in mandatory mediation

\textsuperscript{107} Ibid 295.
\textsuperscript{109} Baron, Corbin and Gutman, above n 5, 296.
\textsuperscript{110} Ibid 302-304.
\textsuperscript{111} Hazel Genn, \textit{Judging Civil Justice} (Cambridge University Press, 2010) 79-80.
\textsuperscript{112} Ibid.
\textsuperscript{113} Ibid.
\textsuperscript{114} Ibid.
\textsuperscript{116} Ibid 411. See also Hazel Genn, Shiva Riahi and Katherine Fleming, ‘Regulation of Dispute Resolution in England and Wales: A Sceptical Analysis of Government and Judicial Promotion of Private Mediation’ in
risks losing the value of court adjudication which diminishes the public role of the civil justice system and public dissemination of judicial decisions.\textsuperscript{117} Adjudication facilitates vindication of rights rather than comprise, allowing for claims of injustice to be heard.\textsuperscript{118} For instance, in the medical negligence context plaintiffs who are the victim of medical error may wish to have the matter heard and decided in a public forum so that such errors can be discovered and prevented in the future. Genn suggests that participating in court proceedings can also be empowering for the parties.\textsuperscript{119} Further, mandatory mediation presents as a threat to common law precedent which facilitates articulation and clarification of the law, effects justice between parties and has potential to deter future misbehaviour.\textsuperscript{120}

In the US, Carrie Menkel-Meadow opposes mandatory court-instituted ADR, and expresses scepticism regarding its use in a court-connected context where she argues the process can be distorted by lawyers’ adversarial culture.\textsuperscript{121} Menkel-Meadow contends that ADR has become increasingly institutionalised through use by courts and private organisations, but also that the process has become legalised by being subjected to legal rules.\textsuperscript{122} She stresses that the key to effective dispute resolution processes is found in voluntary participation yet many programs make ADR mandatory.\textsuperscript{123} In her view, courts are ‘at best ambivalent’ as to whether to mandate settlement, but time and case efficiency factors might override this reluctance to mandate settlement.\textsuperscript{124}

While Menkel-Meadow is an advocate of ADR, she cautions that mandatory mediation must be coupled with certain safeguards to protect the legitimacy of the process. She suggests seven: (1) that settlement outcomes procured through mandatory mediation should not be binding; (2) that legal protections are offered, such as a record of proceedings, to overcome coercive settlement conduct; (3) court-related ADR should be facilitated by a judicial officer other than the one appointed at trial; (4) provision of appropriate settlement training to

\begin{thebibliography}{99}
\bibitem{Genn} Hazel Genn, ‘Why the Privatisation of Civil Justice is a Rule of Law Issue’ (36th F A Mann Lecture, Lincoln’s Inn, 19 November 2012) 15-16.
\bibitem{Ibid} Ibid 17.
\bibitem{Ibid} Ibid.
\bibitem{Ibid} Ibid 18.
\bibitem{Ibid} Ibid 17.
\bibitem{Ibid} Ibid 18.
\bibitem{Ibid} Ibid 24.
\end{thebibliography}
facilitators; (5) evidence of systematic evaluation of ADR; (6) different forms of ADR should be unbundled and separately evaluated; (7) the nature of process varies so allow judges to experiment with different process but allow legal challenges.125

Woodward has highlighted the tension that exists between traditional adversarial litigation and ADR which is reflected in two schools of thought: some argue that their objectives are incompatible whilst others contend that ADR should continue to be integrated into the court process.126 Woodward sees this division as being centred around philosophical differences where ADR is seen as voluntary, flexible, confidential and informal whilst the court process is seen as rigid, public, regulated and litigious.127 Olivia Rundle’s research into lawyers’ perspectives on court-connected mediation highlights the tensions that arise when mediation is conducted as part of the court process.128 Her solution is centred on the crucial role of lawyers to advise their clients of their legal rights and responsibilities, empowering them to make individual decisions, which in turn satisfies the court’s obligation to apply the law.129

Some of the criticisms aimed at the use of mediation in the legal system are that it may minimise the significance of legal principles and precedents, and perpetuate power imbalances.130 Commentators have also questioned whether court mediation can deliver justice to the parties.131 In this regard, social psychologists have revealed that people’s notions of fairness and justice are dependent on subjective perceptions of procedure and outcome, not on objective measures such as time or cost effectiveness.132 The need for participants in a legal system to experience fairness both in the legal process and in the outcome of a decision is reflected in procedural justice theory. Research in this area emphasises that participants’ subjective perceptions of procedural justice will affect how they think about and react to a legal outcome.133 Procedural justice research indicates that one

125 Ibid 42-44.
127 Ibid 164.
129 Ibid 36.
131 Ibid.
132 Ibid [18].
aspect of procedural satisfaction is the ability of participants to be heard in the dispute resolution process, to be allowed to tell their story and to be treated with respect. Hollander-Blumoff and Tyler contend that procedural justice is not only limited to the adversarial context but is also present in ADR, and that participants may choose to engage in non-adversarial processes because they appear fairer. In a medical negligence context, procedural justice theory would support the use of court-connected mediation as a mechanism allowing the plaintiff’s non-legal objectives (such as expressions of emotion, regret and remorse) to be met.

Mandatory mediation is not without critics, and some commentators question whether mandatory court-connected mediation is appropriate. Richard Ingleby questioned whether settlement should always be seen to be the desirable outcome, and contends that mandatory mediation is not constructive due to the loss of the defining characteristic of voluntariness. As such it risks increasing costs and formality, and challenges the rule of law. Proponents of mandatory mediation view it as a positive tool that can assist in managing court lists and save costs, time and emotional energy for the parties. Further, the mediation process is more consensual than the litigation process and parties cannot be forced into a settlement.

Another argument is that certain cases (such as family law cases with a history of violence or cases that require a definitive ruling for precedential value) are not suited to mediation. Yet, in the majority of cases mediation is suitable and the parties are able to select mediators with the skills, experience and expertise relevant to their area of dispute. In fact, mediation may be of particular benefit in medical negligence disputes given the cost and complexity of litigating these disputes and the heightened emotions involved. Finally, the argument that mediation threatens the rule of law should not be given too much credence as mediation does

135 Hollander-Blumoff and Tyler, above n 133, 12-13.
138 Mahoney, above n 82, 120.
139 Ibid.
140 Hilary Astor and Christine Chinkin, Dispute Resolution in Australia (LexisNexis Butterworths, 2nd ed, 2002) 276-282.
141 Ibid 287.
not seek to abolish the court system, only to complement it. While critics caution about the dangers of mandatory mediation, the increased use of court-connected mediation in many contexts would reflect the recognition and acceptance of mediation as a legitimate process of dispute resolution, one that offers many benefits not readily apparent in traditional adversarial avenues of dispute resolution.

3.6 THE ROLE OF LAWYERS IN MEDIATION

The rise in court-connected ADR (particularly mediation) in the Australian legal system means that lawyers increasingly participate in these dispute resolution processes. Given that the majority of participants are legally represented at mediation, the approach and attitude of lawyers are an integral aspect of the mediation process. Most disputes will settle before reaching an adjudicated decision, therefore it is imperative that lawyers participating in ADR processes refrain from adopting an aggressive adversarial stance and instead remain settlement focused. Lawyers can thwart the dispute resolution process if they adopt an adversarial style in mediation. Cooper suggests that the key to successful dispute resolution advocacy is the ability of lawyers to ‘switch hats’ between adversarial advocacy in a courtroom and dispute resolution advocacy in mediation.

Lawyers are required to actively encourage their clients to participate in ADR because of overarching purpose and pre-action legislative requirements, professional conduct rules and non-binding guidelines. For instance, lawyers have a duty to advise and assist clients with

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142 Ibid.
146 Donna Cooper, ‘Representing Clients from Courtroom to Mediation Settings: Switching Hats Between Adversarial Advocacy and Dispute Resolution Advocacy’ (2014) 25(3) Australasian Dispute Resolution Journal 150.
147 Ibid 158.
148 The Legal Profession Uniform Law Australian Solicitors Conduct Rules 2015 (‘ASCR’) r 7.2 provides, ‘A solicitor must inform the client or the instructing solicitor about the alternatives to fully contested adjudication of the case which are reasonably available to the client, unless the solicitor believes on reasonable grounds that the client already has such an understanding of those alternatives as to permit the client to make decisions about the client’s best interests in relation to the matter.’ Further the ASCR r 34.1.1 requires lawyers not to make ‘any statement which grossly exceeds the legitimate assertion of the rights or entitlements of the solicitor’s client’ and r 34.1.3 prohibits lawyers from using tactics that go beyond legitimate advocacy.
the filing of a genuine steps statement in federal jurisdictions. Lawyers also owe a general duty to a client to act with honesty and courtesy, competence and diligence, loyalty and confidentiality. However, a question arises around whether lawyers owe the same duties in mediation as they normally would in court. In addition, the existence of voluntary guidelines may assist lawyers in setting the standard expected in mediation.

Lawyers have the capacity to influence the mediation process. Rundle asserts that lawyers are influential in shaping the dispute resolution process, including influencing their clients’ needs and expectation. For instance, lawyers can ensure their clients experience empowerment and self-determination by allowing them to be active participants able to tell their stories or express their emotions. In contrast, lawyers might adopt an adversarial approach and take a rights-based evaluative style in ADR which risks transforming the mediation into a court-room. In the early 1990s Menkel-Meadow expressed her concern that lawyers involvement in ADR risks colonising the settlement process. Menkel-Meadow contends that lawyers colonise ADR by approaching settlement adversarially, and by bringing legal, technical and procedural matters associated with court proceedings into the settlement arena. She contends that while courts use ADR to increase case settlement efficiency, lawyers may use the ADR process to their client’s advantage to control time, and impact on discovery or rules of procedure.

Menkel-Meadow’s concerns are represented in contemporary mediation research. A Canadian study of the perceptions of legal and lay actors in litigation and mediation of personal injury disputes found that lawyers were seen to dominate the mediation process and frequently ignored their client’s needs. Similarly, an evaluative study of mediation in the

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149 Civil Dispute Resolution Act 2011 (Cth) ss 6-7.
153 Douglas and Batagol, above n 143, 765.
154 Olivia Rundle, ‘Are We Here to Resolve Our Problem or Just to Reach a Financial Settlement?’ (2017) 141 Precedent 12, 14.
155 Carrie Menkel-Meadow, above n 121, 34-35.
156 Ibid 3.
Supreme and County Courts of Victoria showed that in some cases lawyers adopted their preferred mediation process rather than one which served the needs of their clients.\textsuperscript{158} A Tasmanian study found that lawyers and mediators tended to control the mediation process, and were the dominant participants in mediation.\textsuperscript{159} Further, while direct disputant participation is frequently cited as a benefit of mediation, the findings indicated party participation may be minimal because lawyers tend to act as a spokesperson. Rundle concluded that lawyers perceive advocacy to be a fundamental aspect of their role, and thus they discourage clients from participating in court-connected mediation.\textsuperscript{160} These studies support the assertion that lawyers are uncomfortable parting from their adversarial style in a mediation context, and transfer this adversarialism to mediation.

The level of involvement of lawyers in mediation and their approach to the dispute resolution process can vary significantly depending on the dispute context. In an article usefully summarising lawyer approaches Rundle has categorised the various contributions lawyers can make in the mediation process across a spectrum of involvement using five models.\textsuperscript{161} The least involved is the ‘absent advisor’ who supports the client to participate in the process but does not attend the mediation session.\textsuperscript{162} Slightly more involved than the absent advisor is the ‘advisor observer’ who attends mediation but does not engage with the opposing lawyer or the mediator.\textsuperscript{163} In the middle of the spectrum is the ‘expert contributor’ who participates by advising their client on legal issues but restrict other contributions.\textsuperscript{164}

Rundle identifies medical negligence cases as cases where lawyers may appropriately adopt the expert contributor role.\textsuperscript{165} Situated on the more involved side of the spectrum is the ‘supportive professional participant’ who offers legal advice, support and coaching, reality testing of the workability of the settlement and also supports the client through the mediation process.\textsuperscript{166} The most involved lawyer is the ‘spokesperson’ who speaks on behalf of their

\textsuperscript{158} Tania Sourdin, \textit{Mediation in the Supreme Court and County Courts of Victoria} (Department of Justice, Victoria, 2009) iv.
\textsuperscript{159} Rundle, above n 144, 84.
\textsuperscript{160} Ibid 91.
\textsuperscript{161} Olivia Rundle, ‘A Spectrum of Contributions That Lawyers Can Make to Mediation’ (2009) 20(4) \textit{Australasian Dispute Resolution Journal} 220.
\textsuperscript{162} Ibid 222.
\textsuperscript{163} Ibid 223.
\textsuperscript{164} Ibid 224-225.
\textsuperscript{165} Ibid 225.
\textsuperscript{166} Ibid 225-226.
client at mediation and exhibits a high level of control over the process.\textsuperscript{167} Douglas and Batagol used Rundle’s model in exploring approaches taken by lawyers in the VCAT jurisdiction.\textsuperscript{168} Interviews with 16 VCAT mediators about lawyers’ roles in mediation indicated most supported the expert contributor role, followed by the supportive professional participant role.\textsuperscript{169} The mediators in that study valued lawyers who worked collaboratively and encouraged client participation.\textsuperscript{170} All participants indicated they preferred to mediate with lawyers who adopted less adversarial approaches.\textsuperscript{171}

Macfarlane contends that a lawyer’s role is continuously shaped by social and economic interests, and further that lawyers play a key role in endorsing novel practices.\textsuperscript{172} In a comparative study of two Canadian cities, Toronto and Ottawa, Macfarlane explored how the introduction of civil procedure rules mandating early mediation impacted upon lawyer’s attitudes and practices.\textsuperscript{173} In the study, interviews were held with 40 commercial lawyers, 20 from Toronto, a large urban centre of 2.2 million population, and 20 from Ottawa, a medium urban centre with a population of 500,000.\textsuperscript{174} Pursuant to Canadian civil procedure requirements lawyers must formally ‘opt-out’ through the court system (rather than voluntarily ‘opt-in’), mediation must take place before discovery and lawyers are required to bring their client to mediation.\textsuperscript{175} The study results showed that practitioners in Ottawa had a more settled and accepting culture of mediation than Toronto.\textsuperscript{176} While lawyers do not generally appear comfortable with their clients’ direct involvement in mediation,\textsuperscript{177} when mediation was imposed on parties prior to discovery, lawyers found themselves reliant on their clients for information and thus facilitated more client involvement.\textsuperscript{178}

In an Australian study of taxation disputes, Tania Sourdin found that settlement rates through ADR between Victoria and NSW varied substantially. Out of 118 taxation disputes, 58.8 per
cent of Victorian disputes resolved following ADR, compared with 38.5 per cent in NSW. Sourdin suggests that the discrepancy can be attributed to various factors, including a culture of practitioner behavior, and notes that practitioners engage with ADR to varying degrees in different states. Macfarlane attributes the willingness of the Ottawa practitioners to engage in mediation to a combination of legal culture and also increased exposure to mediation. However, cultural change requires more than simple reform to civil procedure rules and instead requires fostering a climate of acceptance and legitimisation of mediation.

The role of lawyers in medical negligence claims more generally was explored through a study using in-depth interviews with 30 medical malpractice claimants from England and 30 claimants from Scotland. In those jurisdictions, the researchers found that medical negligence lawyers take a client-aligned approach, meaning they take into consideration their clients’ practical and emotional needs but do not necessarily follow their clients’ wishes. The study found lawyers were able to manage their clients’ expectations, provide emotional support and keep their clients well-informed. Claimants expressed dissatisfaction when they were unable to obtain non-financial outcomes (such as an apology) or when they were unhappy with the overall outcome of their case, but did not blame their lawyer for such dissatisfaction.

Tom Tyler contends that in tort litigation lawyers assume their client’s primary interest is to receive a large and fair settlement and to have their matter resolved quickly. In an analysis of empirical studies of tort litigation, Tyler found litigants are more procedure- than outcome-oriented, wanting to participate in the settlement of disputes and have their views heard rather than simply focusing on the settlement sum. Tyler concluded that lawyers’ views of client

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180 Ibid.
181 Macfarlane, above n 172, 321.
183 Ibid 173.
184 Ibid 188.
185 Ibid 189.
187 Ibid 201.
expectations are fundamentally flawed and do not address clients’ non-outcome related concerns.\textsuperscript{188}

A British study evaluated the role of lawyers in medical negligence mediation and explored whether the introduction of a mediation pilot scheme was conceived as a threat to medical negligence lawyers.\textsuperscript{189} Data was drawn from a NHS-funded evaluation of the pilot scheme, but also included interviews with 50 solicitors who chose not to participate in mediation.\textsuperscript{190} The study results showed that many of the solicitors found the mediation process unsettling, and they were not prepared for the informality and flexibility of the process.\textsuperscript{191} They frequently adopted an adversarial stance, and their adversarialism was heightened because they were conducting negotiations in the presence of their client.\textsuperscript{192} The study found lawyers were not prepared for the shift in emphasis from them to their client. In other words, the lawyers were accustomed to holding the focus in a court room, to be ‘seen to be doing something’ for their client, while the focus of the mediation was on the client’s narrative.\textsuperscript{193} Out of 50 solicitors who did not participate in mediation, 27 indicated they thought their clients would expect them to have knowledge of mediation because of legislative reforms, but that mediation was not a process which appealed to these lawyers.\textsuperscript{194} Further, the solicitors spoke about mediation as if it were part of the litigation process, rather than seeing it as an alternative.\textsuperscript{195} The authors concluded that lawyers were unnerved by mediation and lacked specific training around appropriate conduct for mediation in personal injury litigation.\textsuperscript{196}

In a US study, researchers evaluated the suitability of mediation for medical malpractice lawsuits involving private hospitals in New York City. Participants in 57 lawsuits were contacted after referral to the study, and interviews were subsequently held with participants and mediators in 31 mediations.\textsuperscript{197} The study found that plaintiff lawyers were more willing to mediate than defendant lawyers, with plaintiff lawyers agreeing to mediate in 49 cases out

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{188} Ibid 203.
\item \textsuperscript{190} Ibid 204.
\item \textsuperscript{191} Ibid 212.
\item \textsuperscript{192} Ibid 213.
\item \textsuperscript{193} Ibid 214-215.
\item \textsuperscript{194} Ibid 217.
\item \textsuperscript{195} Ibid 218.
\item \textsuperscript{196} Ibid 220.
\end{itemize}
\end{footnotesize}
of 57 cases, compared with defendant lawyers who agreed to mediate in 31 cases out of 57 cases.\textsuperscript{198} The investigators noted this was a surprising finding, attributing the refusal to mediate by some lawyers to a range of factors including: the unsuitability of the case for mediation, the threat of legal exposure, differing attitudes towards losing a case, existing settlement negotiations, and the preference of certain mediators or lawyers to increase billable hours.\textsuperscript{199}

The existing literature on the role of lawyers has demonstrated that lawyers’ attitudes and practices can significantly influence the nature of the dispute resolution process, as well as participants’ direct participation. Lawyers generally appear more comfortable with an adversarial style of dispute resolution and have a tendency to use that in mediation. Lawyers also exert a high level of control of the process, tending to act as spokesperson on behalf of their client. Preventing parties from participating in mediation can substantially affect their experience of the process and acceptance of the outcome, resulting in disempowerment and lack of self-determination.

Medical negligence can give rise to emotionally charged disputes, where there is a strong need for parties to express their emotions, seek an explanation for the medical error, or pursue an apology from their medical practitioner. The literature on the role of lawyers has therefore informed the questions in this research, so that participants were expressly asked to reflect on the role of lawyers in the mediation of medical negligence disputes. This was a significant aspect of the research to explore how lawyers saw their role in the resolution of these disputes, the extent of direct participant involvement and the nature of court-connected mediation in practice. Given the literature suggests that lawyers dominate the mediation process, it was important to explore whether they are aware of this tendency and further whether they acknowledge the role of emotion in the resolution of disputes or whether such acknowledgment was sidelined in favour of more legalistic or financial objectives. Accordingly, the next section discusses the literature on emotion in mediation to demonstrate the important role that emotion plays in dispute resolution.

\textsuperscript{198} Ibid 804-805.
\textsuperscript{199} Ibid 813-814.
3.7 EMOTION IN MEDIATION

The exploration of emotion in the mediation process is identified in the literature as the opportunity for parties to reveal underlying interests and concerns of parties through a discourse that allows for emotional expression. Emotion is a key component of conflict, with the emotional experiences of parties typically defining and driving conflict. In negotiations, emotion can drive party decision-making. Emotion has been described as consisting of three components, the physiological experience, a cognitive process and a communicative process, with all three components highly relevant in conflict. There is increasing recognition in literature that attention to emotion is significant in negotiation and in mediation practice. A US study of eighteen mediation simulations and sixteen negotiation simulations conducted using undergraduate students as participants and professional or volunteer mediators found that attention to emotion in conflict management can lead to a transformation of the dispute, including improved communication and greater understanding.

Medical negligence is an area where expression of emotion may be especially valuable to disputants. Mediation of medical negligence disputes often occurs in a court-connected environment, when parties have already commenced court proceedings. The legal actors involved, consisting of the plaintiff and defendant lawyers and the insurance representative, are ‘repeat players’ who might consider the nature of the dispute as ‘ordinary’. ‘Repeat players’ refers to parties who are repeat users of the court system, and who have low stakes in any one case, can maximise long-term gain by resisting settlements, and can also develop long-term relationships with court personnel. Lawyers who represent such parties can also be ‘repeat players’ gaining an advantage by developing expertise in particular legal fields and

204 Jameson et al, above n 202, 184-185.
Institutional processes, as well as reputations that allow them to act as ‘gatekeepers’.\textsuperscript{207} In contrast, plaintiffs tend to be ‘one-shot players’ who often have minimal experience with the legal system.\textsuperscript{208} In circumstances where there is a breach of trust between a doctor and patient, plaintiffs will often have non-legal objectives including seeking an explanation of the medical error or an apology from the practitioner.

Repeat players are said to dominate court-oriented mediations,\textsuperscript{209} and in doing so they sideline emotion and narrowly confine the issues in dispute around the likely outcome if the matter was litigated and a quantitative assessment about how much a defendant is willing to pay.\textsuperscript{210} Ryan contends lawyers distrust emotion and are quick to shut down channels of communication even in circumstances where they might assist their clients.\textsuperscript{211} Thus the one-shot players frequently miss out on opportunities for dialogue and addressing non-legal needs. In a Canadian study of personal injury lawyers, Relis found that lawyers prioritised these interests over their clients’ interests, causing a missed opportunity at mediation for client communication and psychological healing.\textsuperscript{212} Active participation of parties gives effect to the traditional values of mediation such as self-determination, empowerment and control which in turn improves participants’ perceptions of procedural justice.\textsuperscript{213} This has led commentators to advocate for increased recognition by lawyers of client’s emotional and non-legal needs.\textsuperscript{214}

In the past decade, researchers have paid closer attention to the role that mediators’ understanding of emotion plays in mediation. Picard and Stiltaten explored how mediation practitioners experience learning in mediation and found that emotion was a central feature of the learning process.\textsuperscript{215} A separate study found a positive correlation between a negotiator’s

\begin{itemize}
\item \textsuperscript{207} \textit{Ibid}.
\item \textsuperscript{208} \textit{Riskin and Welsh, above n 205, 864}.
\item \textsuperscript{209} \textit{Ibid 876}.
\item \textsuperscript{210} \textit{Ibid 866}. Riskin and Welsh assert that ‘problem definition’ in mediation has a significant role to play in determining the focus of the mediation and the number of issues that are addressed.
\item \textsuperscript{212} \textit{Relis, above n 157, 126}.
\item \textsuperscript{213} Alison Finch, ‘Harnessing the Legal and Extralegal Benefits of Mediation: A Case for Allowing Greater Client Participation in Facilitative Mediation’ (2010) \textit{21(3) Australasian Dispute Resolution Journal} 155; \textit{Ibid 162}.
\item \textsuperscript{214} Cheryl Picard and Janet Stiltaten, ‘Exploring the Significance of Emotion for Mediation Practice’ (2013) \textit{31(1) Conflict Resolution Quarterly} 31, 31.
\end{itemize}
emotional intelligence and the opposing party’s trust and desire to work together again.\textsuperscript{216} Douglas and Coburn explored mediators’ attitudes and strategies for addressing emotional expression through interviews with VCAT mediators.\textsuperscript{217} All participants in this study thought that emotion was a significant aspect of the mediation process,\textsuperscript{218} with eleven out of sixteen participants willing to encourage or allow the expression of emotion.\textsuperscript{219} Six of the participants discussed specific techniques to encourage emotional expression in mediation, including reflection of emotional content, paraphrasing and questioning.\textsuperscript{220} The authors argue this evidences a shift in practice towards a higher awareness of the emotional dimensions of conflict.\textsuperscript{221}

Lawyers may find it difficult to prioritise emotions in negotiation due to a legal culture that sees emotion as an impediment to rational decision-making.\textsuperscript{222} This hostility towards emotion is arguably deeply ingrained in historic notions of justice affiliated with calm, rational decision-making, making emotion incompatible with reason.\textsuperscript{223} Such inherent hostility towards emotion can cause lawyers to rationalise decision-making and prioritise financial objectives in mediation, while sideling their clients’ emotional needs. Kimberlee Kovach has highlighted the need for lawyers to adopt an ‘ethic of care’, so as to focus not only on rights and duties in dispute resolution, but also on connections between individuals.\textsuperscript{224} This requires lawyers to use skills such as empathy and listening.\textsuperscript{225} A focus on legal rights and duties can result in an evaluative or settlement style of mediation which can compromise self-determination by diminishing the role of the parties in dispute resolution.\textsuperscript{226} Evaluative dispute resolution models are frequently used in court-connected contexts and can also

\textsuperscript{217} Kathy Douglas and Clare Coburn, ‘Attitude and Response to Emotion in Dispute Resolution: The Experience of Mediators’ (2014) 16(1) \textit{Flinders Law Journal} 111.
\textsuperscript{218} Ibid 126.
\textsuperscript{219} Ibid 129.
\textsuperscript{220} Ibid 132.
\textsuperscript{221} Ibid 143.
\textsuperscript{222} Foong, above n 201, 186.
\textsuperscript{223} Ryan, above n 211, 248.
\textsuperscript{225} Ibid 967.
jeopardise participants’ perceptions of procedural justice. Bogdanoski advocates for increased use of facilitative mediation and principled negotiation as preferred dispute resolution avenues in medical negligence disputes because these approaches may better meet the non-financial needs of parties.

Despite the ability of mediation settings to offer participants an opportunity to address emotional issues and non-financial objectives, in practice medical practitioners rarely attend mediation which can diminish the opportunity for plaintiffs to meet these emotional needs. For example, in a US study of mediation of law suits brought against New York hospitals 25 out of 31 plaintiffs attended the mediation but not one medical practitioner attended. Liebman argues that the non-participation of doctors at the mediation of medical negligence disputes constitutes a lost opportunity for: reconciliation between doctor and patient; forgiveness; information giving and gathering; as well as for institutional policy changes to alter practices that have led to the error. Lack of attendance can be detrimental to the doctors themselves as they are deprived of procedural justice through their lack of voice, representation and participation in the dispute resolution process.

Liebman explains that lawyers discourage medical practitioners from participating for a number of reasons, varying from a need to emotionally protect their clients, to overfamiliarity with the evaluative approach to mediation or a lack of awareness of the full benefits of mediation. Yet the presence and active participation of medical practitioners is crucial if the parties are to engage meaningfully in the process. There are many non-adversarial approaches that recognise the significance of emotion in dispute resolution, including therapeutic jurisprudence, restorative justice and procedural justice. These concepts are introduced and discussed in the following section, with particular attention to their significance in mediation of medical negligence disputes.

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229 Hyman et al, above n 197, 807.
231 Ibid.
232 Ibid 148.
3.7.1 THERAPEUTIC JURISPRUDEENCE

The therapeutic jurisprudence movement values the expression of emotion for court users. Therapeutic jurisprudence is a philosophy that considers how the law affects the emotional well-being of court users. In other words, it examines the actions of legal actors to consider the impact of their decisions on the emotional life and psychological wellbeing of those affected by our justice system. Therapeutic jurisprudence asserts that emotional issues are an integral aspect of the dispute resolution process. Therapeutic jurisprudence has been applied to a variety of legal fields, including worker’s compensation. As injured people can be particularly vulnerable, telling their story and receiving validation can alleviate stress. Accordingly, commentators contend that compensation systems should have sufficient flexibility to facilitate an appropriate mechanism for injured people to present their story.

Therapeutic jurisprudence promotes creative problem-solving by lawyers to meet the unique needs of clients. In the context of legal problem-solving, therapeutic jurisprudence suggests that the law should consider emotional factors in legal processes. Therefore, when professionals such as lawyers and mediators, are exercising legal skills, it is important to consider their own and their clients’ emotions in promoting a problem’s comprehensive resolution.

3.7.2 RESTORATIVE JUSTICE

Similar to the therapeutic jurisprudence movement that values the role of emotion in the legal framework, Restorative Justice (‘RJ’) is another non-adversarial practice that acknowledges the role of emotion in dispute resolution. RJ encompasses a set of principles and practices concerned with repairing harm caused by crime by bringing together the victim and

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233 The term ‘therapeutic jurisprudence was developed by Professor David Wexler in the US in the context of mental health. See David B Wexler, Therapeutic Jurisprudence: The Law as a Therapeutic Agent (Carolina Academic Press, 1990); David B Wexler and Bruce J Winick, Essays in Therapeutic Jurisprudence (Carolina Academic Press, 1991).
236 Ibid 39.
238 King, above n 234, 1118.
offender. One mechanism through which this can be achieved is through RJ conferencing, which involves the offender, victim, and family and friends meeting to discuss the harm sustained and possible reparation. Family group conferencing in youth offences was introduced legislatively in the late 1980s in New Zealand. In Australia, RJ practices commenced in Wagga Wagga in 1991 for juvenile offenders and have since been used in Victoria for youth justice and neighbourhood justice. Conferencing is the most commonly used type of restorative justice process in Victoria, and Australia-wide, though victim-offender mediation with a professional facilitator may also be used.

RJ practices are not limited to the criminal context, and are used more broadly in a range of civil matters, including family, child protection, and workplace contexts. ADR and RJ are said to share common origins and principles, particularly the need for participation by all stakeholders in a dispute in order to successfully address conflict. Boulle and Field acknowledge RJ’s close relationship with facilitative dispute resolution processes in the civil context and contend it also has a role to play in shaping lawyers’ professional identity in dispute resolution practice. In the US, Jonathan Todres argues that restorative justice principles can play a crucial role in medical malpractice suits by promoting a healing-centred approach for the aggrieved parties.

The role of emotions in justice processes, together with the value in using restorative justice conferencing has been recognised to address the emotional aspects of crime commission. Commentators have recognised that justice processes tend to focus on the needs of offenders, yet increasing attention is being paid to procedures to allow victims to have their voice heard.

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242 Ibid.
244 Roche, above n 243, 225-226.
245 Boulle and Field, above n 23, 533.
in justice proceedings. While processes such as mediation can facilitate the expression of emotion by aggrieved parties, the rise of evaluative models and lawyers’ adversarial approaches can hinder the ability of parties to use such forums to meet non-legal needs. Therefore parallel processes that attempt to address the emotional aspects of conflict, such as RJ conferencing, may be influential in the resolution of medical negligence disputes.

For instance, the use of an apology to repair the harm has the potential to meet the non-legal needs of disputants and may influence their overall satisfaction with the outcome. A UK study undertaking content analysis of 57 victim-offender mediations found that in all of the cases where an apology was accepted, the victim was satisfied with the mediation outcome. Georgina Richardson and Grant Gillett highlight the necessity for a justice system to meet a variety of disputant needs following medical error apart from financial compensation. They contend that a scheme based on RJ would have the capacity to address patients’ need to be heard, to allow for communication between the parties and also to obtain remedies such as an apology or a change in healthcare practices.

3.7.3 PROCEDURAL JUSTICE

Procedural justice (‘PJ’) refers to the parties’ perceptions of the fairness of a process by which a decision is reached. If disputants perceive dispute resolution processes to be fair, they are more likely to accept the outcomes as fair and this in turn legitimises decision-making institutions. Disputants’ views on fairness are affected by a variety of factors such as voice, process control, participation, trustworthiness, interpersonal respect and neutrality. Hollander-Blumoff and Tyler identified four key criteria that influence parties’ perceptions of fairness: opportunity for disputants to share their stories; neutrality; trust; and courtesy and respect. In a qualitative study assessing interviews with Victorian mediators, Douglas and Hurley found that PJ can occur in mediation but that mediators have not yet

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251 Ibid 792.
252 Hollander-Blumoff and Tyler, above n 133, 3.
253 Relis, above n 157, 163.
254 Ibid 164.
255 Hollander-Blumoff and Tyler, above n 133, 5-6.
realised the potential for mediation to offer this kind of experience for parties.\textsuperscript{256} Providing disputants with an opportunity to have their voice heard during the mediation process is a key aspect of PJ in mediation. A key finding emerging from Douglas and Hurley’s research was that the majority of mediators in the study held the view that parties needed to have their voice heard. In the research many mediators commented on the parties’ desire to share their side of the story.\textsuperscript{257}

In the medical negligence context, it may be particularly important for victims of medical error to be heard by the doctor and to tell their side of the story due to the impact of the negligence on their lives. Yet, when doctors are absent from mediations, plaintiffs are unlikely to feel their voice has been heard and thus parties’ perceptions of procedural fairness is likely to be adversely affected.\textsuperscript{258} In Relis’ study of Canadian legal actors and disputants experiences with medical malpractice mediations, 93\% of plaintiffs and 89\% of doctors discussed the importance to them of ‘being heard’ in mediation.\textsuperscript{259} Meeting these needs was practically difficult given the majority of lawyers in that study expressed they had limited, if any, experience with doctors attending mediation.\textsuperscript{260} In spite of these challenges regarding the culture and practice of law in medical negligence, emotion should be considered a key feature of these disputes and addressing emotional needs of parties may be crucial in allowing parties to experience procedural justice and feel satisfied with the outcome.

Medical negligence disputes can often be emotionally charged and mediation can be an appropriate forum for parties to resolve differences and address the emotional consequences of a medical error. Yet, as the literature has demonstrated, mediation may not be used to its fullest advantage by lawyers who tend to dominate the process. By adopting an evaluative mediation style, attention is diverted to settlement-bargaining and thus no opportunity is afforded for the non-legal needs of the parties to be met at mediation. Consequently, this can result in the parties experiencing a lack of procedural justice in the dispute resolution process.

One aim of this study was to explore to what extent parties in medical disputes engage in mediation and whether emotional issues are a relevant factor for those participating in

\textsuperscript{257} Ibid 83.
\textsuperscript{258} Ibid, above n 157, 127-128.
\textsuperscript{259} Ibid 174.
\textsuperscript{260} Ibid 89.
mediation. Further, it was important to explore whether the mediation process assists participants to express the emotions associated with a medical negligence dispute. In view of these international studies that indicate that lawyers prioritise legal and financial objectives over parties’ emotional needs, it was appropriate to explore whether the same practice occurs in the Victorian medical negligence jurisdiction.

3.8 THE ROLE OF MEDIATION IN MEDICAL NEGLIGENCE AND MENTAL HARM DISPUTES

The traditional response to healthcare disputes has been to ignore them, manage them informally, deal with them through ethics committees or have the cases litigated in the courts. These methods of dispute management have been criticised as ‘costly, time-consuming, complex, stressful, lacking in equal participation, biased and controlling’. In response, mediation and other forms of ADR are increasingly being used in healthcare disputes in Australia. Of medical malpractice law suits, Szmania, Johnson and Mulligan have observed that:

> [e]ven the best-trained physicians can commit errors that result in continuing medical disabilities or even death. The conflicts that result from these errors are often fueled by emotion, and the complexity of modern medical care and can lead to expensive litigation.'

Eric Galton, a leading US mediator, has noted that, ‘[t]rial is like surgery without anesthesia’. Galton contends that when one considers the needs of the parties in medical negligence disputes (such as the expression of regret, sympathy or an explanation as to the reasons for a bad outcome), one will appreciate that mediation is an appropriate and therapeutic resolution mechanism. In this regard, mediation offers an opportunity for an explanation, the potential for an expression of an apology or sympathy and the ability to gain closure or convey forgiveness.

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262 Ibid.
264 Szmania, Johnson and Mulligan, above n 263, 72.
265 Galton, above n 7, 321.
266 Ibid 322-323.
267 Ibid 323-324.
Sheila Johnson is critical of the use of litigation as a means to resolve medical negligence disputes, contending that litigation neither serves to compensate the injured person nor to decrease negligence.\textsuperscript{268} Johnson uses a battle analogy to illustrate her contention:

Litigation is based upon a war model. The parties muster an army (the firm), appoint a general (the lead trial lawyer), choose a battleground (the court with jurisdiction), stockpile the ammunition (discovery), engage in battles (the motion practice), participate in a required peace effort (pre-trial settlement conference), blow each other to bits (trial) and declare a victor (the verdict).\textsuperscript{269}

In contrast, mediation does not result in a winner but empowers the parties to reach agreement.\textsuperscript{270} Further benefits include that mediation can assist with the maintenance of a professional relationship and assist the parties to express their emotions.\textsuperscript{271}

Mediation of personal injury disputes continues to be prominent despite having features which may suggest the unsuitability of such cases for mediation.\textsuperscript{272} Reasons for potential unsuitability include the inequality of bargaining power between plaintiffs and insurer defendants, a limited issue in dispute (damages) and the lack of an ongoing relationship between the parties.\textsuperscript{273} Another complicating factor is the typical absence of the negligent party (the doctor) in mediation, with that role being represented by the insurer.\textsuperscript{274} Some plaintiffs may also prefer to have their matter heard in court.\textsuperscript{275}

Despite these factors, mediation is supported for a number of reasons. One reason is the fear that a trial may negatively exacerbate the plaintiff’s emotions, and another is the risk of public disgrace of the defendant’s professional reputation.\textsuperscript{276} A further reason is the cost of medical negligence litigation which is often complex and lengthy.\textsuperscript{277} Finally, litigation can

\begin{thebibliography}{9}
\bibitem{268} Sheila M Johnson, ‘A Medical Malpractice Litigator Proposes Mediation’ (1997) 52(2) \textit{Dispute Resolution Journal} 43, 44.
\bibitem{269} Ibid 48.
\bibitem{270} Ibid.
\bibitem{271} Ibid 49.
\bibitem{272} Ibid.
\bibitem{273} Ibid.
\bibitem{274} Ibid.
\bibitem{275} Ibid.
\bibitem{277} Ibid.
\end{thebibliography}
raise complex legal issues. This is what makes the benefits of mediation so well suited to medical negligence: it is a confidential process, it is quicker and more cost efficient, the process grants parties more control and is generally less acrimonious than litigation.

The use of mediation to settle personal injury insurance disputes may also have financial advantages for the insurer. An integrative negotiation approach where both parties can achieve their goals may deliver a more satisfactory outcome, one that meets the needs of the claimant whilst reducing the payout figure for the insurer. Mediation allows for positive communication and the exchange of information. The use of a mediator can also prevent hostility spiralling out of control, given the claimant in insurance disputes will frequently experience strong emotions. Further, a mediator can assist to maintain the claimant’s expectations and realistic notions of fairness.

The driving forces for plaintiffs in medical negligence claims often involves more than simply financial objectives. For victims of medical negligence, there is an emotional driving force in instigating a claim, such as the need to have their story heard or the desire to receive an apology from the medical practitioner responsible. Medical negligence disputes are a source of great emotional conflict because plaintiffs have often sustained catastrophic personal injuries or are claiming as a carer for a disabled child or relative. The medical error might even have resulted in the death of a loved one. Consequently, the stories of personal injury conform to the genre of tragedy. Yet litigating in court can turn the narrative into a melodrama. As Hardy puts it:

The plaintiff, ideally characterised as inherently good, suffers from an injury due to the acts or omissions of the defendant, who is characterised as inherently bad. The injury results in the plaintiff’s previously good life completely transforming into a life typified by pain and suffering. The plaintiff consequently feels dissatisfaction with life but resignation to their fate.

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278 Ibid.
281 Ibid 78.
282 Ibid 74-75.
283 Ibid 76.
284 Ibid 77-78.
285 Relis, above n 157, 42-46.
The plaintiff and defendant are linked in a relationship of complementarity in that the defendant is portrayed as highly blameworthy and the plaintiff as not at all blameworthy. The plaintiff makes a public demonstration of virtue and the defendant is publicly judged. The plaintiff is then rewarded to the defendant’s detriment and justice is served.287

To avoid this descent into melodrama, mediation can be the preferred method of resolving disputes, allowing the expression of emotion in a venue far more suitable than a courtroom. In the context of mental harm proceedings, plaintiffs with a psychological condition pursuing a mental harm action may particularly benefit from mediation.288 This is because the process is informal and thus less lengthy and stressful in nature.289 Plaintiffs are also provided with timely breaks if the process of negotiating about anxiety-inducing events, such as the cause of the injury or the pain of living with an injury, become too overwhelming for them.290 The process is also confidential which avoids any shame or guilt the plaintiff might feel from being exposed to public scrutiny.291

Some academics recommend that a facilitative mediation style should be adopted in medical negligence disputes because it addresses the plaintiffs’ emotional needs and interests.292 The facilitative mediation style can be contrasted with using evaluative approaches common in court-connected mediation which involve harsher negotiation practices.293 Evaluative mediation involves the evaluation by a mediator of the legal or other merits of the dispute, in order to reach settlement according to the norms and principles of the relevant field of law.294 Evaluative mediation does not take into account the parties’ subjective needs, interests and priorities.295 In contrast, in the facilitative mediation model the focus is on problem-solving, taking into account the parties’ personal and commercial interests and priorities.296 If facilitative mediation is viewed as having an important role to play in the resolution of medical negligence disputes, it is necessary to explore whether this model is practiced in mediation of Victorian medical negligence disputes.

289 Ibid.
290 Ibid.
291 Ibid.
292 Ibid, above n 228, 81.
293 Ibid 79.
294 Boulle and Field, above n 23, 272.
295 Ibid.
296 Ibid 271.
3.9 PREVIOUS EMPIRICAL STUDIES ON MEDIATION IN MEDICAL NEGLIGENCE

This chapter has demonstrated that the use of mediation in medical negligence disputes is widely supported by academics and members of the legal profession. However, no systematic empirical study on the use of mediation in medical negligence and mental harm disputes has yet been undertaken in Australia. Empirical research on this issue has been undertaken in international jurisdictions and this section outlines the results of several studies relevant to this research.

3.9.1 NORTH CAROLINA MEDIATED SETTLEMENT CONFERENCE PROGRAM

In the 1990s North Carolina became one of the first states in the US to adopt a court-ordered mediation program. An empirical study was conducted involving analysis of court data records of malpractice cases ordered to mediation, observations of 42 mediations, review of 47 closed insurance files, and a survey of 45 plaintiff lawyers, 72 defence lawyers and 32 mediators.

In relation to the timing of the mediation, the study found that in 30.5% of cases, mediation was attempted nine months to one year of the filing date and approximately five months after mediation was ordered by the court. Using a number of variables the researchers also analysed the success of malpractice mediation and concluded that 44% of the mediations were successfully settled either at mediation or through a mediation related settlement. Further, out of the 117 lawyers who were surveyed, approximately 75% supported the referral of disputes to mediation. Many of the participants believed that mediation offered ‘meaningful potential for a “better resolution” of the case’.

As a case management tool, the study showed the mediation process was an effective way to handle those malpractice cases in which both parties have a genuine desire to settle. Many

298 Ibid 113 – 117.
299 Ibid 128.
300 Ibid 129.
301 Ibid 139.
302 Ibid 141.
303 Ibid 142.
cases were resolved directly as a result of the mediation. On the other hand, for those cases in which the parties were not inclined to settle, there was little evidence that the mediation program was able to transform the dispute or significantly alter the parties’ understanding or approach to the case.\textsuperscript{304} Despite the study having been conducted in a different jurisdiction, it serves to demonstrate the importance of mediation in the settlement of medical negligence cases and that its use is supported by the legal profession.

3.9.2. NHS MEDICAL NEGLIGENCE PILOT SCHEME

In response to increasing inaccessibility, costs, delays and unsatisfactory outcomes in medical negligence litigation, the British National Health service funded a pilot scheme in 1995 involving referral of medical negligence disputes to two external mediation agencies.\textsuperscript{305} Evaluations of twelve mediations between 1995 and 1998 were conducted, including 60 interviews with parties involved in the mediations and three observations. Settlement was reached in eleven cases, with some of the cases having non-monetary settlements such as an explanation of the clinical errors, public apologies or improvements to hospitals as a result of the claim being made.\textsuperscript{306} However, lawyers who were interviewed indicated they were uncomfortable with lack of control in the mediation process and addressing non-financial matters in the process.\textsuperscript{307}

Doctors were present in six out of ten mediations involving practitioner negligence. Despite lack of unanimous support for their attendance in all situations, some parties were able to make substantial progress in mediation due to the fact that the doctor was present.\textsuperscript{308} The doctors expressed some dissatisfaction in participating, finding the mediation confrontational, distracting and time-consuming.\textsuperscript{309} Yet, their participation was considered valuable in circumstances where it allowed negotiations to progress, or to permit an explanation, apology or acknowledgment of responsibility.\textsuperscript{310}

\textsuperscript{304} Ibid 151.
\textsuperscript{305} Linda Mulcahy, Ann Netten and Marie Selwood, Mediating Medical Negligence Claims: An Option for the Future (Stationery Office, 2000) 22-23.
\textsuperscript{306} Ibid 31-32.
\textsuperscript{307} Ibid 64-66.
\textsuperscript{308} Ibid 77-78.
\textsuperscript{309} Ibid 106.
\textsuperscript{310} Ibid 77-78.
In summary, mediation was generally considered satisfying in the pilot scheme because of the opportunity to address the needs and interests of the parties rather than simply achieve a settlement. Although a pilot study, this research is significant as it demonstrates the importance of the doctor’s presence at mediation of medical negligence claims in allowing parties’ non-legal needs to be met.

3.9.3 NEW YORK CITY’S PROJECT FOR MEDIATING MALPRACTICE CASES

In a US pilot study, the New York City Project for Mediating Malpractice Cases, nineteen cases of medical malpractice mediations in 2004 were studied to measure participants’ satisfaction with the mediation processes, regardless of whether settlement was reached. Participants included the plaintiff, the plaintiff’s support person, the plaintiff’s attorney, a representative from the Health and Hospital Corporation and the comptroller’s office, and the defendant’s attorney. Thirteen of the nineteen cases settled, and in eleven cases an apology of sympathy or responsibility was offered, with ten of those apology cases settling. Only three of the eight cases where an apology was not offered settled.

The researchers concluded that facilitation of apology was an advantage of mediation, with settlement occurring 2.42 times more frequently when an apology was offered. Despite a strong association between apology and settlement needs, the authors could not confidently assert that an apology always led to settlement, and acknowledged this correlation required further study. Further, the results of the study found that the parties and their lawyers viewed mediation as fair, satisfying and responsive to their interests. Overall, this study is significant because it highlights the important role of apologies in dispute resolution following medical error.

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311 Ibid 104-105.  
313 Ibid 1395.  
314 Ibid.  
315 Ibid.  
316 Ibid 1395.  
317 Ibid 1395.  
318 Ibid 1399.  
319 Ibid 1398.
3.9.4 MEDIATING SUITS AGAINST HOSPITALS

The ‘Mediating Suits Against Hospitals’ study is built on the ‘New York City Project for Mediating Malpractice Cases’ research project and was conducted by the same research team. The aim of the ‘Mediating Suits Against Hospitals’ study was to assess the suitability of mediation of medical malpractice lawsuits involving private hospitals in New York City. Sixty-seven lawsuits were referred to the study, but data was only gathered from 57 cases as 10 cases were withdrawn. 31 out of 57 cases proceeded to mediation. As indicated earlier in this chapter, the researchers found that plaintiff lawyers were more willing to mediate than defendant lawyers, with plaintiff lawyers agreeing to mediate in 49 out of 57 cases, compared with defendant lawyers who agreed to mediate in 31 out of 57 cases.

Out of the 31 cases, sixteen cases settled at mediation and five settled following the mediation. Plaintiffs and lawyers for both sides indicated a clear satisfaction with mediation, as did hospital representatives and insurers. Plaintiffs participated in 25 mediations, with the study investigators noting plaintiff lawyers were concerned about loss of control over their client, or about what their client might hear in the mediation. No treating medical practitioners in the study participated in the mediations, with defence lawyers citing work schedules and the need to protect their client as reasons for non-attendance. The investigators noted that lawyers, hospital representatives and insurers did not fully understand the benefits of mediation, so without medical practitioners’ attendance the focus of the mediation was predominantly on the settlement sum. The mediation style used was facilitative and interest-based (rather than evaluative which focuses more strictly on legal and financial issues) and plaintiff and defence lawyers in the study reported they were satisfied with this approach.

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320 Hyman et al, above n 197, 801.
321 Ibid 804.
322 Ibid 804.
323 Ibid 804-805.
324 Ibid 807.
325 Ibid 808-809.
326 Ibid 815.
327 Ibid 816-817.
328 Ibid 817.
329 Ibid 818.
Apologies from defence lawyers or hospital representatives were given in nine mediations, with eight of those involving an expression of empathy but no admission of fault.\textsuperscript{330} The study also examined changes in practice or policy by hospitals, and found that only in four cases did the defendants listen to and identify a need to improve procedure to avoid or reduce medical error in the future.\textsuperscript{331} The researchers concluded the lack of attendance by doctors reduced parties’ ability to experience the full benefits of mediation, such as the opportunity for plaintiffs to understand or forgive the medical error.\textsuperscript{332} It also deprived doctors of the opportunity to identify and learn from errors in order to improve future healthcare services.\textsuperscript{333} This study is significant insofar as it demonstrates the benefits of interest-based mediation for resolution of medical disputes, and further, highlights the importance of the attendance and participation by medical practitioners at mediation in order to make the process meaningful.

3.9.5 PERCEPTIONS OF LAWYERS AND PARTIES IN LITIGATION AND MEDIATION OF PERSONAL INJURY DISPUTES

Another study relevant to this research is Relis’ empirical study, which gathered the experiences of legal and lay participants, in the mediation of medical injury disputes in Canada.\textsuperscript{334} The data was gathered from 131 semi-structured interviews, questionnaires and observations of the lawyers, parties and mediators in 64 mediations.\textsuperscript{335} In relation to plaintiffs’ litigation aims, Relis concluded that lawyers’ perceptions are that plaintiffs sue predominantly for monetary reasons and consequently lawyers exclude other plaintiff objectives such as an admission of fault or apology for which mediation may be better suited.\textsuperscript{336} The study found strong support from lawyers in participating in voluntary mediation and a lack of opposition to mandatory mediation.\textsuperscript{337} Relis addresses the issue of power in mediation, noting that despite a plaintiff’s desire to have the defendant present at mediation, many defendant lawyers advised their clients not to attend the mediation.\textsuperscript{338} Many lawyers viewed doctors’ attendance at mediation as ‘risky’ because it might increase plaintiffs’ emotional reactions or attendance was considered ‘unnecessary’ because the
insurer indemnified the doctor and thus the doctor was not personally responsible for compensating the plaintiff.\(^339\) Because the doctor is not present at the mediation there is an inability to address emotional objectives and consequently mediations are transformed into venues for ‘bargaining over money’.\(^340\)

An analysis of the participants’ mediation objectives also highlighted the divergence between the plaintiffs’ extra-legal objectives and the lawyers’ tactical agendas.\(^341\) The experiences during the mediation also highlighted this divide: the plaintiffs used the mediation process to express their emotions and needs whereas the lawyers considered the information obtained during the mediation process as strategically important for future litigation.\(^342\) This divergence was also evident with respect to mediator perceptions; the plaintiffs focused on the mediators’ human attributes, whilst the lawyers preferred an evaluative mediation style and focused on the tactical assistance the mediator could offer.\(^343\) Overall, the study is useful to this research as it compares the varying perceptions of legal and lay participants involved in medical injury disputes. It is highlights the extent to which plaintiffs are keen to participate in mediation and the push by lawyers to avoid the presence of doctors at mediation. The study also highlights the relevance of emotion and power as themes prevalent in mediation, which are discussed in more detail in Chapter Six of this thesis.

### 3.10 Legal Education and the Adversarial Culture of Lawyers

The training and education of lawyers, combined with the personality types of individuals attracted to law, would suggest that a majority of lawyers tend to adopt an adversarial approach to lawyering.\(^344\) While this approach is helpful in a courtroom, it can be extremely detrimental in mediation if lawyers dominate the process, control their clients and steer the negotiations towards rights-based or financial objectives. In disputes where emotion is a factor, adversarialism can hinder the ability of participants to express feelings, seek an explanation or apology from the opposing party, or receive emotional closure. To address the

\(^{339}\) Ibid 125.
\(^{340}\) Ibid 126.
\(^{341}\) Ibid 153.
\(^{342}\) Ibid 195.
\(^{343}\) Ibid 224.
critical lack of emotional understanding and intelligence in lawyers, commentators argue that curricular reform in law schools and continuing legal education is needed.\footnote{Ryan, above n 211, 283.}

Macfarlane contends that lawyers construct a professional identity based on their beliefs about their role in the legal profession, and identifies that the dominant values in legal culture are closely affiliated with the adversarial stereotype.\footnote{Julie Macfarlane, \textit{The New Lawyer: How Settlement is Transforming the Practice of Law} (University of British Columbia Press, 2008) 28-29.} These include aggressive argument, positional bargaining, formalistic rituals and procedures, and a strategy to win.\footnote{Ibid 29.} Despite these stereotypes, an increase in ADR has led to a cultural change in the professional identity of lawyers, with lawyers amenable to alternative forms of dispute resolution.\footnote{Ibid 2-3.} Macfarlane explains this is ‘the evolution of a new form of lawyering, which is more effective and more realistic within a changed disputing landscape in which trials are a rarity’.\footnote{Ibid 17.} She suggests there are three core dimensions that distinguish the new lawyer from the old lawyer: first, an increase in negotiation skills; second, an increase in communication as vehicle for resolution of conflict; third, a change in the relationship between a lawyer and client where the lawyer considers the client as a partner in problem-solving thus encouraging active client participation.\footnote{Ibid 23-24.}

Lawyers’ professional identity is influenced from a number of sources, including legal education, communities of practice, personal experiences, mentorship, and professional codes of conduct.\footnote{Ibid 30-46.} To Macfarlane, legal education is a site ripe for change in the promotion and evolution of new professional identities for lawyers.\footnote{Ibid 223-224.} In Australia, ADR education can be provided in law school, in pre-admission training in practical training programs or through continuing professional development of lawyers.\footnote{Charles Brabazon and Susan Frisby, ‘Teaching Alternative Dispute Resolution Skills’ in Charles Sampford, Sophie Blencowe and Suzanne Condlin (eds), \textit{Educating Lawyers for a Less Adversarial System} (Federation Press, 1999) 158.
Corbin, Baron and Gutman advocate for reform in legal education, combined with more directive professional rules, to shift the lawyering culture.\textsuperscript{354} In relation to professional conduct rules, the scholars contend that these rules have traditionally prioritised the lawyer’s duty to the client over interests such as a duty to other parties or to society.\textsuperscript{355} They acknowledge that a welcome addition is a more directive rule obliging lawyers to inform clients of all dispute resolution avenues.\textsuperscript{356} The authors further emphasise the importance of legal education in fostering a change in culture and assert this can be helped by two factors: firstly, the inclusion of Threshold Learning Outcomes in the standards imposed on law schools to emphasise the importance of ADR and secondly, the inclusion of ADR as a core subject in law schools.\textsuperscript{357} The Threshold Learning Outcomes were developed in 2010 and represent a set of six knowledge and skills outcomes expected of Australian law graduates.\textsuperscript{358}

Academics have highlighted how teaching ADR in law schools can assist to shape positive professional identities in lawyers and equip them with the knowledge, skills and attitudes for practice.\textsuperscript{359} Field and Duffy also support the inclusion of ADR as a mandatory subject for law students. They contend that if the significance of ADR in legal practice is accepted, then law schools are failing future legal practitioners because of the lack of ADR content.\textsuperscript{360} The Australian Government’s \textit{Access to Justice} Report recommended that lawyers admitted to practice should be equipped with skills to guide a client through a dispute resolution process, and understand the major ADR processes.\textsuperscript{361} In a subsequent report, NADRAC agreed with this recommendation, and contended that the teaching of ADR in law schools should be

\textsuperscript{354} Corbin, Baron and Gutman, above n 344, 513.
\textsuperscript{355} Ibid 508-509.
\textsuperscript{356} Ibid 509.
\textsuperscript{357} Ibid 511-512.
\textsuperscript{358} For an overview of Threshold Learning Outcomes see Boulle and Field, above n 23, 27-30.
\textsuperscript{359} Rachel Field, James Duffy and Anna Huggins, \textit{Lawyering and Positive Professional Identities} (LexisNexis, 2014).
\textsuperscript{360} James Duffy and Rachael Field, ‘Why ADR Must be a Mandatory Subject in the Law Degree: A Cheat Sheet for the Willing and a Primer for the Non-Believer’ (2014) 25(1) \textit{Australasian Dispute Resolution Journal} 9.
Field and Roy support the introduction of ADR as a compulsory subject in law curricula, advocating for ADR to be made a capstone subject. While many commentators have called for the inclusion of ADR as a mandatory course in legal education, some have highlighted the need to examine how and when it is incorporated into a law degree, in order to maximise benefits. In a study conducted by Douglas consisting of interviews with 24 Victorian and Queensland teachers who taught ADR, all participants endorsed the value of ADR in a law course as well as the need for law students to understand and choose from a range of dispute resolution alternatives. The participants in this study were also asked about the placement of ADR within the law course they were teaching. Three universities offered ADR as a stand-alone compulsory course, another three combined ADR and Civil Procedure as a compulsory course, a further three offered ADR as an elective subject integrated with an earlier compulsory substantive law course, and finally another three universities offered ADR as an elective. The positioning of ADR in the law program varied, with some universities offering it as a first-year subject while others offered it in later years of study. Ultimately the participants in the study endorsed the inclusion of ADR theory and practice as a valuable source of teaching future lawyers negotiation and mediation skills, and supported the inclusion of ADR as a first year subject. The participants were not unanimous in their responses as to whether ADR ought to be taught as a stand-alone module or combined with another area of study.

Greater focus on ADR in legal education is also valuable for educating future lawyers about the importance of addressing emotion in conflict and dispute resolution. Traditionally, legal education has focused on teaching legal principles, fact-finding skills and application of law to facts, yet non-adversarial forms of justice such as therapeutic jurisprudence and restorative justice suggest that emotional intelligence and interpersonal skills are of equal importance.

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365 Ibid 77.
366 Ibid 79.
367 Ibid 79.
368 Ibid 84.
369 King, above n 234, 1097.
These skills include the ability to understand clients’ psychological and emotional needs, and garnering techniques of understanding and empathy.  

Douglas and Batagol have explored how ADR and non-adversarial justice are being used as sites to teach law students about emotion in dispute resolution through interviews and surveys of Australian law teachers.  

When asked about the importance of emotion in ADR, the general consensus of participants was that emotion was an integral part of conflict. However emotion was considered less important by teachers of civil procedure courses which would suggest that combining ADR with more adversarial approaches reduces emphasis on factors such as emotion.  

When asked about incorporating teaching about emotion into ADR courses, participants offered a number of strategies including drawing on literature, class discussion, teaching communication skills, and debriefing role plays. Douglas and Batagol concluded that while ADR is an optimal subject for teaching emotion, not all law schools have fully engaged with this opportunity.

In December 2016, the Law Admissions Consultative Committee revised the Model Admission Rules for legal practice, altering Civil Dispute Resolution (formerly Civil Procedure) to include teaching of ADR. Given that Civil Dispute Resolution is part of the ‘Priestley 11’ core units which law students must complete to gain admission to practice, this recent revision represents a significant shift in the acceptance of ADR in the training and education of lawyers. While this change is relatively recent, it will be an important site for future research to explore its effect on the teaching of ADR in law schools and its subsequent impact on legal practice.

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370 Ibid.  
372 Ibid 114.  
373 Ibid 114.  
374 Ibid 115.  
375 Ibid 116.  
377 Ibid.  

3.11 CONCLUSION

The literature in this chapter has demonstrated that mediation has a vital role to play in the resolution of medical negligence and mental harm disputes. The particular characteristics of medical negligence disputes, such as complexity of medical subject matter and heightened emotions, lend themselves to resolution by alternative means of dispute resolution. Mediation offers an environment capable of catering to the non-legal needs of the parties and also provides a quicker, cheaper and less formal alternative. With the increase of court-connected mediation in the resolution of medical negligence disputes, it is important to explore how mediation is practiced in this niche jurisdiction. This includes exploration of the role of lawyers in mediation, addressing parties’ emotion as an influential factor, and the practical challenges faced by lawyers and parties throughout the process.

Empirical studies in the medical negligence context discussed in this chapter indicate that generally lawyers are more comfortable taking an adversarial stance in mediation, because they are more familiar with this approach. Consequently, lawyers tend to sideline client’s emotional needs in favour of legal and financial objectives. Previous studies also show the necessity for both parties attending and meaningfully participating in mediation to allow for the non-legal needs of the parties, such as the expression of regret, sympathy, an explanation or an apology, to be met. This is consistent with the literature on non-adversarial justice approaches, including TJ, RJ and PJ, which highlight the role of emotion in conflict and the importance of addressing non-legal needs of parties.

Despite the benefits facilitative or interest-based mediation can offer in medical negligence, results of previous studies would indicate that lawyers have a tendency to favour an evaluative or rights-based style of mediation that does not necessarily cater to the needs of the participants. These findings suggest lawyers foster an adversarial culture which is reflected in mediation practice, and in order to shift this culture, more emphasis needs to be placed on legal education and the teaching of ADR in law schools to facilitate this change. In summary, this literature review chapter informs the mediation part of this qualitative research that seeks to explore how mediation of Victorian medical negligence disputes occurs in practice.
CHAPTER 4 – METHODOLOGY

4.1 INTRODUCTION

Chapter Two of this thesis explored the background to major tort reforms in 2002-2003 affecting medical negligence and mental harm proceedings, including challenges presented by injury thresholds, caps on damages and the statutory causation test. The literature described criticism from prominent academics and legal professionals regarding the 2002-2003 reforms to the Wrongs Act, centred on the lack of an empirical basis underpinning the need for the reforms and the rushed nature of implementing the resulting amendments.

Chapter Three of this thesis explored how the shadow of the law can impact upon mediation practice in the medical negligence context, including how lawyers can influence the resolution process and the role that emotion can play in resolving such disputes. The background literature also highlighted the lack of a systematic empirical study into medical negligence litigation and mediation practice in Victoria. In order to address this gap, the empirical component of this research explores whether the Ipp Reforms have had any effect on the litigation and mediation of meritorious medical negligence and mental harm claims in Victoria, from the perspective of lawyers and judges with medical negligence experience. It also explores the potential impact of the 2015 remedial amendments to the Wrongs Act on medical negligence and mental harm claims.

This chapter outlines the scope and aims of this doctoral study. It includes the epistemological and methodological choices for this research and reasons for using a grounded theory approach. The methods used in the study including ethics approval, data collection, sampling, recruitment method and interviewing approach, and data analysis are then addressed. Finally, the limitations of the study are outlined.

4.2 AIMS AND SCOPE OF THE STUDY AND RESEARCH QUESTIONS

The aim of this study is to explore whether the 2002-2003 amendments to the Wrongs Act have presented challenges to the successful recovery of compensation in meritorious medical negligence and mental harm claims. This research may be beneficial in exploring the
challenges faced by medical negligence parties in the litigation of such claims. Another aim of this study was to explore and to understand how the current state of the law has affected court-connected mediation practice in medical negligence disputes. Accordingly, this doctoral research project was confined to exploring mediation of medical negligence disputes in a court-connected environment and issues such as mediation in the hospital and healthcare contexts were not explored in this research. Finally, the research may assist policy-makers in developing possible improvements to the current regulatory framework for the mediation and litigation of medical negligence disputes.

The primary research questions are:

1. Have the 2002-2003 amendments to the Wrongs Act resulting from the Ipp Reforms had any effect on the litigation and mediation of meritorious medical negligence claims?
2. What impact are the 2015 amendments to the Wrongs Act likely to have on the litigation and mediation of medical negligence disputes?

A number of subsidiary research questions also explore the challenges faced by lawyers in medical negligence practice. The subsidiary questions are divided into litigation and mediation categories.

**Litigation Questions:**

- Following the Ipp Reforms, what are the challenges experienced by lawyers in medical negligence litigation? Do these challenges apply to mental harm claims as well?
- Does the element of causation present as a hurdle to plaintiffs succeeding in a negligence case?
- Based on your experience, what are your perceptions about the changes (if any) experienced in the number of litigants commencing medical negligence disputes following the Ipp Reforms?
- Based on your experience, what are your perceptions about the changes (if any) experienced in the compensation payments received by plaintiffs in medical negligence proceedings, following the Ipp Reforms? Do these changes apply to mental harm claims as well?
• What impact do you see the recent 2015 amendments to the *Wrongs Act* having on the ability of plaintiffs to recover compensation?

**Mediation Questions:**

• To what degree do parties engage in mediation for medical negligence disputes? If they do, are emotional issues a relevant factor in participating in mediation?
• Does the mediation process assist participants to express their emotions associated with the medical negligence dispute?
• What is the role of lawyers in the mediation of medical negligence disputes?
• Following the Ipp Reforms, what are the challenges (if any) experienced by lawyers in mediation of medical negligence disputes?
• Is mediation a more suitable dispute resolution avenue than litigation for medical negligence claims?
• What benefits or disadvantages does mediation (as opposed to litigation) have on medical negligence clients (either plaintiff or defendant)?
• Are there any aspects of the medical negligence dispute litigation or mediation process in need of further reform?

**4.3 ETHICS**

Ethics refers to the moral principles governing conduct.\(^1\) It is important for a researcher to adhere to the highest ethical principles possible because failure to do so can have adverse consequences for the research participants and organisations involved. In order to explore the research questions, a qualitative research method using semi-structured interviews was adopted.

Ethics approval for this research (project no. 19618) shows that it was deemed low risk by the RMIT University Business CHEAN Committee and approval was granted on 15 October 2015. A copy of the approval letter is contained in Appendix 1. On 24 December 2015, an ethics amendment approval was granted extending the research sample to Victorian County Court judges with medical negligence experience. The recruitment method was also

\(^1\) Christina Quinlan, *Business Research Methods* (Cengage Learning, 2011), 70.
expanded to include the snowball sampling technique. A copy of this approval letter dated 24 December 2015 is contained in Appendix 2. On 31 March 2016, a further ethics amendment approval was granted allowing Victorian Supreme Court Justices with medical negligence experience to be interviewed for the research. A copy of this approval letter is contained in Appendix 3.

The research participants in this study are Victorian lawyers and judges with medical negligence experience. The participants fall into a low risk category in this study. However, it was important to recognise that participants could face some risk in agreeing to participate in the interview. For instance, the participants may open themselves up to criticism from their employer if they were perceived to be critical of any aspect of their employment. In addition, the lawyers could be criticised by their clients for failing to adopt a certain stance. For instance, a medical negligence defence practitioner whose client is an insurance firm may be criticised for sympathising with plaintiffs. The participants could also be censured by other members of the legal profession which could adversely impact their reputation.

To overcome these ethical concerns, the candidate provided the participants with a consent form prior to commencing interviews. The researcher also ensured anonymity of the research participants by de-identifying participant information. Each participant was categorised as ‘Lawyer Plaintiff’, ‘Lawyer Defendant’ or ‘Lawyer Court’ and assigned a number. Participants were also assured that only the researcher and the researcher’s supervisors would have access to the identifying data.

4.4 EPISTEMOLOGY AND METHODOLOGY

A research paradigm is the framework that guides the conduct of the research. It is the philosophical framework that ensures appropriate methodological choices to serve the purpose and aims of the research. The two main paradigms are positivism and interpretivism. The positivist position supports the view that there is only one objective reality in existence. An alternative paradigm is interpretivism, which holds that social reality is a subjective construction based on interpretation and interaction. It is grounded in the

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3 Ibid 43-45.
4 Quinlan, above n 1, 96.
5 Ibid.
assumption that research on humans and human institutions differs from research into the natural and physical sciences. It is best suited to research exploring participants’ thoughts, feelings and beliefs about a phenomenon.

The research paradigm contains a number of philosophical assumptions. The ontological assumption is concerned with the nature of reality. Positivism supports the view that social reality is objective and external to the researcher whereas interpretivism posits that social reality is subjective and socially constructed. The epistemological assumption is concerned with the processes through which knowledge is created. Under the positivist view the researcher seeks to be objective and distant from the data whereas interpretivism holds that the researcher’s knowledge is obtained through engagement with subjective evidence provided by participants.

Epistemological positions are associated with certain methodologies. Adherence to a positivist paradigm leads to quantitative research aiming to measure and test a hypothesis, commonly implemented through surveys and questionnaires. The interpretive approach is associated with collecting qualitative data. Collecting qualitative data involves the researcher gathering the feelings, thoughts and ideas of the participants. Qualitative research strategies are inductive because they involve the creation of a theory following data collection, rather than the testing of an existing theory.

The most appropriate paradigm for this research is interpretivism. This is because the purpose of the research was to gain an understanding of the impact the Ipp Reforms and the 2015 reforms have had on the litigation and mediation of medical negligence disputes through the views of lawyers representing plaintiffs and defendants. Interpretivism adopts the view that reality is situational and personal, and will vary between individuals. This underpinning is well suited to conducting qualitative research because judges and lawyers are a rich source of information who are well positioned to comment on any challenges experienced by their

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7 Quinlan, above n 1, 105.
8 Collis and Hussey, above n 2, 46.
9 Ibid.
10 Quinlan, above n 1, 96.
11 Collis and Hussey, above n 2, 46.
12 Ibid 52.
13 Bryman, above n 6, 36.
clients in medical negligence litigation and mediation disputes. They are able to comment on
the legal issues that affect the opportunity to be compensated in medical negligence cases
after the Ipp Reforms and can also articulate possible further legislative change.

4.5 GROUNDED THEORY

The philosophical framework and methodology selected as the most suitable to the aims of
this research is grounded theory. Grounded theory was selected as the research methodology
to undertake the analysis of the data. This can be contrasted with corrective justice theory
which was selected as the conceptual framework through which analysis of the data occurred.
While methods such as thematic content analysis or phenomenography can also be used in
qualitative research designs,15 grounded theory was selected as it seeks to include a variety of
data sources that might contribute to theory development. In this research, past literature and
doctrinal analysis of case law and legislation was highly relevant to the development of the
emerging theory.

Grounded theory was first developed by Barney Glaser and Anselm Strauss in response to a
need to generate new theory from data, as opposed to testing existing theories.16 Glaser’s
background was in positivist methodology whereas Strauss was a field researcher who
studied symbolic interactionism (a theory that explains social reality through the manner in
which individuals interact with one another).17 Their combined experience enabled them to
bring a ‘pragmatist philosophical study of process, action, and meaning into empirical inquiry
through grounded theory’.18 Glaser and Strauss’ perspectives on grounded theory
subsequently diverged,19 Glaser’s writings moved towards the theoretical while Strauss’
focus was practical. Strauss later collaborated with Corbin to produce texts which outlined a
structured approach to grounded theory including clear analytical steps.20 As a consequence
of this divergence, grounded theory can be viewed in two different modes: the classic

15 Quinlan, above n 1, 182-188.
16 Barney Glaser and Anselm Strauss, The Discovery of Grounded Theory: Strategies for Qualitative
18 Kathy Charmaz, ‘Grounded Theory: Objectivist and Constructivist Methods’ in Norman K Denzin and
19 Barney Glaser, Theoretical Sensitivity: Advances in the Methodology of Grounded Theory (Sociology
20 Anselm Strauss and Juliet Corbin, Basics of Qualitative Research: Grounded Theory Procedures and
Qualitative Research: Techniques and Procedures for Developing Grounded Theory (SAGE Publications,
('Glaserian') mode originally developed by Glaser and Strauss in 1967 and the latter ‘Straussian’ mode developed by Strauss and Corbin. Given that the Glaserian mode is rooted in the positivist paradigm, the Straussian mode is better suited to the research in this study because of its origins in pragmatism and symbolic interactionism. Further, methodological gaps in the early texts on grounded theory do not assist in the planning and execution of a rigorous study, while the practical rigour of the Straussian mode is more suitable for a doctoral study.21

Grounded theory is inductive, and it is used when the researcher seeks to create a theory from data or when researching a matter about which little is known.22 It is most often used in research with qualitative data sources.23 In contrast with a deductive method, it is not used to test an existing theory, that is, the researcher ‘does not begin with a theory, then prove it. Rather, the researcher begins with an area of study and concepts relevant to the phenomenon are allowed to emerge’.24 Grounded theory is most useful in explaining the phenomenon being studied.25 The way that data is collected in grounded theory studies can take many forms however interviews are the most common method.26

A unique tool utilised by grounded theory is theoretical sampling, defined by Glaser and Strauss as ‘the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges’.27 In this study after initial data collection from lawyers, the researcher decided to extend data collection to Victorian judges and justices to garner a different perspective from them. Members of the judiciary are not only highly experienced lawyers but have the unique advantage of adjudicating medical negligence disputes so it was beneficial to the study to gather reflections from these participants. Theoretical sampling involves accessing an initial source of data, then interpreting the meaning of the data and relating it back to the evolving theory.28

22 Quinlan, above n 1, 183 – 184.
23 Birks and Mills, above n 21, 6.
24 Strauss and Corbin, above n 20, 23.
25 Ibid 16.
26 Ibid 65.
27 Glaser and Strauss, above n 16, 45.
28 Ibid.
Grounded theory outlines methods of data analysis which are executed through coding and categorisation. It is accepted there are many variations of the method of data analysis. The approach in this study is generally consistent with a small ‘g’ grounded theory approach, involving a thematic analysis directed by grounded theory. This approach involved using thematic directions that enabled analysis of data and exploration of themes without necessarily constructing a metatheory from the data.

Coding is the process of analysing the data and identifying the different concepts emerging from it. It occurs by acknowledging that participants’ words represent a broader concept. The next stage in grounded theory analysis is theorising, which involves the researcher identifying the information gained in the data, identifying any missing information and testing a preliminary hypothesis with existing or new data. This means that the entire process of gathering data does not occur at the commencement of the study, but rather continues until the researcher has reached theoretical saturation. Theoretical saturation is a point where no new themes in the data emerge and the data collected does not add to the knowledge already gained.

4.6 DATA COLLECTION

Consistent with the research paradigm and methodology, interviews were the most suitable data collection method for this study. Interviews are used when the researcher is capable of identifying the key respondents integral to the research and engaging them in an interview process. In order to collect the data, the researcher identified a sample of Victorian lawyers and judges with medical negligence experience and interviewed them. The lawyers represent a sample from those instigating and defending negligence claims. The lawyers were identified as the experts in their field best placed to provide reflections on the challenges of practicing in this area since the 2003 and 2015 reforms to the Wrongs Act. Plaintiff lawyers formulate the claims on behalf of their clients and play a significant role in the gaining of

29 Birks and Mills, above n 21, 87.
31 Birks and Mills, above n 21, 91-94.
32 Collis and Hussey, above n 2, 181.
33 Ibid 182.
34 Quinlan, above n 1, 289.
compensation for them. The role of defendant lawyers is to formulate defenses to claims on behalf of insurers and ensure compensation paid is not disproportional. These lawyers attend mediation with their clients and advise them of the desirability of accepting offers of settlement. As repeat players in mediation, they are able to offer insights about their own experiences and the experiences of their clients with this ADR option.

4.7 SAMPLING

In a qualitative study, the ‘richness’ of data is crucial to the study which may be obtained from a smaller number of participants. For researchers gathering quantitative data, a large number of participants is needed in order to ensure that the participants are representative of the population so that the findings have general application. The researcher did not determine the exact number of participants at the beginning of the research process. Rather, the researcher continued interviewing participants until saturation was achieved. In grounded theory, it is important to select participants based on their ability to provide information relevant to the study. In this study, it was envisaged that the researcher would interview between 20 and 40 participants, depending on when saturation was reached.35

Participants were selected using purposive sampling,36 meaning they were selected based on certain characteristics, such as their level of experience in medical negligence. Purposive sampling allowed the researcher to select participants who had information and experience which was relevant to the research questions. Purposive sampling is consistent with the use of grounded theory because it allowed the researcher to select the participants who were able to provide the richest insight into the study phenomenon, based on their experience. An internet search was conducted initially to locate the participants and to determine the extent of their experience in medical negligence. Subsequently, the snowball sampling method was used to

35 As a comparison of qualitative studies in law, see Kathy Douglas and Becky Batagol, ‘The Role of Lawyers in Mediation: Insights from Mediators at Victoria’s Civil and Administrative Tribunal’ (2014) 40(3) Monash University Law Review 758 where 16 mediators were interviewed for the study. Similarly see George Jelinek et al, ‘Barriers to the Operation of Mental Health Legislation in Australian Emergency Departments: A Qualitative Analysis’ (2011) 18(4) Journal of Law and Medicine 716 where 20 doctors and 16 nurses were interviewed for a medical and legal study. See also Greg Guest, Arwen Bunce and Laura Johnson, ‘How Many Interviews Are Enough? An Experiment with Data Saturation and Variability’ (2006) 18(1) Field Methods 59.

36 Purposive sampling is where the researcher makes a judgment about who to include in the research based on the capacity of the participant to inform the research. See Quinlan, above n 1, 213.
allow participants who had already been interviewed to recommend further participants with relevant experience for the study.\(^{37}\)

In order to gain a representative sample, the interviews were conducted with medical negligence lawyers representing plaintiff and defendants, as well as with barristers who usually had experience representing both parties. The use of Victorian participants was based on considerations of budget and accessibility of participants. In December 2015, the researcher decided to expand the range of participants to include Victorian judges and justices with medical negligence experience.

### 4.8 RECRUITMENT

The participants were identified through a website search of Victorian medical negligence law firms and barrister clerk lists. The participants were contacted by email and invited to participate in the research. The email contained a plain language letter and consent form. A copy of the invitation letter and consent form is contained in Appendix 4. If no response were received, a follow up email was sent. If a positive response were received, a date and time for the interview was scheduled. On 22 December 2015 approval was granted by the RMIT University Ethics Committee to expand the recruitment method to include further participants obtained by snowball sampling. This technique continued until the researcher reached saturation point where no new concepts, themes or ideas that would contribute to the research findings emerged.\(^{38}\)

During recruitment, the researcher needed to overcome a number of challenges. Firstly, the research questions focused on experiences prior to and following the Ipp Reforms which limited the pool of participants to senior legal practitioners. The researcher needed to locate participants that held the relevant length of experience in medical negligence. This process became easier with the use of ‘snowball sampling’ as participants could recommend fellow medical negligence lawyers who were sufficiently experienced. Secondly, the research relied heavily on participants volunteering to be interviewed while balancing demands of busy work schedules. The work constraints resulted in several participants rescheduling interviews or

\(^{37}\) Snowball sampling is a technique where the researcher finding one suitable participant, conducting research with that participant and asking that participant to recommend the next participant. See Quinlan, above n 1, 214.

\(^{38}\) Ibid.
advising the researcher they no longer wished to participate. Finally, during initial communications some participants expressed concern about their perceived need to be familiar with the precise nature of the Ipp Reforms. Once the participants were reassured the researcher sought their perceptions and experiences in medical negligence, rather than doctrinal knowledge, they indicated they were comfortable participating in the research project.

4.9 INTERVIEWING

The researcher adopted a reflexive approach while conducting the interviews. Reflexivity in research is ‘grounded in the in-depth, experiential, and interpersonal nature of qualitative inquiry’.\(^{39}\) It emphasises the importance of ‘deep introspection, political consciousness, cultural awareness, and ownership of one’s perspective’.\(^{40}\) Reflexivity involves a researcher’s self-questioning and self-understanding.\(^{41}\) Reflexivity can involve personal reflections on the researcher’s values, epistemological reflections on how the world is known, or ethical reflections regarding the research being undertaken.\(^{42}\) It is important for the researcher to be aware of the effect of their involvement in the research and any impact this may have on the research. For instance, there is a risk that a researcher’s critique of the data can reflect badly on medical negligence practice and expose the participants to criticism from their employer or the legal profession. Therefore it is important for a researcher to be consciously aware of how they can influence the study. In addition, adopting a reflexive approach may assist in avoiding bias on the part of the interviewer by encouraging the researcher to evaluate research processes. A reflexive approach can also help the researcher to adopt a ‘curious’ and ‘open’ stance to the issues under investigation.

When conducting interviews, the researcher used an interview schedule to guide the conversation with participants. A complete list of the questions in the interview schedule is contained in Appendix 5. The researcher asked open-ended questions to allow the participants to provide answers based on their knowledge and experience. Following introductions, the researcher provided an overview of the research to the participant, explained the consent form, and obtained consent for audio recording of the interview. The


\(^{40}\) Ibid.

\(^{41}\) Ibid.

researcher then obtained information from the participant on the nature and duration of their work experience in medical negligence. This preliminary information was followed by a conversation based on the prompt questions contained in Appendix 5.

To trial the interview schedule, the researcher conducted a pilot interview with a participant. The trial resulted in the inclusion of a specific question with respect to causation to directly ask participants whether they thought it presented as a hurdle in meritorious medical negligence claims. Otherwise all interview questions remained the same as those reflected in the interview schedule. The interview data obtained in the pilot interview was relevant to the research questions and was therefore included in the overall study. Once the remedial amendments to the Wrongs Act had taken effect in late November 2015, a specific question about the anticipated effect of the VCEC reforms was included.

The interviews with research participants lasted between thirty and sixty minutes and were conducted face-to-face. The interviews were held between November 2015 and June 2016. All interviews were audio recorded. One third of the interviews were transcribed by the researcher and the remaining interviews were transcribed through a transcription service, OutScribe. The identity of the participants was separated from the data by adopting a numbered coding system. Each participant was categorised as ‘Lawyer Plaintiff’, ‘Lawyer Defendant’ or ‘Lawyer Court’ and assigned a number. The electronic identifying data was kept on secure password-protected RMIT University servers and the printed consent forms and interview notes in locked cabinets on site at RMIT University. The identifying data was only available to the researcher and the researcher’s supervisors.

The semi-structured interviews and open-ended questions allowed the participants to discuss the subject matter openly and to offer their experience and opinions on the topics presented to them. The participants were able to comment on the legal issues that affect the ability of plaintiffs to be compensated in medical negligence and mental harm claims, and could assist with the articulation of possible further legislative change. Further, the participants could offer reflections on how they perceived their role in the mediation of medical negligence disputes, how the shadow of the law impacts upon mediation practice and whether the mediation process allowed for the expression of emotion by the parties.
4.10 DATA ANALYSIS

Consistent with the interpretivist paradigm, analysis of the data was undertaken through emergent themes. In some sections of this thesis a basic numerical analysis is also used to clearly illustrate participants’ responses. This approach is consistent with scholars’ views that a numerical summary can play an important role in qualitative research by offering clarity in the representation of the findings. The process of data analysis is outlined in comprehensive detail below.

4.10.1 OPEN CODING

After the data was transcribed, the researcher analysed the transcripts using open coding to identify relevant themes and concepts. In grounded theory, open coding is the first step in research and involves identifying and labeling important terms in the interview transcripts. Open coding was undertaken manually by the researcher, by analysing the interview transcripts line-by-line to identify key words, sentences or phrases with respect to legal challenges in medical negligence and mental harm claims. This allowed the researcher to remain open to the data and to understand the meaning behind the participants’ words.

The open codes were developed through reading the transcript of the interviews to obtain the emerging concepts. The concepts were then checked or adapted through a second reading of the data. Throughout this process, the researcher created memos to identify the concepts and support them with participants’ quotes. For instance, the researcher specifically questioned the participants about emotion as a factor in medical negligence proceedings and this is recorded as a category. In other instances, themes repeatedly emerged from participants’ responses such as the category of ‘access to justice’. Table 1 contains an outline of the initial codes identified by the researcher:

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44 Corbin and Strauss, above n 20.
45 Birks and Mills, above n 21, 10.
Whenever a significant concept became apparent from reading the interview transcripts, a code was assigned. The data was rich with concepts and sometimes a single paragraph could elicit multiple codes, derived both explicitly from the words of the participants or from what their words implied. For example, the following quote reveals the relevant codes highlighted in bold:

I’ve always really felt I don’t understand why we have an 11 per cent impairment for mental harm claims and six per cent ([Impairment Thresholds]) – I think why should a person with … psychological injury be treated any different to ([Discrimination between Physical and Psychological Injuries]) – differently to a person with a physical injury ([Unfairness]) ([Plaintiff Lawyer 1]).

This quote elicited several codes which referred to the impairment thresholds in medical negligence, the discrimination between physical and psychological injuries under the *Wrongs Act*, and to an overarching theme of unfairness.

<table>
<thead>
<tr>
<th>Table 1: Examples of Open Codes</th>
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<tbody>
<tr>
<td><strong>Access to justice</strong></td>
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<tr>
<td><strong>Access to damages</strong></td>
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<tr>
<td><strong>Cost of litigation</strong></td>
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<tr>
<td><strong>Litigation is an unpleasant process</strong></td>
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<tr>
<td><strong>Unfairness and inequality of reforms and restrictions</strong></td>
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<tr>
<td><strong>Unfairness in mental harm claims</strong></td>
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<tr>
<td><strong>Legal challenges in medical negligence and mental harm claims</strong></td>
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<tr>
<td><strong>Causation as hurdle</strong></td>
</tr>
<tr>
<td><strong>Impact of 2015 reforms</strong></td>
</tr>
</tbody>
</table>
4.10.2 AXIAL CODING

As the concepts from the data were coded, they were grouped together with codes which were similar in nature. This second step in coding is known as axial coding. Strauss and Corbin define axial coding as

a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by utilising a coding paradigm involving conditions, action / interactional strategies and consequences.46

For instance, the codes about ‘restriction of small claims’, ‘impairment level as a restriction’ and ‘restrictions in access to damages’ could all be grouped in a category of ‘Restricting Access to Justice’. The purpose of this grouping was to reassemble the codes into categories so that the researcher could identify overarching themes.

4.10.3 SELECTIVE CODING

The advanced stage of coding in grounded theory is known as selective coding.47 Strauss and Corbin define selective coding as ‘the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development’.48 This lies at the heart of theoretical integration, which involves gathering all of the theoretical concepts into a final grounded theory.49 Birks and Mills contend that theoretical integration commences when the first piece of data is gathered, and develops further as relationships between concepts emerge, until the researcher can pull together a theoretical scheme to create the final grounded theory.50

The core theme that emerged in this study focused on ‘legal challenges in medical negligence and mental harm’. This is used as an umbrella term to describe various aspects of challenges faced by lawyers in medical negligence disputes, including thresholds, caps on damages and causation as restrictions in litigation, and the lack of opportunity to express emotion in mediation. The participants acknowledged both the legal right to take action in medical negligence and mental harm claims and the role of legal avenues such as mediation and litigation to assist with dispute resolution. However, many participants identified challenges with accessing justice in this field. For instance, the participants referred to impairment

46 Strauss and Corbin, above n 20, 96.
47 Birks and Mills, above n 21, 91.
48 Strauss and Corbin, above n 20, 116.
49 Birks and Mills, above n 21, 108.
50 Ibid 109-110.
thresholds and the caps on damages and causation as hurdles preventing plaintiffs from recovering damages.

In relation to mediation, almost all of the participants endorsed the classical attributes of mediation (less adversarial, faster and cheaper) and yet challenges were frequently mentioned about the inability to use mediation to its full effect in medical negligence claims. For instance, plaintiffs play a limited role in mediations and are denied the ability to express emotion, despite medical negligence and mental harm claims often arising in emotional circumstances. This core theme assisted the researcher to answer the central research questions, namely that the Ipp Reforms have resulted in legal challenges for both plaintiff and defendant lawyers, and that these challenges have not been removed by the 2015 reforms. Further, the shadow of the law has a significant impact upon mediation practice, influencing how lawyers conduct settlements of medical negligence disputes in this arena.

4.10.4 DATA VALIDATION

The validation of the data was undertaken by consulting with research supervisors, ensuring the transparency of the research process and seeking disconfirming data. Validity is not considered relevant in qualitative studies insofar as ‘measuring’ validity is concerned.\(^{51}\) For the purpose of the research it was important to gather a broad range of unique responses, hence the need for objective validity was significantly reduced. However, one form of validation is respondent validation, where the researcher provides each participant with an account of the information provided by them in the interview to verify its accuracy.\(^{52}\) The researcher took the opportunity to clarify or confirm answers wherever it was necessary to do so. Further, the researcher offered to send a copy of the transcribed interview transcript to each participant for verification purposes but no formal requests were made by the participants.

4.11 DESCRIPTION OF PARTICIPANTS

There were 24 participants in this study. The participants comprised of three judges and 21 lawyers (including barristers) with medical negligence experience. All participants were employed in Victoria. Eleven participants identified as predominantly representing plaintiffs

\(^{51}\) Bryman, above n 6, 389.
\(^{52}\) Ibid 391.
whilst eight identified as predominantly representing defendants. Five participants (including the judges) were categorised as court lawyers. The participants in the sample were highly experienced in their profession with their average medical negligence experience being 21 years. An outline of the participants’ level of experience is outlined below in table 2:

Table 2: Participants’ Level of Experience

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Details</th>
<th>Years of Medical Negligence Experience</th>
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</thead>
<tbody>
<tr>
<td>P1</td>
<td>Lawyer Plaintiff</td>
<td>15</td>
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<tr>
<td>P2</td>
<td>Lawyer Plaintiff</td>
<td>10</td>
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<tr>
<td>P3</td>
<td>Lawyer Plaintiff</td>
<td>25</td>
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<td>Lawyer Plaintiff</td>
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<td>P5</td>
<td>Lawyer Plaintiff</td>
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<td>P6</td>
<td>Lawyer Plaintiff</td>
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<td>P7</td>
<td>Lawyer Plaintiff</td>
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<td>Lawyer Plaintiff</td>
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<td>P9</td>
<td>Lawyer Plaintiff</td>
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<tr>
<td>P10</td>
<td>Lawyer Plaintiff</td>
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<tr>
<td>P11</td>
<td>Lawyer Plaintiff</td>
<td>28</td>
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<td>D1</td>
<td>Lawyer Defendant</td>
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<tr>
<td>D2</td>
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<td>D3</td>
<td>Lawyer Defendant</td>
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<td>D4</td>
<td>Lawyer Defendant</td>
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<td>D5</td>
<td>Lawyer Defendant</td>
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<td>D6</td>
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<td>D7</td>
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<td>C1</td>
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<td>5</td>
</tr>
<tr>
<td>C5</td>
<td>Lawyer Court</td>
<td>29</td>
</tr>
</tbody>
</table>

4.12 LIMITATIONS OF THE STUDY

One limitation of the study is that the data collection was restricted to participants from Victoria and did not include other Australian states. This decision reflected accessibility, budget constraints and time restrictions of this research. Given the Ipp Reforms affected other Australian states, there is scope for further research in this field in other Australian
jurisdictions. Participants were also limited to medical negligence lawyers and judges. There is scope to conduct further research using medical negligence parties (such as plaintiffs or doctors). This was outside the research aims of this doctoral study. As previously stated, lawyers are best placed to comment on the legal challenges faced in medical negligence disputes and were thus selected for this research.

Although the sample size may seem relatively small, the participants were selected from a pool of highly experienced Victorian tort lawyers and judges, and the focus of this qualitative study is on the depth of experience and relevance of response. Medical negligence is a highly specialised field of negligence, and given the average level of experience of the participants was 21 years, the views gathered represent attitudes of senior members of the profession.

The relatively recent nature of the 2015 remedial reforms also made it difficult for the participants to comment with certainty on the impact of the 2015 reforms on conducting medical negligence claims. Despite this limitation, the participants’ initial reactions are valuable in determining whether the legislature has struck the right balance or whether further reform is needed and further research would be helpful to elicit impact at a time more distant from the initiation of the reforms.
CHAPTER 5 – FINDINGS PART 1: LEGAL CHALLENGES IN MEDICAL NEGLIGENCE AND MENTAL HARM CLAIMS

5.1 INTRODUCTION

More than fifteen years since their implementation, the effects of the Ipp Reforms continue to be experienced by victims of medical negligence and mental harm when seeking compensation for their injuries. The literature review in Chapter Two of this thesis outlined some of the continuing challenges that plaintiffs face in the litigation of medical negligence and mental harm claims, including establishing the element of causation, satisfying permanent impairment thresholds and limits on compensation imposed through caps for non-economic loss damages. The focus of this study is to ascertain whether these challenges were experienced by lawyers in practice. The data was coded and analysed pursuant to the grounded theory methodology outlined in Chapter Four of this thesis. Emergent themes relating to legal challenges in medical negligence and mental harm are discussed in this chapter.

Firstly, this chapter presents findings on the legal challenges in litigation articulated by the participants in this study, including whether the element of causation presents as a hurdle to recovery of compensation meritorious claims. Secondly, findings on the changes in the number of litigants and amount of compensation payments before and after the Ipp Reforms are presented and discussed. Thirdly, the chapter describes the participants’ preliminary views on the likely impact of the 2015 amendments to the Wrongs Act on the ability of plaintiffs to recover compensation. Finally, opportunities for law reform arising out of the analysis of the data are explored, including the introduction of a narrative test currently used in Victorian statutory schemes, as well as the possibility of using a no-fault statutory scheme similar to those which currently operate in other jurisdictions.

5.2 CHALLENGES IN MEDICAL NEGLIGENCE AND MENTAL HARM

Tort reforms in 2002 and 2003 impacted medical negligence and mental harm claims through the introduction of significant injury thresholds, caps on damages and a statutory test of causation. Many commentators have questioned whether these restrictions affect the rights of
plaintiffs in meritorious claims.\(^1\) The participants in this study were asked to reflect on the challenges experienced in medical negligence and could list more than one challenge. The participants were further asked whether these challenges applied in mental harm claims and if their response was in the affirmative, they were invited to elaborate on the challenges. The majority of participants interviewed, 15 lawyers, reported that the significant injury impairment thresholds were the predominant challenge in medical negligence claims. In relation to mental harm, nine participants thought the thresholds were the principal challenge.

The primary challenge raised by the participants was the requirement for plaintiffs to satisfy significant injury thresholds. The underlying theme in the responses was unfairness in situations where plaintiffs had sustained a devastating injury but were unable to satisfy the minimum threshold to qualify for compensation. According to the majority of participants this concern was not addressed by the 2015 changes to impairment levels. For instance, one participant recalled a situation where a plaintiff’s cardiac valve replacement would not have satisfied the threshold without additional scarring:

\[ \text{The important reform was the level of impairment. That can have some really unfair consequences. You can have people with significant issues that don’t satisfy either the 6 per cent, well, now 5 per cent, or the 11 per cent impairment. I had a client that had a cardiac valve replacement and on the basis of the cardiac valve replacement he was only 5 per cent impaired, and then the scarring added to his impairment, but it could have meant that he was locked out. So there are a number of different injuries that just don’t fit into those criteria very well and you get that unfair result. (Plaintiff Lawyer 1)} \]

The unfairness of the thresholds and its adverse effects on people who are not employed, such as non-working mothers, children and the elderly, was expressed by another participant. Where plaintiffs fall into these three categories, their income is likely to be on the lower end of the spectrum, which means their compensation will be low. In order to receive significant compensation, these plaintiffs must rely on non-economic loss compensation. One defendant lawyer stated that it was frustrating that this kind of plaintiff has restricted access to compensation:

From my point of view as a plaintiff lawyer, it was very upsetting to realise that a terrible injury to say an elderly person, a child or a non-working outside the home woman. [I]f they healed at under six – 5 or under – they wouldn’t have access to general damages… [I]t’s particularly ironic in the medical field because…the bulk of people involved in the medical system are women, children and the elderly. (Defendant Lawyer 2)

Another participant stressed that because of the manner in which the injuries are assessed under the AMA Guides, certain injuries, such as scarring, do not attract sufficient compensation:

There’s many instances such as scarring cases that don’t feature very highly on the AMA 5th edition guides, and so people with meritorious claims aren’t necessarily able to pursue a case where they don’t meet the greater than 5 per cent permanent impairment for physical injuries. (Plaintiff Lawyer 3)

Another participant highlighted problems with the need to satisfy permanent impairment requirements, attributing the cause of such challenges to the Ipp Reforms:

The challenge is for people who have significant injuries but don’t turn out to be permanent, or significant injuries that turn out at 4 per cent, [injuries such as] extensive scarring. So these people are equally traumatised as anyone else but they’re cut out… I know one of my colleagues had a matter where his economic loss was cut out by the upper threshold – the three times average weekly earnings thresholds – you see far less of that. It’s more frustrated clients who know they’ve been wronged by a doctor, chiro[practor], physio[therapist] … who are cut out because…of the baseline thresholds. That’s the consequence from the Ipp Reforms. (Plaintiff Lawyer 4)

A plaintiff lawyer identified the challenge of establishing significant injury thresholds and caps on damages after the Ipp Reforms. Notably this participant also identified the difficulty for lawyers of explaining compensation caps to a plaintiff due to the complexity of the legislation:

[T]here are a number of challenges that are faced as a result of the Ipp Reforms. The first of them is, I suppose, in relation to thresholds. So we have the added difficulty of establishing that someone’s got a significant injury or able to bring a claim for pain and suffering damages. It’s an extra hurdle for the plaintiff to jump through. We also have the difficulty of…explaining to our clients why it is that their claim for pain and suffering might be capped
and that can be very difficult in...for people who are catastrophically injured. (Plaintiff Lawyer 2)

The above quotes suggest that thresholds and caps on damages are two continuing challenges under the Wrongs Act which can lead to unfair consequences in medical negligence litigation. Reflecting on these two challenges, one participant thought the legislative restrictions amounted to indirect discrimination:

I think one of my objections always has been that the operation of the legislation is, in fact, indirect discrimination. Because it discriminates against children, it discriminates against people who are elderly or who don’t work because, you know, the right to recover for your economic losses is unchanged, but your pain and suffering damages [is altered]. So those people, I feel, are disenfranchised by the legislation. (Plaintiff Lawyer 8)

5.2.1 CAUSATION AS A CHALLENGE

Six participants thought the causation principle presented an unfair challenge to plaintiffs in medical negligence. The Ipp Reforms prompted the introduction of a two-part statutory test of causation, requiring the plaintiff to satisfy two limbs: factual causation and scope of liability. The first test requires the plaintiff to show their harm was factually caused by the defendant’s negligence. In order to satisfy the second test, the court must be satisfied that it is appropriate for the scope of the negligent person’s liability to extend to the harm. One participant reflected on the problems with the ‘but for’ test, replicated in the factual causation limb of the legislative provisions:

I think there are two things that stick in my mind as examples. [O]ne of them is the return from the March v Stramare test of causation to a ‘but for’ test. I mean the High Court, for those of us who can understand anything the High Court says when it comes to common law, said the ‘but for’ test has got hairs on it. It doesn’t work for reasons which are now well understood and the test of causation is a common-sense test... [W]hy would you have a reform of ‘but for’ when the High Court, the highest court in the land, said, ‘Well we’ve

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abandoned that.’ Historically we’ve abandoned it, it doesn’t work, it [has] got its own problems. (Court Lawyer 2)

Here the participant is questioning why the legislature elected to return to the ‘but for’ test by introducing the factual causation limb in circumstances where the High Court of Australia has said the test is problematic. In relation to the second limb of the test, scope of liability, another participant discussed the challenges around the uncertainty presented by this limb:

The main issue that seemed to come up in [medical negligence] was causation… lawyers, I think, suddenly sort of became conscious of scope of liability and that’s the limb of causation that this, the Ipp Reforms, really highlight and which [is a] real grey area I think. (Court Lawyer 5)

The vagueness surrounding the scope of liability has attracted criticism from these commentators for its lack of precision and clarity,3 which has potential to impact upon the ability of plaintiffs to satisfy this limb of the test.

5.2.2 THRESHOLDS IN MENTAL HARM

When asked about the challenges in litigating mental harm claims, nine participants stated they thought satisfying the significant injury thresholds was the primary challenge. One participant highlighted a problem with the imposition of minimum thresholds in circumstances where plaintiffs have lost a loved one, particularly in relation to the discrepancies that arise because of statutory exemptions.4 For instance, loss of a foetus automatically satisfies the injury thresholds whereas the loss of an adult child does not:

[T]his is the other weird thing about the law. The loss of a baby or a foetus is an exception so you don’t have to get your certificate to get your significant injury. But the loss of a child or an adult son isn’t. You still have to get your 10 per cent certificate, and we had cases where two parents, equally distressed, because [of] the mother’s innate fortitude or the make-up of her brain, she wouldn’t get her certificate and the father would, or vice versa. Well I mean the weird thing is…some people grieve and it’s psychological, it doesn’t become psychiatric… [T]he reason for that is that we’re talking about nervous shock not grief which is all clearly a load of rubbish… [I]t’s really interesting that some people won't get over their 10 per cent

3 Bagaric and Erbacher, above n 2, 765.
4 Wrongs Act 1958 (Vic) s 28LF(1).
threshold and other people will, and for some reason [those who won’t get over are] not entitled to damages. It’s terrible. (Defendant Lawyer 2)

In the above quote, the participant has also highlighted the discrepancies that arise when two plaintiffs might be compensated differently for loss arising from the same tragic event. For instance, in Sorbello v South Western Sydney Local Health Network; Sultan v South Western Sydney Local Health Network5 the mother received 15 per cent more compensation than the father because she satisfied a higher impairment threshold. Ultimate[ly], both parents face the lifelong consequences of their baby’s intellectual injuries caused by oxygen deprivation at birth.

Even where plaintiffs are able to satisfy significant injury thresholds in mental harm claims, their entitlement to compensation is limited by caps on non-economic loss damages. This ultimately affects the quantum of damages in such claims, as noted by a participant:

[Mental harm claims] seem to be treated very conservatively in Victoria in terms of the quantum of the claims. That’s probably the biggest challenge I have in psychiatric claims and…explaining to them that, even if it’s a case where they might have lost a baby for example, that the courts, in my opinion, are quite mean in general damages in those cases. So I think that’s one of the biggest challenges in those cases. (Plaintiff Lawyer 10)

Plaintiffs with pre-existing mental illness can also be unfairly prejudiced by the legislative framework, because the plaintiff cannot rely on pre-existing mental illness to assist them to satisfy the threshold. One participant commented on this issue:

The group of people who miss out are those who already have a mental illness because that’s a person who’s less able to cope with new trauma or new shock or new depression and that person’s overall impairment score, you know, might be significantly above the 10 per cent threshold, but then when you try and untangle it all and they say the person has got more pre-existing than post 2003 injury related impairment, they miss out unfairly. And they’re the ones who are probably often most affected because their overall level of injury is far worse than someone else and they can cope [with it] far less. They’re unfairly prejudiced by the reform, I think. (Plaintiff Lawyer 4)

Explaining the legal requirement of significant injury thresholds in mental harm claims to a client can also be a challenge. One participant stressed that explaining legal requirements is especially difficult in circumstances where the plaintiff has lost a loved one, but asserted this was not due to the Ipp Reforms:

The challenge for a legal practitioner is to, I think, convince or explain to the lay client that you don’t get compensation for the loss of a loved one. You’ve got to have an injury. And a lot of members of the community don’t understand that and find that very, very difficult to take in and understand. But that’s really got nothing to do with the Ipp Reforms. (Defendant Lawyer 8).

The significant injury thresholds are likely to continue to present a challenge in mental harm claims, despite the lowering of the requirement from ‘more than 10 per cent’ to ‘10 per cent or more’. As one participant put it:

I think, [it’s] going to be a little bit better now that the new reforms have come in recently, so the 10 per cent, as opposed to greater than 10 per cent, is actually a significant difference because the way the impairment guides work, there’s a whole raft of diagnoses or psychiatric conditions that will land on 10 per cent, which is why in the first place it was couched as greater than 10 per cent. But it’s still not going to be a complete solution. (Plaintiff Lawyer 6)

5.2.3 DISCRIMINATION BETWEEN PHYSICAL INJURY AND MENTAL HARM

In *Mount Isa Mines Ltd v Pusey* Justice Windeyer highlighted the slow advances of law in keeping up with medical science when he described law as ‘marching with medicine but in the rear and limping a little’. The comment was made in a case where the plaintiffs sought damages for pure mental harm without any physical injury. The comment continues to be relevant in relation to modern legal principles governing mental harm which have not kept pace with medical developments in psychiatry. The law continues to impose more stringent requirements for psychiatric injuries than for physical injuries, thus magnifying the historic distinction between mental and physical injury. Two participants reflected on the unfair consequences that can arise because of such a distinction:

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7 Ibid 395 (Windeyer J).
I’ve always really felt I don’t understand why we have an 11 per cent impairment for mental harm claims and six per cent [for physical injury]… I think, why should a person with psychological injury be treated any differently to a person with a physical injury? [Y]ou do get a situation where someone’s had a pretty devastating event happen, a family member die. They’ve had really significant issues but they’ve managed to recover to a point where a psychiatrist doesn’t believe they have that level of impairment and if there’s no financial dependency claim, there’s no claim for that person… I think [there] can be very unfair sort of consequences there. (Plaintiff Lawyer 1)

Obviously when someone dies that is a pretty horrific outcome for medical treatment… But these people are forced into the same sort of process as someone who has a mental injury or suffers mental harm as a result of their physical injuries. [T]hat’s just unfair, I think, because why are we making people who have lost a son or a husband or a wife prove that they’re over 10 per cent whole person impairment from psychiatric – you know, the shock harm. And it’s got to be more than the normal or expected grief reaction, whatever the hell that is supposed to mean. I think that’s a particularly unfair effect of those changes. (Plaintiff Lawyer 6)

The reflections from participants highlight the challenges faced by plaintiffs who have lost a relative but need to satisfy stringent legal requirements using the same process as a person who has suffered a physical injury.

5.2.4 SCEPTICISM OF MENTAL INJURY

As outlined in the literature review in Chapter Two, courts have historically treated mental injuries with scepticism.9 The Ipp Report acknowledged that one of the reasons for the scepticism is that psychiatric injuries are difficult to diagnose and quantify objectively.10 Four participants stated that this scepticism towards mental injuries is still an ongoing issue, with one participant stating the difficulty that an objective measure presents as a hurdle in mental harm claims:

[T]here’s been a groundswell of work against people who’ve got a mental injury. We, I think cynically, work on the basis [of] ‘if it’s in your head it’s hard to measure therefore we’re going to make it much harder for you to succeed’. You’ve got to be almost the sort of mental

smoking wreck otherwise you don’t get up. But I think [the reforms] have made mental injury claims much harder. (Court Lawyer 2)

One participant asserted that this scepticism is reflected in the need for the plaintiff to satisfy a higher threshold for psychological injuries over physical injuries:

[T]he requirement for significant injury at 11 per cent, now 10 per cent psychiatric injury, is a real shame because it seems to suggest to the plaintiff this element of disbelief in the extent of their injury or the validity of their claim. That seems to be a really unfortunate reflection of the way that general society perceives or views mental harm and the permanency of those injuries. (Plaintiff Lawyer 2)

The court’s scepticism regarding psychiatric injury is also evident in jury trials, with two participants asserting that it impacts on the trial outcome:

I think in fact it’s where [the Ipp Reforms have] had the hardest impact, because being able to demonstrate that you have psychological or psychiatric injury as a result of medical negligence is much more difficult now than it previously was. It’s certainly eliminated those pure mental harm [cases]; there were many more prior to the reforms. And interestingly, as a judge, they’re perhaps not just medical negligence claims, but they are the more difficult ones for plaintiffs to succeed in. Juries have got a real view about psychiatric injury. (Court Lawyer 3)

[T]he main problem with mental harm claims is not the qualification, I think it’s quite easy to get significant injury because so many psychiatrists are very quick to say, ‘It’s a 10 per cent disability’, and it’s a lot harder in organic medicine to say that, but psychiatry being a fuzzier science, the plaintiffs have no trouble in getting psychiatrists to say that they qualify. The main problem with the mental harm cases is juries are cynical, so unless you’ve got a decent organic injury as an adjunct to the psychiatric injury so that the psychiatric injury may have been caused or inflamed by the physical injury… If it’s pure psychiatry alone such as in nervous shock, or a reaction to being bullied for example is another good example, then juries are very cynical. (Defendant Lawyer 7)

The two quotes above highlight that plaintiffs face unique challenges in pure mental harm claims, where unlike physical injury, the level of injury is not as easily assessed.
5.2.5 DISCUSSION

The practitioner perspectives gathered for this research are especially valuable because the participants are highly experienced repeat players in handling medical negligence and mental harm claims, and thus were able to reflect on the continuing shortcomings of the legislation. These responses indicate that significant injury thresholds represent the predominant challenge in both medical negligence and mental harm claims. In addition, some of the lawyers interviewed articulated themes of discrimination and unfairness relating to mental harm claims, where the emotional impact on plaintiffs can be greater than that suffered in physical injuries. For instance, in claims for pure mental harm the plaintiff can be gravely affected due to situations like the loss of a family member, without sustaining any physical harm.

The data gathered in this study indicates that many participants regarded the restrictions imposed by the Ipp Reforms as unfair. Firstly, plaintiffs with psychiatric injuries are put through the same claim process as plaintiffs with physical injuries. Secondly, the significant injury thresholds for psychiatric injuries are set at twice the impairment level for physical injuries. Thirdly, even if plaintiffs satisfy the prescribed thresholds, caps on damages for non-economic loss limit their entitlement to compensation. The result is a discriminatory legislative framework that adversely impacts vulnerable members of society seeking compensation.

5.3 CAUSATION IN MEDICAL NEGLIGENCE AND MENTAL HARM

Following medical negligence, plaintiffs can be left with devastating permanent injuries that warrant compensation. These plaintiffs might satisfy a breach of duty of care yet the statutory test of causation presents a hurdle to successful recovery in meritorious negligence claims. In 2015 reforms, the Victorian government reduced injury thresholds and increased compensation caps but did not address the contentious issue of causation. Causation remains a contentious legal principle following the introduction of a two-part statutory test in 2003 as the two-part test results in many litigants being unable to access compensation. Therefore, one of the key concerns of this doctoral study was whether the principle of causation presents a hurdle to successful recovery of compensation in practice. The qualitative responses of the participants were analysed to extract a positive or negative response. The quantitative analysis is outlined in table 3.
Table 3: Participants’ responses to the question ‘Does the element of causation present as a hurdle to plaintiffs succeeding in a negligence case?’

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of lawyers supporting response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, causation does present as a hurdle to successful recovery</td>
<td>18</td>
</tr>
<tr>
<td>No, causation is not a hurdle</td>
<td>5</td>
</tr>
<tr>
<td>No response specifically to the issue of causation</td>
<td>1</td>
</tr>
</tbody>
</table>

5.3.1 THE CAUSAL HURDLE

In response to direct questioning about whether causation presents as a hurdle to successful recovery, eighteen participants, a significant majority, stated that it is a hurdle. Many of the participants said that causation is the ‘largest hurdle’, a ‘massive hurdle’ or the ‘biggest issue’ in negligence proceedings. For instance, one participant was of the opinion that causation is an even bigger hurdle than the significant injury thresholds

[Causation] is the biggest hurdle. The Ipp Reforms added in the significant injury – permanent significant injury threshold in Victoria, but the biggest hurdle in medical law claims is causation on the balance of probabilities. (Plaintiff Lawyer 4)

VCEC’s report highlighted that the permanent impairment significant injury thresholds were a problem prohibiting successful recovery in certain meritorious claims.\(^{11}\) This resulted in a reduction of the thresholds for spinal and psychiatric injuries.\(^{12}\) The quote above supports the assertion that causation is also a problem and yet VCEC did not consider this issue.

Establishing causation can be more difficult in medical negligence cases, where there is a need for the plaintiff to establish a worse outcome because of negligent treatment. As one participant put it,

…[causation] is the biggest issue that applies across the board. In all of the years I practiced in medical negligence, I’ve had three cases where liability has been accepted and even in

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\(^{12}\) The *Wrongs Amendment Act 2015* (Vic) came into operation on 19 November 2015. This amending act altered to s 28LB of the *Wrongs Act 1958* (Vic) decreasing the impairment threshold level in spinal cases from *more than 5 per cent* to *5 per cent or more* and in psychiatric cases from *more than 10 per cent* to *10 per cent or more*. The amending act also altered the maximum cap on damages for non-economic loss in s 28G of the *Wrongs Act 1958* (Vic) to $577,050.
those cases causation remains an issue because often a person has gone in for an operation, has had an adverse outcome and it’s a matter of teasing out what part of that adverse outcome is due to the negligent act as opposed to something that may have happened in any event despite the best of care. (Plaintiff Lawyer 3)

One participant thought causation can be a central obstacle to the plaintiff’s case:

I think, generally, medical negligence cases are difficult from a causation point of view. So that’s one of the biggest day to day aspects of cases that I’m in, in terms of day to day running of my files. We’ll often have a case where there’s negligence or we think, if I’m for the plaintiff, there’s a pretty good chance of establishing negligence. But causation can be complex and difficult to prove and…whereas in some jurisdictions, that’s not such an issue and people are a bit more casual about causation and more confident they’ll succeed. I think in medical malpractice, if there’s a strong causation argument, you genuinely stand to lose and you just struggle to proceed with the case. (Plaintiff Lawyer 10)

This response highlights that causation in medical negligence litigation is inherently complex and can genuinely prevent a plaintiff succeeding where they are faced with a solid causation argument from the defendant.

Two of the participants expressed the view that causation is a complex concept to communicate to a client. One participant acknowledged this difficulty in circumstances where a breach of duty of care has been established but the causal link remains difficult to prove:

People find it very hard to understand as well, you know, you’re saying to them, ‘I’ve got a doctor saying there’s negligence but I can’t establish that it’s had a worse outcome for you.’ People say, ‘But you told me this doctor was negligent, I have a damages claim.’ Well not unless the negligence has caused an injury and we can’t establish…so a lot of people who have reports to say there was negligence but can’t proceed with the claim because we can’t [say] that it’s actually caused a worse outcome for them. (Plaintiff Lawyer 1)

The above quote suggests the claimant might be expecting corrective justice, because a medical practitioner is found to have breached their duty of care, yet the claimant’s case fails on the legal test of causation. Another participant acknowledged this difficulty:
You already had something going on with you. You went to the doctor’s. On the balance of probabilities, it’s got to be significantly worse for you to get across the threshold. Having proven negligence, having proven significant injury, it’s the hardest bit. (Plaintiff Lawyer 4)

These responses support the academic discussion that causation is a complex principle, both in theory and in practice.\(^\text{13}\)

5.3.2 DIFFICULTIES WITH THE STATUTORY TEST

The introduction of a statutory test has arguably made it more difficult for plaintiffs to satisfy causation when compared with the previous common law test. One participant addressed this issue:

[I]f you look at *March v Stramare* and the cases that followed it and the enshrining of a different test and the abandonment of ‘but for’ you can see where ‘but for’ I think may well in worthy cases exclude those cases and prevent them from succeeding. Whereas if the ordinary test of causation of common law was applied I wouldn’t say they’d succeed but they’d have a better chance. So maybe the purpose of these reforms, and this is what I think is the undercurrent of these reforms, and the undercurrent is just to make claims harder because there needs to be some sort of economic and social containment… Social and economic containment by making claims harder… [T]hat’s what I think Ipp set out to achieve and that’s what he’s achieved with these reforms. (Court Lawyer 2)

This participant proposes an economic efficiency theory as the driver of the Ipp Reforms, namely the imposition of restrictions to limit successful recovery of compensation. In a negligence context, economists are concerned with the imposition of liability rules that promote and encourage economic efficiency.\(^\text{14}\) In other words, the role of tort law is simply costs allocation and the aim of tort law should be minimising the cost of accidents and reducing the cost of avoiding them.\(^\text{15}\)

Another participant focused on the factual causation element and stated the statutory reforms have not had a significant impact on causation:


\(^{15}\) Calabresi, above n 14.
[T]he test at common law and the test under the Wrongs Act – it’s almost splitting hairs quite frankly, in true application. I mean, you know the March v Stramare common sense test as opposed to the factual causation two limb test… I can’t see the outcome being all that different at the end of the day. (Court Lawyer 3)

The participant’s views are premised on the similarity between the common law ‘but for’ test and statutory ‘factual causation’ test, which both require that the harm be caused by a breach of duty of care. While the first limb of causation may be quite clear, the second limb appears to be more problematic. One participant focused on the problems with the statutory ‘scope of liability’ test and relied on case examples in New South Wales\(^\text{16}\) to illustrate the difficulties:

On causation, obviously, the second limb of the test that it was codified was new, I suppose, this idea of normative causation, or the policy question some people call it. I have to be honest, it’s not really had an effect on claims until recently, and even then, the effect is limited. There’s not been a case in Victoria on it. However, our very litigious friends in New South Wales have run a number of cases on that, well, where that issue’s been considered, starting in 2013-ish, and it’s clear that it is an issue and has effected causation. (Plaintiff Lawyer 6)

Another participant identified challenges with the ‘scope of liability’ test:

[A] lot of lawyers I think suddenly sort of became conscious of scope of liability and that’s the limb of causation that this, the Ipp Reforms really highlight and which, I think, is probably caused, that’s the real grey area I think, so the challenge is around that. (Court Lawyer 5)

The same participant elaborated on the statutory test, highlighting that one effect of the Ipp Reforms is the need for judges to articulate their reasoning with respect to causation around two clear elements:

[O]nce upon a time, maybe courts might have tended to gloss over causation a bit more and with Ipp Reforms sort of spelling out, this is what causation is all about and it’s got two elements and you must satisfy each, and really focusing as, it took a while, but really those appellate courts are saying, ‘Look, judges really need to address both elements here.’ [F]or starters making courts focus and be a bit more sort of analytical in looking at things and, ‘Have we satisfied this test?’ I think [for] most of the … cases, the ‘but for’ is relatively easy

\(^{16}\) The participant referred to Paul v Cooke [2013] NSWCA 311 (19 September 2013) and Wallace v Kam (2013) 297 ALR 383, both of which originated in New South Wales.
to satisfy. But then you’ve got those sort of more nebulous ones, where scope of liability comes in and pulls the wool out from under a plaintiff, and trying to understand what comes within that scope of scope. (Court Lawyer 5)

As noted, this theme was raised by Bartie who contends that the legislative amendments sought to reform the courts’ approach with respect to the principle of causation and the way that judges were conducting their analysis. Bartie describes the ambition behind the Ipp Reforms to causation as two-fold: the first is the desire for courts to depart from the ‘common sense’ and ‘remoteness’ approaches to causation, and the second is prompting the courts to undertake an in-depth analysis of the considerations relating to causal issues. In relation to the ‘scope of liability’ element, Bartie acknowledges the breadth of the provision and highlights the potential risk that this element may render the other elements superfluous. Bartie concludes that it may be preferable that judges be left to develop the area of law relating to causation without interference from the legislature.

Adding to the criticism of the statutory reforms to causation, one participant asserted that the previous ‘common sense’ test under the common law functioned appropriately and the two-part test is ‘formulaic’:

I think the causation provisions are nonsensical and they try to make something formulaic where it worked quite well as pure common law with the High Court saying well, ‘causation is a matter of common sense,’ and I think juries regard it as common sense too. But it complicates the charge to the jury going through various statutory layers to demonstrate causation. So again, viewed academically you would think that it would be all too hard, but in the context of jury litigation, if a jury think that as a matter of common sense, a given injury is connected to the surgical misadventure, as an example, they’ll take the step without worrying about the various steps that the statute sets out. (Defendant Lawyer 7)

Another participant focused on the ‘evidentiary gap’ provisions in s 51(2) of the Wrongs Act and accepted that even science sometimes cannot satisfactorily answer causal questions:

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17 Bartie, above n 2, 415.
18 Ibid 416.
19 Ibid 436.
20 Ibid.
…that’s a real challenge and there is a provision in the Wrongs Act – the evidentiary gap provision. People try to use that provision which…my understanding of it is, basically, a court being willing to get a plaintiff home on causation, where the negligence is sufficiently strong and where science is unable to bridge that gap… [T]hat’s an issue, I think, is that, in a lot of the cases, the science isn’t strong enough to categorically say one way or the other. (Plaintiff Lawyer 10)

5.3.3 PROBLEMS WITH CAUSATION DO NOT STEM FROM IPP

Six participants asserted that problems with the causation principle may not necessarily be as a result of the law reforms stemming from the Ipp Report. For instance, one participant highlighted that causation in medical negligence is manifestly complex:

So in asbestos litigation, for example, causation is very difficult from a scientific point of view, but every asbestos case pretty much wins because there’s just an understanding, really, that people aren’t going to take the point. It’s very rare that cases run. There’s the odd one that runs. But medical malpractice is a different world to that. So that’s the day to day thing. I’m not sure if that arises out of the reforms so much, as opposed to just being a general malpractice issue. (Plaintiff Lawyer 10)

The above quote shows that causation is particularly difficult in medical negligence cases. This assertion is supported by another participant, who stresses that causation is potentially more problematic in ‘failure to warn’ medical cases:

So in the medical cases, causes are not obvious and more importantly, in the medical cases which involve not inappropriate treatment but a failure to give advice, well the cause is critical because you have to show that had you been given the right advice that would have changed the outcome. And really that means you would have had a different method of management. So that issue really never arises in, you know in general common law cases. There are very few common law cases that involve advice cases other than professional advice. And in terms of injury there are very few that involve, advice cases that involve anything other than medical cases. So you’ve got that, you’ve seen the cases that people will be saying for example ‘If I’d been told this I wouldn’t have had the surgery,’ and the Court’s found that there was a failure to tell but it didn’t make any difference because the person was presenting with such a condition that it probably wouldn’t have made any difference. So that issue of causation is a big issue in all medical cases. More so in advice cases but I don’t know that the amendments to the Wrongs Act have made many changes to that. (Court Lawyer 1)
This quote highlights that medical negligence cases involving a practitioner’s failure to warn can have their own peculiar problems, which are not experienced in traditional common law claims or even professional negligence claims. Addison acknowledged these difficulties were faced in failure to warn cases between 1992 and 2002 decided pursuant to common law principles, noting that patients were less likely to succeed in an action alleging a negligent failure to inform than in the previous decade. Following the insertion of a two-part statutory test of causation, these problems continue to arise in ‘failure to warn’ cases such as Wallace and Odisho. The decision in Wallace has been described by Faunce as part of a judicial trend to ‘go cool’ on patients’ rights, in medical negligence cases involving failure to disclose a material risk.

5.3.4 COMPARING MEDICAL NEGLIGENCE WITH TRANSPORT ACCIDENT AND WORKCOVER CASES

This difficulty of establishing causation in medical negligence cases is even more prominent when compared with transport or workplace accidents, as acknowledged by one participant:

[I]t's a different situation than say, you know, a transport accident case. You’re driving a car, someone smashes into you, you then have your broken neck. There’s a very clear causative link. With medical negligence cases, by definition there is an illness or an injury or a syndrome or a pathology before the interaction with the doctor or hospital. So the question of whether this injury, illness, syndrome was worsened because of the lack or the wrong treatment is fundamentally a very different question and a classic example is a failure to diagnose cancer. (Defendant Lawyer 2)

Another participant affirms this assertion, and highlights that causation in medical negligence cases takes up a large portion of litigation:

[P]ractically in the common law, medical malpractice is the place where causation gets the most airtime. In the context of industrial accident, occupier’s liability, general injuries it rarely gets much airplay but in med mal it really does. (Defendant Lawyer 4)

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These two quotes demonstrate that medical negligence is different to transport accident and workers’ compensations claims, where recovering compensation is a simpler process. VCEC’s inquiry acknowledged the inequities arising out of the inconsistency in the provisions, highlighting that recovery under the transport accident and workplace legislation is under a no-fault statutory scheme.\textsuperscript{23} Whilst some of the inequities were responded to (such as the injury thresholds for spinal injuries and psychological injuries and the caps on non-economic loss), others like the causation principle were barely acknowledged by VCEC.\textsuperscript{24} This represents a lost opportunity to seek submissions on this principle from the legal community.

5.3.5 OPTIONS FOR REFORM

None of the participants offered a definitive solution to the problems posed by causation principles however one participant called for uniformity across the states:

\begin{quote}
It would be nice if all of the states in Australia had similar provisions. I think it’s really hard, particularly for insurer clients, to get their head around the various provisions that differ from state to state and I wonder why it needs to be like that. That would be an ideal; to have more similar if not identical provisions. It won’t happen but nevertheless if I had my wish list…
\end{quote}

(Defendant Lawyer 3)

Another participant thought that the recent law reforms were welcome but that governments should regularly review the law. The participant also highlighted that the courts have been adapting to the new laws and engaging in their own reform:

\begin{quote}
[W]e’ve been engaged in two years of reform here in the court in personal injury cases. The legislative reforms I think are all appropriate, the ones that have been passed of recent times, there’s nothing in those that’s controversial or I think is going to be better or much worse. It’s good that governments go back and review and think about these things, so I see that as a positive. Within the court system, as I said, we have done a lot of work in terms of the way we manage cases for a number of reasons. (Court Lawyer 3)
\end{quote}

\textsuperscript{23} VCEC Report, above n 11, 20-23.

\textsuperscript{24} The VCEC Report only mentions ‘causation’ ten times throughout the entire report and this is mainly in the context of the Medical Panel being unable to determine causation issues.
5.3.6 DISCUSSION

The views of the majority of participants interviewed show that causation is a difficult hurdle in medical negligence litigation. Arguably, the issue is with the vagueness of the ‘scope of liability’ element and this is supported by academic literature as well as the data. The case law, mainly in NSW, shows that causation is the final hurdle for plaintiffs to overcome. Six participants did not think that the problems with causation stemmed from Ipp, but rather, they are of the view that causation is an inherently complex principle. Barbara McDonald supports this, stating ‘causation is a notoriously difficult question for lawyers, philosophers and scientists alike.’\textsuperscript{25} She further elaborates: ‘In law, academic and judicial views go around and around with no-one ever entirely satisfied that he or she has got it exactly right or has solved all issues of logic, legality and morality’.\textsuperscript{26} The senior tort lawyers were quick to criticise causation yet none of them was able to offer a definitive solution. This suggests that there may be no simple solution. In Chapter Seven of this thesis, the author considers three possible solutions: (1) the codification of the causation principle; (2) amendment of existing statutory provisions to offer more clarity; or (3) the implementation of a reversal of the onus of proof for causation. Causation is consistent with the corrective justice theoretical framework because it determines the causal link and liability between the wrongdoer and the sufferer.\textsuperscript{27} Yet many participants in this study viewed it as an excessively high threshold to overcome. In such circumstances, the introduction of a no-fault scheme embodying distributive justice may have fairer outcomes for the community. These reforms are considered in Chapter Seven of this thesis.

5.4 PRACTITIONERS’ PERCEPTIONS ABOUT THE CHANGES IN LITIGATION TRENDS AND COMPENSATION PAYMENTS BEFORE AND AFTER THE IPP REFORMS

One of the key research questions for this thesis was to explore whether the 2003 amendments to the Wrongs Act resulting from the Ipp Reforms had any effect on the litigation and mediation of meritorious medical negligence claims. Participants were asked to offer their perceptions regarding the number of litigants commencing medical negligence disputes post the Ipp Reforms and whether the participants had observed an increase or

\textsuperscript{26} Ibid.
decrease based on their experience. Litigation trends are an important aspect of this research because the perceived increase in personal injury claims was one of the drivers of the Ipp Reforms. Many academics have been quick to counter these claims. For example, Chu highlights that in 2001 civil litigation rates had been falling 4% a year in the preceding four years.\textsuperscript{28} Further, Professor Wright’s research showed that litigation rates were not increasing prior to the commission of the Ipp Report.\textsuperscript{29} There have been no contemporary quantitative studies commissioned to assess whether the Ipp Reforms and the 2015 reforms have had any effect on the litigation rates in medical negligence and mental harm claims.

The research questions do not purport to gather objective empirical data. Rather, the participants were asked to offer their perceptions on the numbers of litigants commencing medical negligence post-Ipp, based on their experience. The obvious limitation of gathering subjective responses is that they are based on participants’ observations and experience, rather than any objectively substantiated numbers. The participants’ responses are set out in Table 4 below:

Table 4: Participants’ responses to the question ‘Based on your experience, what are your perceptions about the number of litigants commencing medical negligence disputes following the Ipp Reforms?’

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant perceived a decrease in the number of litigants following the Ipp Reforms</td>
<td>13 participants</td>
</tr>
<tr>
<td>Participant perceived an increase in the number of litigants following the Ipp Reforms</td>
<td>2 participants</td>
</tr>
<tr>
<td>Participant did not perceive a change in numbers</td>
<td>4 participants</td>
</tr>
<tr>
<td>Participant could not comment</td>
<td>5 participants</td>
</tr>
</tbody>
</table>

\textsuperscript{28} Chu, above n 1, 142.
The majority of participants expressed the view that they perceive the number of litigants to be lower following the reforms, although they stressed that the decline was not as drastic as some commentators foreshadowed at the time of the Ipp Reforms. A defendant lawyer explained the phenomenon experienced with a new wave of reforms, explaining a surge in litigation followed the enactment of the reforms in 2003, followed by a slight decline and then consistent numbers:

I know when the reforms were first introduced but not yet enacted, there was a huge spike in activity in order to get people in before the reforms became active. Since then I think there was a slight decline from usual baseline data in terms of the number of claims that were brought, but then I think it stayed pretty consistently around that level. You might say litigation decreased slightly but my own personal opinion is it hasn’t decreased to the extent that people were foreshadowing at the time the reforms were first raised and then enacted. (Defendant Lawyer 3)

Many participants explained that their perception of a decline in litigation rates is due to the inability of injured persons who fail to satisfy the thresholds to pursue their claim:

It’s certainly fallen. We’ve got a presentation that one of the insurers did about things falling that I can probably dig out. There's no question that it’s fallen. But that’s the thresholds. The thresholds knocked out claims. (Plaintiff Lawyer 6)

A fellow plaintiff lawyer did not perceive much of a change in the number of litigants. The participant agreed that certain claims were ‘knocked out’ because they could not satisfy the thresholds, but explained that these lower quantum cases may not have been viable in any case:

I think medical negligence cases are complex and it’s expensive litigation. And it’s rare that there’s an open and shut case in medical negligence and so those lower end claims that are wiped out by people not reaching the physical and mental threshold for impairment means that the lower quantum cases are just knocked out. They’re not viable but may not have been viable in any event. And I say that because their legal costs would exceed any payment that they would receive. So whilst I think there are definitely some cases that are not able to be pursued because of the 2003 Wrongs Act reforms, I think generally the lower end claims were never viable given the difficulty of this litigation and the cost that would follow. (Plaintiff Lawyer 3)
Participants were also asked about their perceptions of any changes in the compensation received by plaintiffs in medical negligence and mental harm claims. Ten participants did not perceive any significant change, save for an increase due to indexation. The findings are presented in table 5 below.

Table 5: Participants’ responses to the question ‘Based on your experience, what are your perceptions about the changes (if any) experienced in the compensation payments received by plaintiffs in medical negligence proceedings, following the Ipp Reforms?’

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant did not perceive a change in quantum of damages</td>
<td>10 participants</td>
</tr>
<tr>
<td>Participant perceived quantum of damages as higher following the Ipp Reforms</td>
<td>6 participants</td>
</tr>
<tr>
<td>Participant perceived quantum of damages as higher following the Ipp Reforms</td>
<td>4 participants</td>
</tr>
<tr>
<td>Participant could not comment</td>
<td>4 participants</td>
</tr>
</tbody>
</table>

A defendant lawyer explained they perceived claimants were now receiving higher levels of compensation, but that was because lower quantum claims were not pursued. This means that a claimant who may have received a small sum of compensation prior to the Ipp Reforms would not receive zero, but that the value of the claim for those who do satisfy the thresholds has increased:

I think they’re getting more, but that’s because that the value of the claim is more if you get over the threshold. The minor claims are now effectively eliminated. But that’s because of the thresholds. So the person who goes to the doctor and the doctor does something wrong, and the claimant then suffers some temporary exacerbation of a relatively minor condition, they might have issued and got $5,000 before the thresholds, but now they don’t issue. But of course, as a direct result of the thresholds it’s only the more serious or the significant injuries I suppose, that get through the gateway. So they’re naturally going to be worth more, in terms of non-economic loss damages anyway. (Defendant Lawyer 8)

When discussing whether the restrictions have affected sums of compensation, twelve participants explained that they perceived the thresholds and caps have adversely affected
mental harm claims in particular. A plaintiff lawyer described damages awards in mental harm claims as ‘mean’ and insinuated that it’s partly due to the sceptical perception of psychiatric claims:

I think [damages are] too conservative, they’re too mean. There was a case called Karamesinis a couple of years ago where a guy was killed and his parents were awarded $175,000 for psychiatric injury each and that was said to be at the higher end, given what they’d been through. They’d previously lost another child. Now, I think that’s pretty mean and I think there’s just a general perception about mental health claims that means people pay less. (Plaintiff Lawyer 10)

The sentiments of distrust and scepticism were echoed by a defendant lawyer who explained there is a ‘lurking distrust’ of psychiatric claims that has a direct correlation to the compensation awarded for mental harm claims when compared to physical injury.

Even the genuine [mental harm claims] never ever get what they’re worth, there’s always a lurking distrust, or that they’re going to get better when the case is over. A person with irreversible brain damage is not going to get better, but a person with a psychological problem – so thinks the jury, and I think [so] too – has a prospect of getting better. But there are some very genuine mental harm cases, there’s some appalling cases of nervous shock. I’ve got one where a young man couldn’t find his brother and so went looking for him, and he found his brother had [committed suicide] by hanging from a tree, and the body had been hanging there for about a week, it had been fly-blown, and this kid just freaked out, and entirely reasonably. He might as well have brain damage but he has not; if he did have brain damage he’d be worth – for the same symptoms – he’d be worth $3.5 million. His case was settled for $350,000. (Defendant Lawyer 7)

The example of mental harm compared with organic brain damage given in the quote above illustrates the discrimination between physical and psychiatric injuries in the legal framework.30

In summary, while the data gathered from the participants was subjective and reflected participants’ perceptions of changes in the number of litigants and quantum of damages (as opposed to objective empirical data), it was nevertheless beneficial in providing insight into perceived trends before and after the Ipp Reforms. As indicated earlier, the Ipp Reforms were

30 Forster and Engel, above n 8, 593.
perceived by many as being ‘reactive’ to an ‘alleged’ or perceive insurance crisis, therefore it was helpful to gather reflections from medical negligence practitioners on this matter.

5.5 IMPACT OF THE 2015 REFORMS ON PLAINTIFFS IN MEDICAL NEGLIGENCE AND MENTAL HARM

As outlined in Chapter Two of this thesis, in 2015 the Victorian government enacted amendments to the Wrongs Act attempting to strike a balance between affordable insurance premiums and the need to compensate the meritorious claims of individuals who have suffered loss. Despite only a recent implementation of the legislative changes at the time the interviews were conducted, it was nevertheless beneficial to obtain the views of senior tort lawyers about the likely impact of the 2015 reforms.

Chapter Four of thesis explains that the participants in this study have capacity to provide important insights into the challenges faced by plaintiffs pursuing medical negligence and mental harm claims in Victoria and whether the 2015 amendments prompted by the VCEC Report are sufficient to address these challenges. The majority of the interviewees saw the reforms as a positive step forward for claimants but suggested that the changes could have gone further in terms of the thresholds and the need for a test that took account of the personal circumstances of a claimant. Table 6 summarises the responses of the lawyers to a specific question about whether the 2015 amendments will have an impact on plaintiffs’ ability to recover compensation.

Table 6: Participants’ responses to the question ‘What impact do you see the 2015 reforms having on the ability of plaintiffs to recover compensation?’

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of lawyers supporting response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2015 reforms will not have a significant impact</td>
<td>7</td>
</tr>
<tr>
<td>The 2015 reforms will have some impact</td>
<td>11</td>
</tr>
<tr>
<td>I do not know / I am unsure</td>
<td>2</td>
</tr>
</tbody>
</table>
5.5.1 NO SIGNIFICANT IMPACT

Seven participants expressed the view that the changes would not have any significant impact. In other words, these participants believed the 2015 amendments will not necessarily make it easier for plaintiffs to recover compensation. In the view of the participants, this was principally because the maximum amount of damages for non-economic loss is awarded in the most severe cases. For instance, one participant explained that the maximum non-economic loss damages were awarded in ‘high quantum’ cases with injuries such as cerebral palsy or quadriplegia, but claimants with such extensive injuries could also recover under separate heads of damages:

I don’t think the increase in the cap is significant. In cases that are going to get a maximum for general damages, high quantum cases, generally often have a lot of quantum related to care components, whether it be a cerebral palsy case or a quadriplegic case and, in fact, the generals end up being often a minority section of the damages. It might be a couple of million for the other components. So another 50 grand [50,000] I don’t think makes much difference. (Plaintiff Lawyer 10)

Another participant noted the increase to the damages cap will likely make only a modest difference:

[H]aving gone up to $577,000 there is a higher level, but I think that makes a modest difference because if it’s a claim that’s worth somebody getting the cap for general damages then it’s obviously a very significant claim and an extra $50,000-$70,000 is neither here nor there in the outcome… So I don’t see that change having any significant impact. (Defendant Lawyer 3)

In other words, this participant suggests the amendment will only affect high-end claims. That is, even if a plaintiff is entitled to the maximum cap for non-economic loss the minor increase in compensation is unlikely to have a substantial practical impact.

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31 See for instance a recent decision of Sorbello v South Western Sydney Local Health Network; Sultan v South Western Sydney Local Health Network [2016] NSWSC 863 (24 June 2016) where the parents of a child who sustained severe brain injury due to oxygen deprivation at birth sued for mental harm. Non-economic loss for the mother was assessed at 35 per cent and for the father 20 per cent.
The participants’ views that the amendments are unlikely to have a significant impact on plaintiffs is consistent with the stated aim of the VCEC inquiry not to undermine the intent of the 2002-2003 tort law changes or adversely impact the price and availability of indemnity insurance.\(^{32}\) One of the participants expressly acknowledged that VCEC did not wish to ‘open the floodgates’ to unmeritorious claims:

I don’t really think that it’s going to have an enormous effect on claims… VCEC were pretty clear in saying that they don’t want to open the floodgates. (Plaintiff Lawyer 6)

VCEC anticipated that two effects of the reduction of impairment threshold levels would be an increase in insurance claims costs by $0.6 to $4 million per year and an increase in insurance premiums by 0.1 to 1 per cent.\(^{33}\) However, given the recent nature of the reforms, it was unsurprising that one participant stated they have not seen any significant impact since the introduction of the 2015 reforms:

I haven’t observed any great impact. The only thing is that it does, it softens the harshness of the previous reforms. [I]t permitted some plaintiffs who previously wouldn’t have qualified to commence proceedings, it permitted them to do so… [C]ertainly I’ve not experienced there’s been an avalanche of cases, unmeritorious or otherwise, that have flown as a result of those reforms. (Defendant Lawyer 4)

The participant appears to suggest that as the 2015 reforms will only have an impact on borderline claims, the reforms are unlikely to unleash an avalanche of unmeritorious negligence claims. Another participant stated that the reduction in thresholds may make a small difference by allowing borderline claims through, however that change is unlikely to be significant:

[It] probably broadens the field a little bit, but not much. I mean, you just broaden the class a bit in terms of people that can recover, so if you have a back injury and the panel said 5 per cent, you wouldn’t get up, but now you would… but I don’t know that it makes a big difference in terms of the numbers, it might increase the numbers a bit, but I wouldn’t think it’d be a huge amount. (Defendant Lawyer 5)

Similarly, another lawyer was of the view the 2015 reforms would not have a great impact:

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\(^{32}\) VCEC Report, above n 11, 14.
\(^{33}\) Ibid 93.
Will it make a significant difference? I don’t know. I doubt it, is my gut feeling. (Court Lawyer 3)

Two participants, while acknowledging the beneficial nature of the reforms for claimants, expressed a need for further reform:

I think they’re a good start. That’s the first and foremost point. They’re a good start. They should go further. (Plaintiff Lawyer 4)

I think they’re welcome, and I think they are two [thresholds and caps] of the really serious bits that did result in a lot of injustice. I certainly would have liked to see them go a bit further. (Plaintiff Lawyer 8)

5.5.2 THE REFORMS WILL HAVE SOME IMPACT

The majority of participants, 11 out of the 20, thought that the 2015 amendments would have some impact on the ability of plaintiffs to recover compensation. They endorsed the changes to the thresholds as providing claimants with a more balanced access to compensation through the changed thresholds. A number of the participants differentiated between physical and psychological injuries. For instance, a participant noted that the amendments have potential to have a significant impact in claims for compensation for physical injuries:

[T]hey’re going to have a significant impact with respect to physical injury because the change in the threshold to 5 per cent, rather than above 5 per cent, captures quite a significant group of people… But part of the discussion as to whether the changes should be introduced was just how many cases was the change from more than 5 per cent to 5 per cent going to capture, and it does capture quite a large cohort of changes. (Court Lawyer 1)

This quote suggests the reforms have the potential to affect a large number of participants despite a small increase to the threshold. Another participant thought the reforms would have a positive impact on access to justice by increasing the number of plaintiffs who qualify for compensation, without adversely impacting upon insurance costs:

I think they were necessary amendments; they won’t influence the cost substantially, there’ll be a small increase in the volume and a small increase in the quantity of damages. But I don’t think it’s going to be a costly amendment, but it’s going to get rid of some injustice in a few cases. (Plaintiff Lawyer 9)
This seems to suggest the 2015 reforms have struck a fair balance, insofar as they will not open the litigation floodgates but will eliminate some of the injustice caused by the Ipp Reforms. Similarly, another participant described the 2015 amendments as ‘pretty fair’ and pondered whether it will make it slightly easier for plaintiffs to bring a claim:

I think it’s probably…a pretty fair amendment. Will it necessarily open up the door and make it easier for plaintiffs? Perhaps it will, but in my experience the matters that I was involved in generally, the plaintiffs, it was very clear cut whether they were over the 5 per cent or 10 per cent threshold anyway. Perhaps it will affect the ability of claimants who are bringing psych claims which, I think, is harder to establish. It may make it a little bit easier for them, but I mean at the end of the day I don’t think that the impact, well in my view, will be too great. (Court Lawyer 4)

These perspectives suggest the effects of the 2015 reforms are remedial in nature without undermining the entire purpose of the Ipp Reforms, which is ultimately consistent with VCEC’s objective.

5.5.3 SPINAL CASES

Six participants indicated that amendments will have particular impact in spinal cases, as was intended by VCEC’s recommendations. Participants highlighted the injustice caused by threshold levels requiring more than 5 per cent impairment, in circumstances where an injured person may be assessed at 5 per cent. As discussed in Part III of this paper, the application of the AMA Guides can lead to unjust results for plaintiffs because of the manner in which injury thresholds are categorised. One participant referred to the unjust application of the AMA Guides and thought the amendments would have a positive impact on the ability to recover compensation for spinal injuries, noting:

We didn’t talk about the 5 [per cent], but it’s only back cases as you know, and that was much more unjust because it seems all right at five but it meant more than 5, and the next notch is 10, so [that] meant you’ve got to get 10 per cent, and under the guidelines you’ve got to be nearly dead to get 10 per cent for an organic injury. So therefore whilst it’s only restricted to back, I think it will increase the number of cases by a third. (Defendant Lawyer 7)

The above quote suggests the minor difference between a ‘5 per cent’ and ‘more than 5 per cent’ threshold can have significant practical consequences. A similar view was shared by a
different participant, acknowledging that plaintiffs with spinal injuries faced a significant threshold hurdle in applying for compensation:

I think the biggest thing is that the people with back injuries in the industrial context will have a greater chance of getting up because it was terrible before because there were plenty of people at 5 [per cent], because of the way the tables worked, so I think that will be helpful… [T]he spinal assessment will make a significant difference in the number of claims that get over the threshold. (Plaintiff Lawyer 11)

Whilst the amendment to the threshold in relation to spinal injuries appears to be minor, these participants suggest that it may have a significant effect in practice.

5.5.4 PSYCHIATRIC INJURIES

The legal position relating to mental harm has been criticised for discriminating between physical and psychiatric injury. Forster and Engel contend that statutory reforms to mental harm have reinforced and magnified the historic distinction between the two.34 This distinction was reflected in the Wrongs Act provisions which required a more than 5 per cent whole person impairment for physical injury and more than 10 per cent for psychiatric injury. One participant acknowledged the difficulty in satisfying the previous thresholds and considered the reduction of the threshold to equal to 10 per cent may allow more plaintiffs to initiate claims:

[T]he mental claims I think you had to have more than 10 per cent to be able to bring a claim for a mental injury. That was almost impossible because what you need to prove for 10 per cent you needed to be a smoking wreck. You needed to be more than a smoking wreck in order to get up. So I think that’s probably let more people in. (Court Lawyer 2)

VCEC acknowledged the difficulty of plaintiffs satisfying the more than 10 per cent threshold, mainly due to an anomaly in the application of the tool used to assess the impairment.35 Psychiatric injuries are assessed pursuant to the Guide to the Evaluation of Psychiatric Impairment for Clinicians (GEPIC).36 The anomaly arises because the Wrongs Act threshold and the GEPIC categories do not align, enabling a person with 11 per cent

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34 Forster and Engel, above n 8, 608.
35 VCEC Report, above n 11, xxvi.
impairment to recover compensation while a person with a 10 per cent threshold would be ineligible. The unfairness arises because a person may have a valid diagnosed psychiatric injury, but if they do not satisfy the quantitative assessments, they are prevented from recovering any compensation. One participant reflected on the frequent inability of participants with psychiatric injuries to satisfy the more than 10 per cent threshold:

[W]ith the psych injuries, a lot of people have got 10 and no more, and so that will have an impact for those particular cases. (Lawyer Plaintiff 8)

Participants’ comments in this regard suggest the threshold for psychiatric injury is quite high, meaning that only plaintiffs with the most severe psychological injuries will satisfy the thresholds, further reinforcing the historical distinction between physical and psychological injuries.

5.5.6 NARRATIVE TEST

VCEC considered the introduction of a ‘narrative test’ in assessing threshold requirements. The use of a subjective test would address the rigidity of the thresholds under the AMA Guides. At present, assessment of whether a person meets the significant injury threshold under the Wrongs Act is predominantly quantitative because of the requirement that the injured person must have the prescribed whole person permanent impairment. However, consideration of some qualitative factors are taken into account in the assessment of injury under the AMA Guides, such as when assessing scarring or the impact of pain from an injury. Impairment thresholds are arbitrary and do not distinguish between the loss of a finger to a bank representative who could continue in their occupation, as opposed to a pianist whose career would be destroyed.

Whilst the participants in this study did not expressly articulate the need for a narrative test, many comments alluded to the need to take into account individual circumstances, such as plaintiffs’ pain and suffering, which may not necessarily be considered in the application of

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37 VCEC Report, above n 11, xxvi.
38 Chapter 15 in the AMA Guides which deals with chronic pain is excluded from providing guidance for injury assessment under the Wrongs Act 1958 (Vic) s 28LB. However, each individual chapter dealing with various parts of the body includes a component for pain.
the current assessment. One participant articulated this issue in the context of medical negligence:

[One consequence of the reforms is that it] adds a level of complexity in terms of the impairment requirements. It affects medical negligence cases particularly where there has been the usual example of scissors being left in post-surgery, where there’s obvious negligence. But once the scissors are removed and although the patient has had a traumatic time, there’s no permanent impairment, and therefore they wouldn’t have a cause of action even though they could quite easily prove liability and causation. (Plaintiff Lawyer 3)

Undeniably, there is a tension between the need to compensate victims of medical negligence and a need to maintain affordability of insurance premiums. There is also merit in a system that is predictable in that the scheme can be applied uniformly to claimants. However, it is important that the law take into consideration individual circumstances affecting people’s lives. The introduction of a narrative test into the Wrongs Act would ensure plaintiffs who are currently prevented from accessing compensation have the opportunity to do so.

As outlined above, VCEC considered the introduction of a narrative test following recommendations based on the experience of lawyers from the Australian Lawyers Alliance, the Law Institute of Victoria and the Monash Law Students Society Just Leadership Program. The Law Institute of Victoria provided an example of pain and suffering experienced by a woman suffering sciatic nerve pain. Under the previous ‘more than 5 per cent’ threshold, the woman in the example would not have been able to recover compensation despite her quality of life drastically deteriorating. In their submission, the Law Institute of Victoria outlined the qualitative factors that are not captured by the quantitative assessment under the AMA Guides.40 For example, following the injury the woman’s daily capacities and independence are curtailed, her sitting and standing ability is restricted to 40 minutes, she can walk only short distances and is no longer able to attend to most ordinary domestic tasks.41

Opponents argued against the narrative test because of the risk it would lead to increased costs.42 Other risks of adopting a narrative test include definition and interpretation risks, as

40 Law Institute of Victoria, Submission No 13 to Victorian Competition and Efficiency Commission, Inquiry into Aspects of the Wrongs Act 1958, Submission 12 September 2013, 6-7.
41 Ibid.
42 The Municipal Association of Victoria was one such opponent: VCEC Report, above n 11, 42.
well as the risk that poor claim management by insurers in the injury claims process could set a precedent of accepting unmeritorious claims. An alternative to the narrative test available to VCEC was to recommend use of chapter 15 of the AMA Guides which deals with evaluation of pain in significant injury assessments.

VCEC rejected the introduction of a narrative test because of the risk it would increase the number of claims (including for claimants who were already within the threshold percentage but were seeking to increase their impairment percentage), causing an increase to court and administrative costs and ultimately leading to increased medical indemnity insurance premiums.

The VCEC Report alluded to the unfairness caused by the permanent impairment thresholds and caps on damages, with this unfairness also reflected in the Second Reading Speech of the Wrongs Amendment Bill 2015 (Vic). The unfairness of the regulatory framework was also echoed by the participants in this study:

I think there are quite a number of people now with genuine negligence claims and I’ve had to say to people, ‘I can’t proceed because we can’t establish the level of impairment.’ So recently I had a client who had a hip replacement, had Moore’s arthroplasty, got an infection, had to have that removed, another hip replacement put in and she didn’t get through the Panel to establish a 6 per cent impairment or more which I thought was terribly unfair but very difficult to appeal the Medical Panel’s decision. So therefore we were kind of just locked out. (Plaintiff Lawyer 1)

The challenge is for people who have significant injuries but don’t turn out to be permanent or significant injuries that turn out at 4 per cent [such as] extensive scarring. So these people are equally traumatised as anyone else but they’re cut out by the thresholds… I mean, compared to doing the TAC work that I used to do, the medical law claims seem to be far less generously compensated than [TAC]—unfairly. (Plaintiff Lawyer 4)

44 VCEC Report, above n 11, 41 - 42.
46 Victoria, Parliamentary Debates, Legislative Assembly, 16 September 2015, 3281 (Martin Pakula). The Hon Mr Pakula noted, ‘While there is evidence to suggest that the tort law reform project was successful in reducing insurance premiums, there are concerns that the reforms have disproportionately affected the rights of claimants to access damages, and some deserving claimants have been denied compensation.’
The participants’ quotes reflect the unfairness that can result from the current legislative regime, in circumstances where plaintiffs with substantial and painful injuries cannot satisfy the threshold requirements.

Concepts of certainty and predictability relate back to the rule of law, which outlines basic requirements of a legal system, such as equality and legal certainty. In the context of tort law, Witting has contended that the development of policy should be made with regard to values of certainty, consistency and predictability. Pursuant to this view, a regulatory approach assessing and compensating injury should render consistent and predictable compensatory payouts. As an example, the New Zealand compensation scheme is the ultimate model of regulatory consistency, providing predictable compensation for all injured people. In Australia, the imposition of thresholds and caps on damages presents some level of consistency in the types of cases that warrant compensation and the level of damages awarded. However, the drawback of such stringent regulatory equality and predictability is the failure to provide for individual circumstances.

A possible solution is the introduction of a provision, similar to the economic loss section relating to motor vehicle injuries in section 56A(3) of the Civil Liability Act 1936 (SA), which provides:

- a court may award damages in a case that would otherwise be excluded if satisfied –
  (a) that the consequences of the personal injury with respect to loss or impairment of future earning capacity are exceptional; and
  (b) that the application of the threshold set by that subsection would, in the circumstances of the particular case, be harsh and unjust.

The introduction of a narrative test would achieve regulatory consistency with transport accident and workplace legislation. Ten participants in this study compared negligence

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47 Stephanie JA ter Borg and Suzan Stoter, ‘Is Goal-Based Regulation Consistent with the Rule of Law?’ in Mortimer NS Sellers and Tadeusz Tomaszewski (eds), The Rule of Law in Comparative Perspective (Springer, 2010) 60.


under the *Wrongs Act* with transport accident and workplace injuries. All were of the view that recovering compensation under these statutory schemes was easier than the *Wrongs Act*. One participant explained:

> With transport accidents and WorkCover, it’s much more straightforward. I was in an accident, I’ve got an injury. I was lifting something at work, I’ve got a back injury… I don’t see why in medical negligence claims people should be treated any differently to transport accident victims, or public liability also has a three year time limit, but why people should be treated any differently to those that have been involved in car accidents or WorkCover incidents? (Plaintiff Lawyer 1)

Hurdles faced by plaintiffs under the *Wrongs Act* are much more stringent than under other personal injury schemes, leading to the assertion that the Victorian Government has been too tentative in their recent reforms. The Victorian Government should have considered the introduction of a narrative test or similar initiative to deal with injuries that do not meet the objective whole person permanent impairment thresholds.

At this stage it is difficult to make a final assessment regarding the effectiveness of the changes that were implemented. It is important to allow a period of time to elapse to allow for the implementation of the amendments. It would then be advisable to conduct research that captures the experiences of plaintiffs and insurance companies to ascertain the effectiveness of the 2015 amendments. Empirical research that provides details regarding the amounts of compensation provided to plaintiffs is recommended. In addition, case studies on the effect of compensation levels on recipients will be useful to evaluate how the compensation has affected their experience of managing their impairment.

### 5.6 TIME FOR A NO-FAULT APPROACH?

Despite not expressly advocating the adoption of the New Zealand scheme in Australia, the participants in this study endorsed the benefits of no-fault schemes, such as those used under

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the Victorian transport and workplace accident legislation. The participants highlighted a range of benefits including the simplicity of the claims process:

It’s definitely a simpler process. I mean, the TAC have a protocol for dealing with matters before they’re issued. That’s probably because liability and causation aren’t so difficult in majority of TAC claims. I think that the conference process is much less formal. It allows for a resolution. (Plaintiff Lawyer 2)

Medical law is crying out for a similar process to the TAC process, I think. (Plaintiff Lawyer 4)

Without being prompted by the interviewer, ten participants compared the claims process in medical negligence and mental harm claims to the process in transport and workplace accidents. All of these participants were of the view that the claims process and statutory requirements under the schemes were far more straightforward, producing fairer results.

The problems raised by the participants in this study suggest that the current negligence legislative framework requires reform. There are two options that should be considered: reducing the significant injury thresholds, or adopting a statutory scheme similar to that operating in NZ. The recent reduction of the thresholds by the Victorian parliament was conservative, reducing the thresholds by one per cent in spinal and psychiatric injuries. The threshold for physical injuries remains unaltered at ‘more than 5 per cent’ while the threshold for psychiatric injuries is still double that of physical injury. A reduction in the thresholds may not alleviate the discriminatory features of the legislation, because the imposition of thresholds itself acts as a hurdle to plaintiffs recovering compensation in legitimate claims.

An argument for imposing thresholds was to reduce the number and cost of smaller (‘trivial’) claims yet it would appear, according to many lawyers in this study, the smaller scale injuries are not trivial. Damages for non-economic loss are essentially compensation for ‘pain and suffering’ corresponding with a subjective response to physical and emotional trauma, yet the Victorian legislation focuses on objective assessments of an injury. Therefore

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52 Transport Accident Act 1986 (Vic) and Accident Compensation Act 1985 (Vic).
53 Wrongs Amendment Act 2015 (Vic) s 11 altered the definition of ‘threshold level’ in the Wrongs Act 1958 (Vic) s 28LB.
54 Ipp Report, above n 10, 188.
55 Mendelson, above n 13, 671.
reducing injury thresholds would allow more claims, however it would not eliminate the problems intrinsic to thresholds.

A solution that would alleviate the problems with the current framework is the adoption of a statutory scheme to replace the common law fault-based system. Various legal commentators support the introduction of a no-fault scheme in Australia, particularly in relation to medical liability, because a no-fault scheme offers predictable care and support, consistent coverage of injured people and a more efficient system. One concern with use of a statutory scheme is the ‘one-size-fits-all’ compensation payouts that may not be sufficiently generous to compensate catastrophic injuries. Stephen Todd evaluated whether the NZ scheme operates adequately to compensate in medical injury cases, and concluded that the compensation is reasonably generous and available with minimum formality. Insofar as compensation for medical injury is concerned, the NZ scheme excludes ordinary consequences of treatment and the injured person’s pre-existing health condition. It also excluded compensation for pure mental harm.

One recommendation the Australian legislature might consider is the introduction of a similar statutory scheme for treatment injury, with a broadened scope to include actions for pure mental harm. This solution merits detailed consideration by the legislature, such as a detailed enquiry by the Productivity Commission, a suggestion offered by Weisbrot and Breen. The implementation of such a scheme would be a step in the right direction towards achieving justice for victims of medical negligence and mental harm.

5.7 CONCLUSION

In summary, the findings of the research described in this chapter demonstrate that significant injury impairment thresholds were considered the predominant challenge amongst the various challenges such as caps on damages and causation, in medical negligence and mental harm claims. The reflections of senior tort practitioners show that the current regulatory framework

57 Todd, above n 49, 1216.
58 Weisbrot and Breen, above n 56, 296.
is perceived as overly restrictive and adversely impacting injured plaintiffs, resulting in unfairness and discrimination. According to participants, the 2015 amendments to the Wrongs Act were a step in the right direction towards improving access to justice by lowering thresholds, however these amendments are arguably insufficient to ease the restrictions imposed by the Ipp Reforms. The solution may be the introduction of a no-fault statutory scheme similar to the scheme currently operating in NZ, with the aim of producing a cost-effective scheme to compensate victims of medical negligence and mental harm claims.

When questioned about causation, a substantial majority of participants were of the view that causation is a hurdle in medical negligence litigation. The views on the reasons vary, with some asserting that the statutory test is the cause of the problems whilst others were of the view that causation in medical negligence is inherently complex and that the problems with causation do not stem from the Ipp Reforms. The participants in this study did not expressly articulate a solution to the difficulties presented by the causation element, suggesting that there may not be a simple or obvious solution and more investigation may be required.

The challenge to meritorious claims represented by the hurdle of causation, acknowledged by most of the participants suggests that the VCEC Report and subsequent law reform in 2015 presented a lost opportunity for the Victorian government to revisit the operation of the causation principle in practice. As one participant noted, the law is changing. VCEC was evidence of the need for continuing revision and identified that the next law reform opportunity should include causation. In the light of corrective justice theory and the need to compensate those who have been injured in medical negligence, this situation warrants further consideration.

When questioned about the likely impact of the 2015 reforms on medical negligence and mental harm claims, the majority of participants were of the view that the 2015 reforms will have some impact on the ability of plaintiffs to recover compensation in meritorious medical negligence and mental harm claims. The views regarding the impact vary, with some practitioners believing that greater impact will be on physical injuries (including spinal injuries) while others believe it will impact psychiatric injuries more. Although the majority of the participants saw the amendments to the thresholds as a positive change for claimants some regarded them as too modest. Many of the participants expressed doubts about the effectiveness of the amendments in alleviating the harshness of the Ipp Reforms. Although
the participants did not specifically articulate the need for a narrative test as outlined in the VCEC Report, they did mention the importance of individualising damages where there may be circumstances that result in claimants being unable to satisfy the impairment thresholds. Analysis of the data in this study indicates the 2015 reforms have not yet achieved the balance between the need to compensate claimants and the cost concerns regarding insurance premiums.
CHAPTER 6 – FINDINGS PART 2: MEDIATION OF MEDICAL NEGLIGENCE AND MENTAL HARM CLAIMS

6.1 INTRODUCTION

As discussed in Chapter Three of this thesis, legislative endorsement of mandatory dispute resolution processes has entrenched ADR processes including mediation into the Australian civil justice system. In the medical negligence context, a matter is unlikely to be litigated at trial unless the parties first attempt mediation. The use of mediation in medical negligence disputes offers not only opportunities for swift resolution of such disputes but also has the potential to allow claimants to experience a process that addresses both legal and non-legal needs. The role of the lawyer in medical negligence mediation can vary across a spectrum ranging from adopting a collaborative problem-solving approach, to transferring adversarialism from the courtroom into mediation. The widespread use of mediation in medical negligence warrants exploration of how this form of dispute resolution is used in practice, the extent of engagement with the process by legal and non-legal actors and the challenges experienced in attempting to reach settlement.

This chapter presents the second part of the findings of this thesis. Consistent with the research methodology in Chapter Four of this thesis, grounded theory was used to code and analyse the data to extract emergent themes. The chapter presents a discussion of the themes relating to mediation practice in medical negligence disputes. Firstly, the extent of engagement with the mediation process is discussed. Secondly, the chapter contains findings with respect to emotion, and whether the mediation process allows for the expression of emotion. Thirdly, the role and influence of lawyers on the mediation process is then explored. Finally, opportunities for reform are explored. Expanding legal education is suggested as a catalyst for shifting the culture of the legal profession to capitalise on the opportunity offered by mediation as a process offering emotional closure for the parties.

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1 This is because of a combined effect of the Civil Procedure Act 2010 (Vic) s 7 and court practice directions. See County Court of Victoria, Practice Note: Common Law Division – Medical List No 1 of 2015, 24 July 2015, [66].
6.2 ENGAGEMENT WITH MEDIATION

The privileging of ADR as a valuable and inherent component of a dispute resolution process is evident in state and federal legislation, with further endorsement in recent law reform commission reports. In medical negligence disputes, the County Court practice directions also stipulate that all proceedings in the Medical List must be subject to mediation. This legislative endorsement of ADR and particularly mediation as part of case management is echoed in the reflections of the participants.

All of the lawyers interviewed expressed support for mediation in medical negligence claims processes, although they proffered a variety of reasons for this support. Participants were asked whether they thought mediation was a more suitable dispute resolution avenue for medical negligence claims, compared to litigating at trial based on their experience. All 24 participants endorsed the benefits of mediation and responded in a manner that either expressly stated it was a more suitable dispute resolution avenue, or implied through their response that it was. Participants offered the following descriptions:

[M]ediation is an intrinsic and very desirable aspect to litigation… (Defendant Lawyer 1)

Mediation [is] a really important step in the process and there’s a lot of advantage for both sides if a matter can be resolved at mediation rather than proceeding to trial. (Plaintiff Lawyer 2)

I can’t speak highly enough of mediations… (Defendant Lawyer 3)

I think it’s a very important method. I think it has proved successful. (Plaintiff Lawyer 8)

As much as it’s against every barrister’s commercial interest to promote mediation, it’s the best for the protagonists involved. (Defendant Lawyer 4)

The overwhelming majority endorsed the benefits of mediation as reflected in the quotes outlined above.

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2 Civil Dispute Resolution Act 2011 (Cth) s 6; Civil Procedure Act 2010 (Vic) s 7.
4 County Court of Victoria, Practice Note: Common Law Division – Medical List No 1 of 2015, 24 July 2015, [66].
When asked to what level they engaged in mediation in medical negligence disputes, 16 participants stated they engaged because the process was court-ordered and thus mandatory:

[T]hey’re court ordered – there’s always a mediation prior to trial. (Plaintiff Lawyer 5)

[T]hey’ve got no choice. They’re always court ordered. But you do see ones that aren’t court ordered where people, for example early on, want to meet and discuss. I would be very surprised if anyone said it wasn’t successful. It has been successful in a number of cases. It’s got, in the medical negligence field, it’s got advantages for both plaintiffs and defendants. (Plaintiff Lawyer 7)

Every order in any litigation in the common law division will include a mandatory requirement for mediation so it’s absolutely imperative. (Court Lawyer 2)

One participant stressed that mediation is part of the litigation process, rather than a complete alternative to it, and indicated judges were actively promoting mediation:

Mediation is a part of litigation. No case is listed for trial until it’s been mediated at least once and judges are now more actively suggesting mediation, even during the running of a trial. So all parties engage in mediation for medical negligence disputes and have for many years. (Defendant Lawyer 1)

Eight of the 16 participants did not expressly use the words ‘court-ordered’ but used language which indicated that participating in mediation was a compulsory part of the dispute resolution process. In other words, it was simply something the participants saw as obligatory:

Mediation is almost universal in medical negligence claims. (Plaintiff Lawyer 4)

All of the litigated claims that I’m in, we absolutely always go to mediation. I can’t think of one where we haven’t unless it’s clear cut negligence and there’s a very reasonable quantum claim being made that you don’t want to incur the costs of mediation. But for all of the others we always go to mediation. (Defendant Lawyer 3)

[Pl]arties are told there’s going to be a mediation, there always is and they’re told that mediations have reasonable prospects of success and that there are good reasons for participating in a mediation. So I don’t think they’re given much choice about it, they’re not
asked – I’ve never asked a plaintiff do you – or a defendant – do you want to go to a mediation? They’re ordered, so it’s more we’re going have to do a mediation so here’s the story about mediation. (Plaintiff Lawyer 11)

The quotes above reflect the current use of mandatory mediation in the Victorian medical negligence context. As indicated in Chapter Three of this thesis, imposition of mandatory mediation in the court system attracts various concerns. With the widespread use of mediation due to support from policy-makers and the judiciary, there are those who assert that imposition of mandatory mediation can threaten the rule of law and result in the erosion of common law rights.5 For example, Genn argues that mediation can be beneficial where the process is voluntary, but sees the civil justice system as a necessary backdrop against which mediation can operate.6 Genn emphasises the value of public adjudication and common law precedent, and cautions about unknown consequences of unregulated processes in private disputes resolution.7 However, in this thesis participants readily accepted the imposition of mandatory mediation. None of the participants discussed a lack of opportunity to litigate in court, nor did they critique the mandatory nature of mediation in the manner of Genn and other writers.

In contrast to the participants who stressed that their participation in mediation was mandated, other participants did not frame their engagement with mediation as part of the institutional compulsion of case management. Rather, these participants expressed insights regarding the positive benefits of mediation. Eight participants thought Victorian legal and non-legal actors engage willingly, using terms such as a ‘fruitful tool’ to describe mediation:

I think that mediation remains a really fruitful tool for resolving complaints. Parties generally approach it with good intentions and they engage constructively in the main… The parties

7 Hazel Genn, ‘Why the Privatisation of Civil Justice is a Rule of Law Issue’ (36th F A Mann Lecture, Lincoln’s Inn, 19 November 2012) 15.
always engage in mediation in medical negligence disputes. To the extent that they engage I think it is pretty constructive. (Plaintiff Lawyer 2)

Participants also indicated there was ‘genuine goodwill’ about participating in mediation (Plaintiff Lawyer 8) and that the ‘main players are pretty keen’ to mediate (Defendant Lawyer 5). One participant stressed that ‘the desire to mediate is enormous’, particularly for defendant doctors who have a professional reputation to preserve:

The insurer and the insured, in particular [the] insured doctor, has got a great desire to mediate. Doctors in particular when matters go to trial, whether they reach verdict or not, run the risk of real damage to professional reputation... So the desire to engage in mediation is enormous for all the obvious reasons, costs, compromise, risk, all of that, but there’s that real personal element in [medical negligence] for the defendant as well as the plaintiff, obviously. That means that there is a real willingness and preparedness to mediate. (Court Lawyer 3)

The participants’ language demonstrated they had a compelling desire to engage in mediation, indicating a strong community of practice amongst medical negligence lawyers. Participants’ attitudes towards mediation were indicative of wholehearted endorsement, not simply as a response to mandatory imposition of mediation, but rather indicating a change of culture. Macfarlane has recognised that in the past 30 years a significant change in the dispute resolution culture has occurred and that lawyers have needed to be responsive to this change. ⁸ In many cases lawyers are now playing a different role, their focus shifting from advocacy to problem-solving and resolution of disputes. ⁹ Similarly, the majority of the participants in this study showed a strong commitment to mediation, with many of them finding the dispute resolution process valuable. Macfarlane suggests that lawyers’ attitudes towards mediation become more positive over time following repeated experiences of mediation. ¹⁰ While lawyers may initially be unfamiliar or uncomfortable with the process, they experience a shift in practice the more they engage with the process. ¹¹

When asked about the advantages of mediation, the participants endorsed many of the classical attributes of mediation including: mediation is cheaper and less stressful than trial, i

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⁹ Ibid 9.
¹⁰ Ibid 11.
¹¹ Ibid.
does not involve giving evidence in court which itself is stressful for claimants, it does not waste court resources, it avoids the risk and uncertainty of a trial verdict, it saves time, afford privacy and assists with a speedier resolution. In this study, 23 participants stressed that cost was a major benefit. Some participants simply listed it as a benefit while others expanded on their response by explaining the enormous expense of litigating a medical negligence case at trial, so that the more modest cost of mediation offered a cost-saving opportunity. Cost is often the driving factor of choosing ADR over litigation, because the perceived cost of litigation encourages parties to attempt settlement.\textsuperscript{12} For example, one participant stated:

\begin{quote}
I think the lawyers embrace it well, and they look forward to it. Because litigation’s amazingly expensive, and … the courts order that there be a compulsory mediation before the trial, usually three or four months or maybe even longer, but I often get a call before those orders are made for the parties to engage in a mediation. And even sometimes, without there being proceedings issued. So I think the lawyers like it because it reduces costs, if they can resolve it. (Defendant Lawyer 8)
\end{quote}

The use of legislation is a way to change the culture of lawyers and their approach to mediation. The introduction of the ‘overarching obligations’ provisions through the introduction of the \textit{Civil Procedure Act 2010} (Vic), requiring the facilitation of ‘just, efficient, timely and cost-effective resolution of the real issues in dispute’ has assisted with the increase in alternative means of dispute resolution annexed to the court process.\textsuperscript{13} Three participants recognised the role legislation has played in encouraging acceptance of mediation in civil disputes. For example, one defendant lawyer recognised the importance of legislation in tempering the litigious culture and highlighted that the legislative provisions have assisted parties to engage with ADR:

\begin{quote}
I think the Civil Procedure Act has been an excellent introduction. I think that is having quite an impact on cases in this jurisdiction and I am heavily in favour of that Act and the need to have a proper basis for everything that you allege. And I think it has gone further to encouraging parties to try and resolve matters earlier and to cooperate with one another. (Defendant Lawyer 3)
\end{quote}

\textsuperscript{12} \textit{Michael King et al., Non-Adversarial Justice} (Federation Press, 2\textsuperscript{nd} ed, 2014) 98.

\textsuperscript{13} \textit{Civil Procedure Act 2010} (Vic) s 7.
This quote demonstrates the successful use of public policy legislation in Victoria as a tool to shift the culture of lawyers from adversarialism and litigation to a more collaborative problem-solving focus. Macfarlane highlights that policy makers in North America have prioritised cost-savings and efficiency in the court systems by encouraging earlier and more informal resolution of disputes.\textsuperscript{14} She contends that the increasing use of ADR has led to a cultural change in the professional identity of lawyers, with lawyers responsive to alternative forms of dispute resolution.\textsuperscript{15}

Menkel-Meadow also posits that cultural change amongst the legal profession is required but questions whether the introduction of legislative rules or procedure is solely capable of reforming the adversarial system.\textsuperscript{16} Menkel-Meadow suggests that a variety of dispute resolution methods will facilitate choice for parties and allow lawyers to have greater flexibility in the dispute resolution models they choose to adopt.\textsuperscript{17} However, Genn remains sceptical about the use of public policy legislation to impose mandatory mediation, and argues that public adjudication and access to justice through the courts continues to have a fundamental purpose in dispute resolution.\textsuperscript{18}

One participant in this study explained that judges are using the legislative provisions to ensure court resources are used wisely, so that parties genuinely attempt mediation, and if their attempt is unsuccessful, then the parties are prepared for trial:

I think the judges are getting very critical under the Civil Procedure Act if they feel that a proper attempt at mediation hasn’t occurred or that medical reports are starting to be exchanged after the medication process because then, of course, you have a trial looming and you’ve got the possibility that the trial may be adjourned if there’s further…investigations after the mediation. (Plaintiff Lawyer 1)

Despite the many advantages of the Civil Procedure legislation, one participant posited that the opportunity for parties to attempt mediation in medical negligence cases occurs far too

\begin{itemize}
  \item \textsuperscript{14} Macfarlane, above n 8, 2.
  \item \textsuperscript{15} Ibid 2-3.
  \item \textsuperscript{16} Carrie Menkel-Meadow, ‘The Trouble with the Adversary System in a Postmodern, Multicultural World’ (1996) 38(1) \textit{William & Mary Law Review} 5, 42.
  \item \textsuperscript{17} Ibid 43-44.
\end{itemize}
late in the dispute resolution process, and that processes used to resolve TAC and WorkCover disputes are preferable because they take place much earlier:

The Civil Procedure Act talks about there being pre-trial resolution opportunities. It doesn’t happen in medical law and it should. It’s only got a three year time limit and such a short time limit on discoverability compared to TAC and WorkCover. You’ve got a mandatory pre-issue process in WorkCover, an opt-in protocol process in TAC which works very very effectively to get through at least half the claims before a case has even started or a dollar spent on a writ. Medical law is crying out for a similar process to the TAC process, I think. Pre-issue mediation, pre-issue judicial conferencing [or] pre-issue informal conferencing between the parties would get rid of a lot of these disputes, I reckon. (Plaintiff Lawyer 4)

Transport and workplace accident claim systems have successfully implemented pre-action protocols which assist with the early resolution of disputes.19 Such early resolution of disputes can have a positive effect on claimants, with one study having found that the time taken to resolve a dispute may have a direct correlation to a claimant’s perception of justice. Genevieve Grant’s research explored the claims-processing experiences of 332 participants who had pursued a workplace or transport accident claim.20 Grant found that there is value in acknowledging the role played by the claims process experienced by injured claimants as a primary facilitator of access to justice.21 That can include factors such as the length of a claim, whether claimants are informed about entitlements and ensuring claimants do not receive information that is overly complex and confusing.22

Consistent with the findings in Chapter Five of this thesis where participants highlighted the benefits of statutory schemes, the participant’s quote presented above indicates such schemes also have advantages in dispute resolution processes and procedures. One clear advantage is that pre-action protocols encourage parties to resolve their dispute prior to instigating court proceedings, resulting in fiscal savings for the parties and reducing the burden on court resources. A study of construction lawyers’ and mediation in Scotland supports the use of mediation early in the dispute on the basis that it encourages resolution before parties become

21 Ibid 654.
22 Ibid 650.
too entrenched in deep-seated positions. However, despite key benefits of adopting pre-action protocols in no-fault schemes, such as efficiency in dispute resolution and payment of compensation, pre-action protocols can have disadvantages. For instance, Legg and Boniface caution that mandatory pre-action protocols can result in front-loading of costs for parties and also risk an increase in compliance or ‘satellite’ litigation where parties contest the imposition of cost orders for failing to comply with the requirement for pre-action protocols. Provided relevant protections are included to allow parties to avoid pre-action protocols in exceptional circumstances (such as the vulnerability of a party or the need to pursue a test case in court), Legg and Boniface acknowledge pre-action protocols have many strengths.

The suggestion of participants to introduce pre-action mediation is interesting in the light of the former Labor state Victorian government’s attempt to introduce mandatory pre-action protocols in 2010, with the provisions being repealed only a year later with a change of government. Yet, pre-action mediation is being used in some Australian jurisdictions to resolve medical negligence claims and it is also showing promising signs of being effective internationally. In South Australia, the introduction of the Supreme Court Fast Track Rules 2014 (SA) means that parties are required to satisfy a number of requirements before commencing court proceedings, including exchange of evidence relating to liability and causation.

Similarly, international jurisdictions have used contractual methods of introducing requirements for pre-suit mediation to reduce legal costs and resolution time. The Florida Patient Safety and Pre-Suit Mediation Program was introduced in January 2008 and involves patients signing a pre-suit mediation agreement before receiving medical care, obliging them to mediate before commencing court proceedings. Evaluation of the program’s effectiveness from commencement in 2008 until 31 December 2015 showed a reduction of

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25 Ibid 57.
resolution time and an 87% reduction in defendant legal expenses.\(^2^8\) These examples indicate a tripartite approach to dispute resolution may be beneficial in encouraging early resolution of medical negligence disputes: firstly, legislative endorsement of ADR through legislation such as the Civil Procedure Act 2010 (Vic); secondly, court endorsement of pre-action mediation through court rules and practice directions; and thirdly, contractual pre-action mediation requirements akin to the Florida program.

Analysis of the participants’ responses indicates there is a high level of engagement with mediation, with two thirds of the participants engaging in the process because of a legal requirement to attempt mediation. A further third indicated Victorian lawyers engage constructively because of a culture that fosters goodwill about ADR. These findings support the use of court-ordered or mandatory mediation in the medical negligence context, with all participants endorsing the benefits of mediation.

Mandatory mediation can be a powerful case management tool, saving resources for parties and the court, and encouraging parties to use reasonable endeavours to resolve a dispute.\(^2^9\) Advocates of mandatory mediation contend that mandating ADR increases court efficiency, saves costs, time and emotions for the parties.\(^3^0\) On the other hand, commentators caution that a cultural shift would need to occur in the legal profession if mandatory mediation were to be implemented.\(^3^1\) The findings in this study suggest lawyers practising in the Victorian medical negligence jurisdiction have embraced mediation wholeheartedly, demonstrating a cultural shift towards non-adversarial practice in this legal practice group.

However, a non-adversarial culture does not appear to be thriving in all jurisdictions, with several participants drawing a distinction between Victorian and NSW lawyers’ attitudes towards mediation. For instance, one participant identified a clear distinction between

\(^{28}\) Ibid 5.


\(^{30}\) Mahoney, above n 29, 126.

\(^{31}\) Redfern, above n 29, 11.
attitudes of NSW practitioners suggesting they have a tendency to treat mediation as a formality, compared with Victorian lawyers who engage more enthusiastically:

In New South Wales the attitude was that mediation was a bit of a formality. In Victoria it’s the exact opposite. The reason why we have so few cases proceeding to trial is that parties meet, talk, discuss and settle. (Court Lawyer 1)

Two participants highlighted the litigious culture of lawyers practising in NSW, explaining the tendency of lawyers in this jurisdiction to adopt an ‘all or nothing’ mentality and an aggressive adversarial approach to dispute resolution:

The practical effect is that people don’t want to run trials because juries are unpredictable. And maybe that’s a good thing, but you know, we’re, sort of, forcing more compromises and settlements before trial because they’ve run a lot of stuff in New South Wales and there’s obviously problems with that as well because then it becomes all or nothing. (Plaintiff Lawyer 6)

But I think one of the great credits I heard from [an event] I went to, there were people from all over Australia representing [administrative tribunals and courts], who said “We really admire Melbourne because you’ve got one of the most vibrant private and institutional systems of mediation in Australia”. So Melbourne’s very, very mediation driven. It’s almost as if it is the venue … [Sydney lawyers] have a very aggressive, very aggressive attitude amongst solicitors and barristers on either side and they say some things, I mean I’ve been involved in some interstate mediation and I’m thinking gee what have…what are you saying all this for! You know it got really ugly around the table. But then we’d go outside and have a bit of a chat and we’re mates. (Court Lawyer 2)

The responses of the above three participants indicate a distinction between Victorian and NSW lawyers’ approaches to dispute resolution, consistent with findings of a recent study evaluating ADR in disputes about taxation. In the Australian study of 118 taxation disputes, 58.8% of Victorian disputes resolved following ADR, compared with 38.5% in NSW. Sourdin suggests that the discrepancy can be attributed to various factors, including a culture of practitioner behavior, and notes that practitioners engage with ADR to varying degrees in different states. The findings of Sourdin’s study would appear to support the views of several participants who observed a difference in approach of lawyers in the two states.

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Macfarlane’s comparative study of attitudes and practices of Toronto and Ottawa commercial litigators endorses the view that legal culture of lawyers can vary across jurisdictions depending on the local professional culture within each city and also exposure to mediation. The study found that Ottawa practitioners have a more established culture of documentary disclosure and exchange than in Toronto. There was also a strong preference for evaluative mediation in the Toronto sample. In addition, the Ottawa lawyers spoke more positively about, and appeared more comfortable with their client’s involvement in mediation. Analogous to Victorian and NSW practitioners, Ottawa lawyers exuded a more positive attitude toward mediation and were simultaneously critical of the adversarialism displayed by their lawyer counterparts in Toronto. Yet the introduction of mandatory mediation indicated a growing rise in acceptance of mediation at both sites, including a shift in attitudes towards accepting mediation in Toronto despite the resistance within this group.

Macfarlane attributes the difference in attitudes and practices between the two cities to two key factors. The first is local legal culture which is influenced by local leadership and professional relationships and seems to be stronger in smaller cities. The second factor is the extent of individuals’ experience in mediation. In Ottawa 100% of cases went to mediation compared to 25% in Toronto, and this familiarity with the mediation process meant Ottawa practitioners more easily embraced mediation. While the limited number of responses in this doctoral study comparing the Victorian and NSW jurisdictions does not conclusively establish the former are more willing to engage in mediation of medical negligence disputes than the latter, it certainly shows a greater disposition towards non-adversarial practice for Victorian lawyers than NSW lawyers. Macfarlane’s research endorses the conclusion that civil procedure rules alone are unlikely to foster a change of culture that embraces mediation.

6.3 SUITABILITY OF MEDIATION IN THE MEDICAL NEGLIGENCE CONTEXT

As discussed in the literature in Chapter Three, certain areas of legal practice where disputes are relationship-focused or involve an emotional dimension may be better suited to less

34 Ibid 285.
36 Ibid 314.
37 Ibid 299.
38 Ibid 300.
39 Ibid 318.
adversarial methods of dispute resolution. Medical negligence disputes are a highly specialised niche of legal practice, integrating complex principles of law and medicine and frequently involving a breakdown of an existing relationship between a doctor and a patient. Hence the resolution of such disputes occurs in an emotionally charged environment where the needs of the parties involve more than merely financial objectives.

In addition to advantages relating to the relationship between the parties and their emotional needs, mediation of medical disputes can have benefits such as confidentiality and costs savings, as well as deepening awareness regarding medical errors and how to avoid them in the future. Commentators have endorsed the use of ADR processes to resolve medical malpractice claims because they are informal, confidential, speedy, enforceable, cost effective and consensual as opposed to determinative. Given that the mediation literature pertaining to medical negligence disputes suggests their suitability, it was imperative to ascertain whether participants in this study viewed mediation as a suitable form of dispute resolution of medical disputes.

Arguably cost is a particularly prevalent factor in the resolution of medical negligence disputes, which frequently involve complex medico-legal issues that can result in lengthy and expensive litigation. When endorsing mediation as a preferable method of dispute resolution in medical negligence claims, many participants acknowledged that mediation is advantageous for both parties.

My experience is mediation is an intrinsic and very desirable aspect to litigation in that it takes place usually when interlocutory procedures have been completed. So I think there are great advantages in mediation not as opposed to litigation but as a part of it, and I think that [it] advantage[s] both plaintiffs and defendants. (Defendant Lawyer 1)

I think that mediation’s a really important step in the process and there’s a lot of advantage for both sides if a matter can be resolved at mediation rather than proceeding to trial. Trial’s costly and expensive and stressful always and those are the only certainties, for the result is unknown. (Plaintiff Lawyer 2)

These quotes indicate that mediation can have advantages for the injured claimants, as well as for defendant doctors. In advocating for continued use of mediation in the resolution of medical disputes, all participants endorsed many of the classical attributes of mediation including cost, certainty, control, confidentiality and less emotional stress for the parties:

I think number one, the legal costs are much less significant at mediation. And there’s a much less significant stress level for clients at mediation than there would be at court. (Plaintiff Lawyer 1)

Speed, certainty, saving on costs, are all huge factors. The fact that [the parties] don’t have to generate evidence. There are some people who’ve suffered badly whose claims you just can’t run because they can’t generate the evidence. (Plaintiff Lawyer 11)

[T]he advantages are you’ve got a certain result. I mean, if you go to court, you might win, you might lose, and no case is unlosable. Particularly with the added variable of the jury, which, you know, you just never know who’s going to be sitting in that box, and you have very little control over it. (Plaintiff Lawyer 8)

Some participants highlighted that mediation can be particularly beneficial in reducing stress and managing emotions for the parties:

[Mediation is preferable] in the sense that everyone gets a result. And you get the result without your client going through a fairly stressful situation. (Plaintiff Lawyer 5)

You’re dealing with human beings, and I think the courtroom and the trial process is the worst possible way for the resolution of a dispute – not just because of the emotional impact on the individuals, but the issues are never, ever… the courtroom’s so artificial. (Court Lawyer 3)

Despite so many participants citing the advantages associated with the mediation process, some participants qualified their responses by acknowledging that mediation operates in the shadow of the legal framework and advocated for the necessity of trial in the resolution of some matters:

You can’t have mediation without having a trial system because that’s there for actually settling – when I say settling I mean settling by [court] order - the dispute… [M]ediation wouldn’t work if it didn’t have a court system in the background which is a shadow in which the mediation system operates because people see that if you don’t settle at a mediation it has
to be settled in the courtroom. And that can be unattractive for lots of people for lots of reasons. (Defendant Lawyer 6)

In this quote, the participant is elaborating upon a rights-based negotiation approach that facilitates settlement of disputes in the shadow of the legal system. Macfarlane acknowledges that the anticipation of future litigation influences the manner in which lawyers approach negotiation, so their decisions regarding settlement and disclosure of information occur against the backdrop of a likely court outcome. This encompasses a rights-based position where lawyers prioritise the need to convince a court of the superiority of their client’s claim. In other words, lawyers are using the trial process and authority of judges to settle cases by negotiating in the shadow of the law, but in many instances without the need for trial. When embodying a rights-based model, lawyers may become entrenched in their positions making it extremely difficult to resolve disputes that do not require rights-based solutions.

Macfarlane contends that a better strategy is to adopt ‘wise and transparent bargaining’ towards the best possible solution in the circumstances such as addressing emotional or non-legal needs of the parties. Similarly, some commentators have acknowledged that settlement negotiations are influenced by the shadow of the law, while others stress that mediation should be seen as a dispute resolution process in its own right rather than merely a process of settling disputes in the shadow of expected court outcomes. Despite the acknowledgement of the necessity of trial, participants proffered colourful descriptions of the harrowing trial process which are set out below, indicating that trial should be reserved as a dispute mechanism of last resort for medical disputes.

6.3.1 TRIAL IS WORSE THAN MEDIATION

Six participants definitively asserted that the trial process is far worse than the mediation process in medical negligence matters. Some participants highlighted the benefits of mediation by contrasting it with the process of trial, describing the trial process as a ‘traumatic’, ‘gut-wrenching’ and an ‘awful’ experience for the parties:

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42 Macfarlane, above n 8, 66-67.
43 Ibid 85.
44 Ibid 53.
Any settlement of a case is a better thing to do than having the risk and trauma of running a trial. You know the trial’s a gut-wrenching experience for the barristers who know all about it, let alone for the poor parties who have to front up day after day and endure cross-examination and watch people saying and doing things that they don’t think are right, or you know, it’s just terrible for them and then at the end one gets vindicated and the other doesn’t, so that’s horrific too. So at least with a mediation there’s the prospect of a result where neither one feels run into the ground. (Plaintiff Lawyer 11)

Litigation is traumatic for plaintiffs as well as defendants. No one wants to be dragged through that. [A] lot of plaintiffs think that they would like to have their day in court but it’s awful. (Defendant Lawyer 2)

Trials are publicised; They’re costly. They’re time consuming. I imagine they would be incredibly intimidating for a plaintiff and I think they all just increase the level of stress and anxiety of all involved. So trial really is the last option. (Defendant Lawyer 3)

These quotes from participants endorse the view held by many proponents of mediation that litigation can be a stressful and negative experience for clients. Menkel-Meadow contends that the adversarial system is inadequate to meet the often complex and multi-faceted problems of parties in disputes. She is critical of the ‘limited remedial imaginations’ of courts and their tendency to produce binary, win-loss solutions. Adopting a postmodernist critique, Menkel-Meadow challenges the notion that there is simply one ‘truth’ or one accurate version of the facts. She contends that the adversarial system should be used in circumstances where it is most appropriate and where parties freely choose such an avenue, as a ‘court of last resort’. Further, Menkel-Meadow posits that the only way to truly reform the adversarial system is to ‘oppose’ it with other forms of dispute resolution processes such as mediation, to allow parties greater choice in how to resolve disputes.

Johnson has used a war model to illustrate the brutality of trial, asserting that parties ‘blow each other to bits’ and declare a victor. Interestingly, one participant thought that settlement negotiations can evoke a similar outcome where participants walk away slightly wounded.

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48 Menkel-Meadow, above n 16, 7.
49 Ibid 7.
50 Ibid 33.
51 Ibid 43.
Yet the participant asserted this was a positive factor because everyone involved has contributed to the final outcome:

It’s much better to have a process in which you get together, talk about a case and make an agreement. And the best settlement involves everyone walking away battered, bruised and bloodied basically because everyone has given, everyone’s got, everyone’s compromised, but everyone’s agreed that they can live with the end result. (Court Lawyer 1)

This participant appears focused on a battle leading to compromise, which reflects a preference for an evaluative style of mediation, rather than on achieving an interest-based negotiation that may accommodate the parties’ distinct needs. The evaluative and interest-based styles of mediation are discussed in more detail in later sections of this chapter.

6.3.2 COST IS A SIGNIFICANT ADVANTAGE

The primary advantage of mediation raised by the participants was cost savings. As indicated the majority, 23 participants, expressed the view that reducing costs was by far the biggest advantage in mediation because expenses affiliated with trial, such as cost of senior and junior counsel, medical reports and expert evidence, were reduced. Many participants commented on the high expense of a trial:

[W]hat it does is save trial fees and they are huge really. In terms of, you know, the costs of a medical trial, or any trial, they’ll generally involve senior and junior counsel, they’ll involve at the bar table, you know, at least two solicitors assisting each party, so that’s about $50,000.00 a day. Costs go into hyper drive. (Court Lawyer 1)

Cost. You know, the cost of the trial is outrageous. One side with a silk and junior barrister running in the County Court jury in the civil jurisdiction, three weeks, you’re looking at $200,000… You’ve got the doctors, the witnesses - once you get into the second week, your daily hearing fees are $1000 a day. Jury fees are the same. You know, the solicitor’s time is just so expensive that as many cases as you can resolve through alternate dispute resolution and mediation the better. (Plaintiff Lawyer 5)

[Participating in mediation does] reduce the cost because sadly, you know, litigation in the Supreme Court probably costs a minimum of $25,000 a day and so two weeks is a quarter of a million dollars so there’s got to be a lot of work done by practitioners to try and save their clients that sort of money. (Defendant Lawyer 1)
I think the lawyers like mediation because it reduces costs, if they can resolve it… It costs a fortune to have a trial. (Defendant Lawyer 8)

If it takes more than one mediation then go for it, is my view. I mean it’s much more cost effective. You would never run a medical negligence matter to trial without having a QC involved really. That is incredibly expensive. (Defendant Lawyer 3)

These findings indicate that avoiding the cost of a trial was a major incentive for practitioners to encourage their clients to participate in mediation. The practitioners viewed mediation as saving their clients enormous expenses associated with litigation. Some participants also acknowledged that the cost incurred in running a trial had wider repercussions for the general community. For instance, one participant recalled that calling a doctor to give evidence in court caused the cancellation of procedures on public hospital waiting lists:

I had a case dealing with – a breast cancer case, a failure to diagnose, and I had - I remember this trial vividly – I had two experts who had to cancel two public lists each, so it’s four public lists [that] were cancelled for them to attend court. So the incidental cost to the community was enormous. The people who were waiting for surgery on public lists got it cancelled so these doctors could come to court. I thought there’d be outrage in the community if people knew of that. (Court Lawyer 3)

Another participant discussed the cost to the community not only because of disruption to patients in the healthcare system, but also because it places a burden on court resources and members of the community who are called as witnesses:

It’s a huge amount of time, and the cost to community is even greater, because there’s a judge sitting there, and there’s a jury that gets paid, but you pay transcript fees, and there’s a lot of dislocation. You have the doctors who are involved and the hospitals involved who have to have their usual routines disrupted because they’re involved in litigation, so they’ve got to go and sit in court, or give evidence, or whatever, so it’s a very expensive exercise, but the reality is, there aren’t that many of these claims that run. (Defendant Lawyer 5)

6.3.3 CERTAINTY OF OUTCOME

While cost savings were seen as the predominant advantage of participating in mediation for medical negligence claims, participants also stressed that certainty of outcome was achieved
far more easily in mediation because of the unpredictability of juries. One participant explained that expert evidence is highly technical and emphasised that there is no control over how a jury might decide facts:

[T]he evidence is technical and it’s complicated, it’s heavily reliant on experts. So it’s sort of out of the parties’ hands in many ways as to how that expert goes and whether they’re believed. They may be right and the jury just decides not to accept their evidence, and there’s no control over that. So I think that’s another reason that mediation’s more appropriate. (Plaintiff Lawyer 6)

Another participant agreed that juries can be unpredictable, asserting that occasionally members of the jury do not make decisions rationally but rather outcomes are based on how favourably juries perceive the parties:

[Y]ou’ve got to put your trust in the judge and/or the jury; what are they thinking? Judges are calm I suppose and rational. Juries can sometimes, we think, and I don’t know this for a fact, but I can’t help feeling that sometimes it’s a bit of a popularity contest. And sometimes the thinking of a jury can be distant from the questions that you ask them and the facts and issues that you put to them… I did a case involving a young woman who I thought ‘Oh yeah she might succeed, she might not.’ I thought she was worth about $250,000. The jury gave her $1.4 million. Now why? They hated the defendant. (Court Lawyer 2)

6.3.4 CONFIDENTIALITY

Apart from costs and certainty of outcome as important advantages of mediation, practitioners also raised confidentiality as a significant benefit of participating in mediation, particularly given the reputation of doctors and hospitals is on the line. As one participant put it:

I think one of the main benefits [of mediation] is [that] it provides a confidential forum for parties to openly ventilate the issues and try and distil some of the key parts of the dispute. I think particularly when you’re dealing with health professionals for example, or any sort of professional, you obviously need to take into account that, at the end of the day, this is their reputation on the line and their livelihood. I think in that respect if matters can be resolved at a mediation or shortly thereafter on a confidential basis, I think that’s going to probably, from the practitioner’s point of view as well, be a better outcome for them. (Court Lawyer 4)
One participant stressed that confidentiality of settlement was crucial not just for doctors, but also for plaintiffs who are unlikely to want private aspects of their dispute publicly aired by the media:

[Mediation is] private and confidential so we haven’t got doctors and nurses with their faces in the paper or cameras chasing them down the road. The same for plaintiffs. They’re not exposed to the media. The whole world doesn’t know that they are suing because they say their child was unwanted. The media is generally always averse to hospitals’ interests but it likewise can be very averse to plaintiff’s interests. There is none of that. It is all confidential.

(Defendant Lawyer 3)

In total, five participants highlighted the importance of confidentiality, particularly in light of the role of media. In addition to protecting the privacy of the parties, one participant observed that keeping medical negligence out of the spotlight keeps the public’s confidence in the health system intact:

It helps maintain public faith in the system I think as well, because the only cases that make it to the media are the sensational ones or the ones that grab headlines. And the ones that grab headlines in this context are the record verdicts, the unscrupulous behaviour of health institutions or health practitioners. So mediation has the benefit of keeping that out of the public eye, so that, because those sorts of examples really only incur the ire of the general public because it denudes their faith in the medical system, it denudes their faith in the legal system, because they think ‘My God, how can this have happened in the first place?’ or ‘How could that person have got so much money?’ So I think it’s good, it permits the participants to maintain control over their dispute, and it saves people having to air their dirty laundry.

(Defendant Lawyer 4)

The disadvantage of preserving confidentiality is the risk that medical errors will be concealed from the public domain. This will prevent hospitals, clinics and practitioners from addressing medical errors and imposing safeguards for the future. Confidential settlements may also prevent negligence from being uncovered by the public. Practitioners from Australia’s leading medical negligence law firms have recently called for a centralised national system to monitor healthcare complaints so that all complaints could be filtered
through a single system.\textsuperscript{53} They contend that while the terms of the financial settlement may be kept confidential, plaintiffs should not be prevented from discussing their experiences publicly.

6.3.5 DISCUSSION

Given the advantages of mediation have long been recognised in many legal disputes, combined with its frequent use in the medical negligence jurisdiction, it was unsurprising that the practitioners who participated in this study uniformly endorsed the use of mediation for medical negligence disputes. The findings indicate that the participants in this study clearly perceived the advantages of mediation over litigation. Insights provided by the participants suggest they believe medical negligence claims are conducive to resolution by mediation because of a saving in costs and time, and also because the approach allows party control over the process. Expense was a significant factor, with participants emphasising that the complexity of issues and length of expert evidence in medical negligence trials can lead to exorbitant fees.

These findings are consistent with previous studies involving lawyers and mediation of medical negligence disputes. In a North Carolina study, 75 per cent of lawyers who were surveyed indicated they would support the referral of a malpractice case to mediation.\textsuperscript{54} A New York study using structured interviews with participants and mediators found plaintiff lawyers were more willing to mediate than defendant lawyers.\textsuperscript{55} In contrast, the findings of this research show that all 24 participants were willing to engage with the mediation process although this willingness may be stimulated by legislation and court practice directions.

The findings of this research are similar to the findings of a Canadian empirical study of perceptions of legal and lay participants in personal injury disputes. In that study, Relis found that lawyers showed strong support for participation in voluntary mediation and, further, did

\begin{itemize}
\item \textsuperscript{54} Thomas B Metzloff, Ralph A Peeples and Catherine T Harris, ‘Empirical Perspectives on Mediation and Malpractice’ (1997) 60(1) \textit{Law and Contemporary Problems} 107, 141.
\end{itemize}
not exhibit opposition to mandatory mediation. The participants in this doctoral research study also showed a similar acceptance of mediation, though they did not differentiate between voluntary and mandatory mediation. They highlighted the positive attributes of the mediation process and encouraged client participation in the process, even when mediation was mandated or court-connected.

Previous studies and the findings of this research would indicate a growing culture of non-adversarial legal practice and a changing legal landscape in medical negligence litigation. The introduction of court rules in South Australia encouraging pre-action protocols for resolving medical negligence claims and the use of contractual provisions in Florida to encourage pre-suit mediation are indicative of the necessity for such tools to encourage early resolution of disputes. Combined with policy shifts encouraging increased use of ADR, the landscape may be ripe for introduction of pre-action protocols or mandatory mediation as ‘the extra dose needed to cure the medical malpractice crisis’. 57

6.4 EMOTION AND MEDIATION OF MEDICAL NEGLIGENCE DISPUTES

The literature review in Chapter Three of this thesis has demonstrated that emotion is a crucial component of dispute resolution. Parties in dispute will frequently have an emotional reaction to conflict, including fear and anger. This may be more prevalent in medical negligence disputes where a patient sustains harm due to their doctor’s error; the resultant effect is that the conflict is fueled by emotion. Previous studies show that addressing emotional needs of the parties has the ability to transform the issues in dispute. For instance, Jones suggests that emotion defines conflict, hence triggering events that cause conflict elicit emotion. Emotional intensity is linked to emotional communication, thus

56 Tamara Relis, Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties (Cambridge University Press, 2009) 82.
61 Jones, above n 60, 90.
perceptions of emotional situations may further affect conflict. Maise suggests that stimulating or tapping into emotions can assist parties to move beyond negative emotions such as hatred or violence. Therefore allowing parties to acknowledge or express emotion in the mediation of medical disputes may assist with conflict transformation and be a key to successful resolution.

One of the espoused advantages of mediation in medical disputes is that the process allows an opportunity for the parties to obtain an explanation, to express an apology, to receive sympathy or to gain closure. However, this may not always occur in practice. In some instances this is because the mediation process is dominated by lawyers who sideline parties’ emotional needs and interests. Another issue more broadly is the development of a legal culture in medical negligence that does not value emotion and actively suppresses parties’ engagement with the mediation process.

Lawyers who engage in the mediation of medical negligence disputes may sideline clients’ emotions to focus on financial interests, or they may simply lack the skills to engage with the emotional aspect of conflict. In such circumstances if lawyers dominate the mediation process, they may impact on a client’s ability to tell their story, express emotion or address non-legal issues which in turn stands as an obstacle to settlement. Some commentators contend that lawyers should encourage greater party participation in the mediation process and thus empower parties to gain control and self-determination in the process.

Given the increasing recognition of the role of emotion in dispute resolution, it was worthwhile exploring the role of emotion as a factor in medical negligence disputes and whether the mediation process allows for the expression of emotion. When asked ‘Are emotional issues a factor in mediation?’ eighteen participants indicated it was a factor, two did not directly answer the question, while four said the answer depended on the circumstances. These four practitioners elaborated that an answer depended on whether the

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63 Maïse, above n 60, 193.
dispute was viewed from the plaintiff’s or the defendant’s perspective, the seriousness of the injury, and whether the dispute involved the death of a family member.

6.4.1 IS EMOTION A FACTOR IN MEDICAL NEGLIGENCE DISPUTES?

Eighteen participants considered that emotion was a significant aspect of medical negligence disputes. Consistent with the literature on the prevalence of emotion in medical negligence claims, one participant put the heightening of emotional issues down to a breach of trust between a patient and their doctor:

[T]here’s no aspect of litigation in which emotional issues don’t play a big part; that’s the starting point, particularly if you’ve got injuries. But you can’t ignore that in medical cases they play an even bigger part because you start off with a relationship between a patient and a doctor, or a patient and an institution which is one of trust and if it’s felt that there’s a breach of the trust then the emotional impact of that is always very significant. So if you’re bowled over by someone who’s driving badly, well you’re very cross with that person but if it’s your best friend or someone that you trust who’s let you down completely it’s a much more emotional case. And in medical cases people trust their doctors, people have relationships with their obstetricians, people trust their hospitals and when they’re let down it plays a very big part in the whole process. (Court Lawyer 1)

The participant distinguished between medical cases and transport cases where a plaintiff is injured by a negligent driver, asserting the breach of trust fuels emotion and this plays a role in the process of dispute resolution. One emotion that can be particularly prevalent in medical disputes is anger, as articulated by a participant who stated that plaintiffs are so emotionally invested in their claim that it seeps into their bloodstream:

Is there an emotional side of it? Absolutely. And it comes in several forms. There’s just plain downright anger and until you can remove that from the picture you don’t get someone thinking rationally and they just won’t listen. Secondly people make an investment in their claim and it’s understandable why they’re living that claim day in [and] day out. And some people, unhappily, become absorbed in their litigation to such an extent that they start to become more disabled than they were before the claim started. In other words, it gets into their bloodstream. (Court Lawyer 2)

Fifteen participants saw emotion as predominantly plaintiff-orientated. They thought this was because plaintiffs are emotionally invested in pursuing a claim, feel aggrieved that their
doctor has breached their trust by committing an error and must come to terms with the pain and suffering associated with their injury. One lawyer described emotional stressors as ‘enormous’ for plaintiffs because of the personal significance of claims to them:

In terms of the emotional stressors for mediation, it’s enormous. A plaintiff is in a position where they’ve never been before. They’re out of their comfort zone. They’ve got to make important decisions and the subject matter is very personal and critical to every aspect of their life and the outcome of the mediation will have a great impact on their future quality of life. So emotionally it’s enormous. (Plaintiff Lawyer 3)

Another plaintiff lawyer explained that emotional issues are a factor for plaintiffs because their lives have been dramatically altered by an injury, whereas for doctors the mediation is a commercial operation:

On the whole, emotional issues are certainly more relevant for plaintiffs than defendants. Defendants are always – almost always – insurance companies who are able to… you know, they’re experienced litigants; they’re able to bring a commercial approach to it, with some exceptions. And they can try to take the emotion out of it. They try and look at their bottom line, work out what’s going to happen in court, what’s the jury going to do, what’s the judge going to do. But plaintiffs can be much harder and it can be their life; this is their one and only chance, their one and only case and their life can have been altered dramatically by what they’ve been through and it could have been extremely traumatic. They might have lost a loved one as part of it, it might have been the loss of a child or something like that or something very dramatic like that. And so those cases are difficult at mediation and emotional factors are harder. (Plaintiff Lawyer 10)

The significance of emotion in medical negligence claims for injured plaintiffs has been recognised in a Canadian explorative study. In the study of 64 court-orientated medical malpractice mediations undertaken by Relis, plaintiffs were asked about their mediation aims. In their responses, all plaintiffs interviewed stated they wanted to be seen, and have their stories about what they had been through heard by the opposing side. 67 While plaintiffs accepted that obtaining financial settlement was one aim, they also stressed other objectives such as wanting to hear the defendant’s perspective, seeking answers or explanations about what had occurred, or obtaining an acknowledgement of their suffering. 68 Further, plaintiffs

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67 Relis, above n 56, 142.
68 Ibid 142.
were interviewed about their objectives during mediation, including needs and fears, with emotional factors being particularly prevalent for female disputants. Out of 11 female plaintiffs interviewed, 100% spoke about emotional needs in a mediation forum (versus 33% of 6 male plaintiffs interviewed).\textsuperscript{69} Therefore Relis’ study confirmed that emotional or ‘human’ factors played a significant role in mediation of medical disputes.

In contrast to the findings of this doctoral study where participants acknowledged the central role of emotion and non-legal objectives in mediation, the majority of lawyers in Relis’ study thought that plaintiffs sued solely or predominantly for financial reasons.\textsuperscript{70} These lawyers seemed to disregard many of the non-financial objectives of plaintiffs, including admission of fault, acknowledgment of harm, retribution for defendant conduct, prevention of reoccurrences, answers, and apologies.\textsuperscript{71} When asked about mediation objectives, the legal actors focused predominately on monetary settlement.\textsuperscript{72} Relis concludes that resolution of medical malpractice disputes occurs in a parallel world, evidencing a disparity between legal and lay actors, with lawyers’ practices grounded in tactics and strategy while lay disputants’ focus is on psychological needs, feelings and emotions.\textsuperscript{73}

Participants in this study acknowledged that emotional issues are more significant for plaintiffs, because doctors rarely attend mediation. Doctors are indemnified by insurance companies and therefore the hospital or insurance representative participates in the bargaining process on doctors’ behalf:

\begin{quote}
I think emotional issues are a relevant factor and [plaintiffs] find it extremely nerve-wracking. Doctors generally don’t. We tend to leave doctors out of it and we just have them on the phone if we need to. But insurers are the ones who are coming up with the money so really the doctor doesn’t need to participate. So doctors really don’t get any particular emotional connection to the mediation. (Defendant Lawyer 2)
\end{quote}

\textsuperscript{69} Ibid 147.
\textsuperscript{70} Ibid 34.
\textsuperscript{71} Ibid.
\textsuperscript{72} Ibid 132 - 136. Out of interviews with 10 physician lawyers, 80% mentioned monetary settlement as a mediation aim. Out of interviews with 13 hospital lawyers, 75% mentioned monetary settlement as a mediation aim. Out of interviews with 19 plaintiff lawyers, 74% mentioned monetary settlement as a mediation aim.
\textsuperscript{73} Ibid 153.
Despite acknowledging significance of emotion, the lawyer’s description of the absence of the doctor from the mediation prevents the process achieving its fullest potential because of a lack of opportunity for a meaningful interaction between the parties. One participant identified that, in theory, both parties are present at mediation but in practice that rarely happens because the parties are kept in separate rooms. Therefore no opportunity materialises for the expression of emotion and emotional issues are not resolved:

[T]hose emotional issues don’t get resolved in mediation because when you get taught about mediation, the plaintiff and the defendant are always in the room in that hypothetical sense. In the mediations in personal injury litigation that never happens, it’s always the lawyers in one room talking about it and then we go and talk to our client outside of it. So that tends to be the way. So those emotional issues don’t get addressed in the mediation room. They get addressed where we talk to the client and say, ‘You’ve got to look at this as a commercial operation.’ (Plaintiff Lawyer 5)

Like defendant lawyers representing the insurer, this quote shows that even plaintiff lawyers view mediation as a commercial operation rather than as a forum for exploring emotional or psychological needs of their clients. The lack of doctors’ attendance at mediation is a significant obstacle preventing the exploration of non-legal or non-financial objectives. In Relis’ study, lawyers indicated they had little or no experience in mediation where doctors were present, though the few who did described the experience positively.74 The majority of legal participants (physician, plaintiff, hospital and mediator lawyers) offered reasons both in favour and against doctors’ attendance, and only a small proportion of participants were firmly in the ‘against’ camp.75 The reasons most frequently cited against doctors’ attendance were that it heightened emotions and animosity in mediation and, further that doctors do not instruct on the quantum of compensation so there is little practical utility in their presence.76 Interestingly, while the lawyers in the study cited doctors’ busy work schedules as a barrier to attendance, none of the lawyers interviewed by Relis raised this constraint.77

When asked about reasons in favour of doctors’ attendance, the two most frequently cited responses of participants were that it would benefit plaintiffs (acknowledging the psychological and emotional aspects of the dispute) and also to encourage settlement, though

74 Ibid 89.  
75 Ibid 92.  
76 Ibid 92.  
77 Ibid 100.
participants also acknowledged it could benefit doctors to learn from their error or lead to improvement in the quality of healthcare. The minority of plaintiff lawyers (25%) who were in the solely pro-attendance camp acknowledged that doctors’ attendance could assist with plaintiffs’ non-legal needs, including the benefit of an emotional confrontation or an explanation from the doctor. Relis concludes that for the lawyers mediation was a forum centered on strategy, negotiation, and settlement. In other words, it was a forum where ‘money talk’ played out, so lawyers generally perceived their clients’ attendance as either assisting or hindering the achievement of this settlement goal.

Participants in this doctoral study saw emotion as interfering with decision-making, with one plaintiff lawyer stating that occasionally mediation is halted to prevent a plaintiff making an emotionally-fuelled decision:

> Emotional issues, I could only guess from the defendants’ perspective and I wouldn’t like to, but from the plaintiff’s point of view sometimes, I think that the enormity of it becomes overwhelming and sometimes we have to cut mediation short because we’re concerned that there’s so much information for them to take on and the emotion of that becomes so much that they’re not — they may not make the right decision for their case. (Plaintiff Lawyer 2)

This focus on the quantum and the customary use of shuttle mediation where parties are kept in separate rooms suggests that the participants are using an evaluative or settlement model of mediation. In an evaluative model or style of mediation, the aim is to reach a settlement that accords with external norms and principles, such as the legal principles that would dictate the outcome in court proceedings. In facilitative mediation the focus is on the interests of the parties, while in a settlement model the focus is on the quantum of money that forms the settlement. Parties will gradually shift from their initial positions until they either reach an agreement or fail to settle at all, but ultimately the goal of this model is to reach settlement.

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78 Ibid 93.
80 Ibid 100.
82 Ibid 271.
83 Ibid.
84 Ibid.
The model that the participants in this study have adopted resembles the evaluative or settlement model of mediation, because it precludes dialogue and negotiation about non-legal interests and constrains the conversation around the sum of money the insurer defendant is willing to pay. Using an evaluative or settlement style of mediation in medical negligence engenders potentially negative implications around the inability to use mediation to its fullest capacity, including the inability to meet the non-financial needs of the parties which can ultimately affect future doctor/patient relations.

While the majority of participants saw emotion as a factor for plaintiffs, one practitioner who had previously acted for medical practitioners recalled a phone call where the emotional impact on the doctor was apparent:

I had a doctor call once – he was a military doctor. A young cadet had just killed themselves and he was the last person to see them. At the end of the phone call, I just said to this particular doctor, ‘Do you have someone to talk to?’ and he said, ‘Oh, I'm fine.’ I said, ‘No, no, that wasn’t my question.’ I said, ‘Do you have someone to talk to because I suspect this is really stressful for you and I just want to make sure you’re okay.’ And he, sort of, went, ‘Yeah’. He called me the next day and actually said, ‘I wanted to thank you,’ he said. ‘You caught me off guard asking me if I was okay, because as doctors, nobody ever asks us if we’re okay, we always ask if they’re okay.’ So the emotional side of it is enormous. (Court Lawyer 3)

This quote acknowledges the considerable emotional impact medical error can have on defendant doctors. In Relis’ study, physicians were asked their views on attending mediation. While they found the mediation of disputes stressful or upsetting, all 12 physicians were willing to participate in mediation, particularly as it allowed them to explain their story. The physicians viewed their presence at mediation as important in order to facilitate ‘real’ mediation, one with human interaction and an opportunity for parties to ‘feel better’. The doctors’ responses indicated their focus was also on addressing emotional and psychological needs, as well as having an opportunity to explain their perspective. While doctors and plaintiffs were on opposite sides of the dispute, their emotional needs in mediation were quite similar and in direct contrast to lawyers’ commercial or rights-based positions.

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85 Relis, above n 56, 106.
87 Ibid 107.
The majority of participants in this research saw emotion as a significant factor in medical negligence disputes. Many thought plaintiffs were ‘heavily emotionally involved’ and the experience was often ‘extremely traumatic’. Breach of trust by a doctor or a hospital was seen as a substantial factor driving emotion. The significance of these findings is that the majority of practitioners acknowledged the existence of emotion in medical negligence disputes, rather than ignoring it. Therefore it was important to explore whether the practitioners were allowing or encouraging the expression of emotion in mediation, sidelining emotion or discouraging it altogether.

6.4.2 DOES MEDIATION ALLOW FOR EMOTIONAL EXPRESSION?

Recognising the role of emotion in mediation of medical negligence disputes and allowing disputants to express emotion can assist with the transformation of conflict. Expression of emotion can also be an effective tool in prompting the negotiation to move forward. Jones and Bodtker acknowledge the importance of emotion in mediation practice and contend that to fully understand the nature of conflict, mediators must attend to the emotional triggers of disputants in recognising or defining conflict.\(^89\) However, Ryan observes that lawyers have an inherent distrust of emotion and are quick to close channels of emotional communication, even in circumstances where it might genuinely assist with negotiation.\(^90\)

Mediation literature suggests that healthcare disputes are filled with emotion and the participants in this research confirmed that emotion is indeed a significant factor in such disputes. Mediation may be a beneficial process for allowing parties to confront one another and to express emotion, particularly in personal injury or family disputes. Therefore it was crucial to explore whether this occurs in the medical jurisdiction.

When asked ‘Does mediation help with the expression of emotion?’ twenty participants said it does not. One participant did not directly respond to this question and two stated that it depended whether the dispute is viewed from the perspective of plaintiffs or defendants. Only one participant thought that mediation assisted parties to express their emotion, though the participant was a former in-house counsel so perhaps limited in the practical experience of


the other participants. Despite their view that mediation did not assist with the expression of emotion, nine participants highlighted the role of apologies in medical disputes, stating that an apology is of ‘great assistance and provides closure to plaintiffs’ and in past disputes ‘the most important [outcome] to the plaintiff was an apology from the hospital’.

In answering whether the mediation process assists parties to express their emotions, an overwhelming majority asserted that parties do not get to express their emotions because they do not actively participate in the process:

[It] doesn’t really happen. Usually in these cases, personal injury cases across the board, [a] plaintiff will attend a mediation but won’t participate in the joint session. (Defendant Lawyer 4)

No, because they don’t participate in the actual process. They participate in the sense they’re cooped up in a room and their barrister goes backwards and forwards, ‘So we’ve got some more money,’ or ‘We haven’t got enough for any more,’ as the case may be, and we’re talking about plaintiffs because there’s nothing very emotional from the defendant’s viewpoint. (Defendant Lawyer 7)

Another participant contrasted mediation of medical negligence claims with mediation of family disputes, as well as with the process of conciliation frequently used in workplace accident claims, and said the process in medical negligence radically differs:

It’s not a mediation like a Family Court mediation. It’s shuttle mediation. It’s not conciliation. It’s lawyers talking across a table and going and sitting in a room with their client so it’s not a particularly emotional thing. (Defendant Lawyer 2)

The participant described mediation as ‘shuttle mediation’ which means parties are kept in separate rooms and the mediator moves between the rooms to meet the parties, therefore this process affords no real opportunity for the parties to meet face-to-face. There are various reasons to use shuttle mediation including where there is a need to protect the physical and emotional safety of parties, to allow expression of strong emotions by one party without the other party being present, or to allow private discourse with the mediator rather than the opposing party in order to avoid blame or other emotional reactions.\(^91\) Shuttle mediation is

\(^91\) Mieke Brandon, ‘Use and Abuse of Private Session and Shuttle in Mediation and Conciliation’ (2005) 8(3) ADR Bulletin 41, 44.
necessary in circumstances where the parties are physically located remotely from one another, or to keep parties apart for safety reasons where there is a court order or apprehended violence order, as well as in international mediations where there is a need to preserve diplomacy.\textsuperscript{92} While the shuttle mediation style can be beneficial in some specific circumstances, the lack of interaction between the parties more generally reduces the efficacy of the mediation process. The emphasis is placed on the mediator who becomes responsible for communication between the parties, with risks of misreporting facts or dealing with parties’ unresolved emotional issues.\textsuperscript{93}

Boulle and Field contend that shuttle mediation is a manifestation of adversarial legal culture. They suggest mediators frequently resort to this style of mediation following opening statements and that this style is supported by lawyers who perceive that joint sessions could weaken their client’s case.\textsuperscript{94} This ‘fallback’ use of the shuttle mediation style cannot be justified in all legal settings and should arguably be reserved for circumstances where it is genuinely necessary to counteract distance, or preserve safety or diplomacy.\textsuperscript{95}

Lawyers may perceive that allowing their clients to express emotion shows weakness or risks revealing information that may give rise to a tactical advantage should the matter be litigated at trial. Many of the participants in this study who thought the mediation process does not allow for the expression of emotion explained the lack of opportunity was because the plaintiff is not physically present in the negotiation room for primarily ‘tactical’ or ‘strategic’ reasons:

So the first thing is that in almost all the mediations I’ve been engaged with, the plaintiff doesn’t enter the room with the other side. They don’t get an opportunity – mostly for tactical reasons – to explain their version of events or to express their hurt, their dissatisfaction directly to the lawyers or to the insurers. So that’s the first point. Secondly, almost all these matters are resolved with a denial of liability and with confidentiality. So how much satisfaction can the person get that there’s a recognition of what’s gone wrong and why, when those factors are at play, and then they don’t have the opportunity to say their piece. (Plaintiff Lawyer 2)

\textsuperscript{92} Boulle and Field, above n 81, 286-287.
\textsuperscript{93} Mieke Brandon, above n 91, 45.
\textsuperscript{94} Boulle and Field, above n 81, 287.
\textsuperscript{95} Ibid.
The participant explained that plaintiffs do not get an opportunity to describe their version of events or express their feelings as they are prevented from speaking for tactical reasons. The participants’ responses indicated that this was due to an apprehension that the plaintiff may inadvertently disclose material harmful to their case. A practitioner stated that defendant lawyers do not have access to the plaintiff during the mediation because they have been instructed by their lawyers not to say anything, and this defendant lawyer agreed with the approach taken by opposing colleagues:

The plaintiffs themselves don’t tend to come into the joint session and we don’t have access to them usually in the mediation process. We know they’re sitting in another room giving instructions but that’s the extent of it. Those that have sat in on a mediation don’t tend to say anything because they’ve quite rightly been told by their lawyers not to say anything.

(Defendant Lawyer 3)

A plaintiff lawyer described that keeping plaintiffs away from the defendant and their lawyer is ‘strategic’ because if the mediation is unsuccessful, the plaintiff’s lawyers want to save ammunition for trial:

Typically, we do keep the plaintiff away from the defendants so they don’t get to go in a room. Typically, the doctor who’s at fault or the hospital doesn’t come to the mediation; it’s their insurer. Rarely do they come. Typically, the plaintiff is also kept out of the mediation room and doesn’t even hear the presentation and that’s for emotional reasons, often, because of what I’ve already just said about them being emotional. But it’s also strategic, because you don’t want to give the defendant any kind of forensic advantage – you want to maintain all your forensic advantage as a plaintiff and you don’t want the defendant to see the plaintiff or know what the plaintiff’s like until the plaintiff gets in the witness box. So I’m not sure the plaintiff always gets to express their emotions to the extent they might like to at mediations.

(Plaintiff Lawyer 10)

Anger is an emotion that is particularly prevalent in the context of medical negligence disputes, especially where plaintiffs feel aggrieved that a doctor has broken the trust in the doctor-patient relationship by committing an error that has led to a devastating injury. One participant was firm in the response that mediation offers no real opportunity for closure:

Because the reasons a person may have come to see the lawyer in the first place might have been loss of trust in their longstanding doctor which might be a breakdown of, you know, a
relationship you had for a long time or being really angry or upset by what’s happened and the mediation process does not address that at all … Emotional opportunities – there’s no real opportunity there. No one gets closure in the end. (Plaintiff Lawyer 4)

Scholars have recognised that in addition to anger another emotion that can arise in conflict is fear.\(^{96}\) One participant raised the notion of fear, stating lawyers usually have to reassure plaintiffs they do not have to confront their doctor at mediation:

In terms of confronting the doctor I normally have to reassure them that they won’t have to confront the doctor and that they’ll be in a breakout room on their own and the people that they will engage with on the day is limited. (Plaintiff Lawyer 3)

This indicates that there are some benefits to keeping the parties separate at mediation, because it may protect a vulnerable party. In contrast, some participants indicated that they had experienced mediations where the parties confronted each other and were able to express emotion, which led to a positive result:

[There were] a couple of mediations where the plaintiffs were present and they certainly had an opportunity and did utilise that opportunity to speak about their injuries and the matter. And I think that in those circumstances that was probably a positive thing for them and for the rest of the parties to hear as well. But for the most part generally the clients were not there. (Court Lawyer 4)

The findings with respect to emotion mirror the findings in Relis’ study where the legal actors focused predominantly on using mediation as a settlement or bargaining arena, seemingly disregarding parties’ non-legal objectives.\(^{97}\) Relis contends that lawyers are rights-orientated and their training leads them to focus on financial issues. She holds the civil justice system responsible for ‘conditioning’ lawyers to avoid human needs, instead focusing predominantly on financial aspects of disputes.\(^{98}\)

Riskin and Welsh highlight that one of the great promises of mediation is attention to the underlying interests of parties,\(^{99}\) yet this is often compromised by the mediation procedures

\(^{96}\) Adler, Rosen and Silverstein, above n 58, 161.
\(^{97}\) Relis, above n 56, 34.
\(^{98}\) Ibid 62.
adopted by ‘repeat players’, namely lawyers, mediators and insurance representatives who have repeated contact with the legal system. Using rational or legal approaches, lawyers can adopt procedures in mediation that overly confine the issues in dispute so that attention to underlying interests such as psychological or emotional needs of the parties are excluded. Therefore, the focus on litigation can result in disputants missing out on a vital opportunity to use a dispute resolution process that suits their needs. Using a case example of parents with a disabled child caused by negligence of a hospital, they assert that the repeat players in that case largely ignored psychological and relational interests (termed personal ‘core’ issues). Mediations were structured to focus on concerns of the lawyers (rules and standards), thus sideling emotions and non-legal needs of the parties.

Riskin and Welsh contend that ‘problem definition’ is significant in the resolution of disputes, because repeat players tend to impose a narrow definition in mediation and thus limit the opportunity for discussion of other non-legal issues. To overcome this, they emphasise the need to make problem definition an explicit process so as to adopt an appropriate problem definition in dispute resolution. They propose adoption of court rules directing mediation programs specifically for lawyers and mediators with a view to mapping and setting questions in pre-mediation sessions to assist with problem definition. Further, they advocate for ‘customized mediation’ designed to fit the needs of the specific parties rather than simply use a process that focuses on standard litigation issues.

6.4.3 AN ‘ADAPTED’ MEDIATION MODEL

The participants in this study acknowledged the significant role of emotion in medical negligence disputes, yet the style of mediation used by these participants precludes emotional expression. Participants’ responses indicated that the mediation model used in medical negligence disputes strays from the purely facilitative model taught in mediation training. Instead, the ‘adapted’ model is heavily influenced by the shadow of the law so that during
mediation focus is on achieving settlement according to parties’ legal entitlements. Parties are kept out of the mediation room hence their participation is limited. One participant acknowledged that mediation of personal injuries in Victoria differs to the theoretical process based on interest-based negotiation taught in training courses:

In Melbourne or in Victoria, the personal injuries mediations don’t follow the model that the courses train you in. We’ve adapted our own. And that is, we very rarely would have a plaintiff present during the joint decision, it’s an exceptional thing. But usually the doctors aren’t present. If it’s a hospital involved, you’ll frequently get a representative from the hospital. And you’ll also have a representative of the insurer for either the doctors or the hospital. But the plaintiff doesn’t take any part. So they don’t get a chance to unload if they want to. (Plaintiff Lawyer 7)

Interestingly, this participant explained that legal practitioners in the medical negligence jurisdiction have adapted their own model of mediation, so that plaintiffs are not present during settlement discussions and do not take an active role in the negotiations. Even if the plaintiff wanted to confront the doctor, that opportunity is limited because a hospital or insurance representative frequently attends on behalf of the hospital or doctor. Therefore, no opportunity for emotional confrontation is afforded to plaintiffs. Perhaps the unique characteristics of medical negligence disputes lend itself to a tailor-made mediation model.

Medical negligence disputes involve a complex highly-specialised intersection of law and medicine, mediation of which occurs in the shadow of the law. These disputes often involve an inequality of power between a doctor or hospital who is well-resourced and a plaintiff who might have limited involvement with the legal system. Critically, medical negligence disputes frequently involve severe physical or psychiatric injury, permanent disability or even death so plaintiffs are emotionally invested in their claim. Lawyers may play a critical role in protecting their clients by shielding them from further emotional stress, but by restricting client participation in mediation the core feature of mediation, party self-determination, is compromised.

The participants’ quote above also hints at the development of a subculture amongst Melbourne’s medical negligence practitioners, who have devised their own processes or ‘way of doing things’ which places lawyers at the forefront of disputes and sidelines direct participation by disputants. Macfarlane refers to the existence of a ‘local legal culture’
amongst lawyers where communities of lawyers develop their own norms and values. Thus membership in a practice group, such as in the area of personal injury, directly contributes to lawyers’ identity and professional development, and can also have an impact on the level of cooperation, adversarialism and degrees of formality evidenced in dispute resolution. Macfarlane also asserts that lawyers are influenced by their clients, so that when faced with constantly emotional or angry clients, lawyers might adopt community strategies to blunt that emotional impact. In the medical negligence context, where disputes are often fuelled by heightened emotions, it is unsurprising that lawyers within the community have adopted a unique practice to respond to the characteristics of their clientele. This ‘adapted’ model used in Victorian medical negligence disputes requires further empirical investigation, but at its core undeniably resembles an evaluative or settlement style of mediation.

6.4.4 THE ROLE OF APOLOGY IN MEDIATION

Apologies following medical error can have critical significance in medical negligence disputes, as individuals are more likely to pursue a legal cause of action against a doctor in circumstances where they have not received an explanation, an apology or some admission of wrongdoing. In other words, the absence of an apology can have a direct influence on whether plaintiffs pursue a legal cause of action, particularly where they feel aggrieved following medical error and an apology is not forthcoming. The participants in this study acknowledged that emotion was a significant factor in medical negligence disputes, and one key avenue of addressing parties’ emotional needs is through the use of an apology.

The importance of an apology has become increasingly prevalent in negligence claims following the introduction of provisions into the Wrongs Act stipulating that an apology does not equate to an admission of liability. More recently, the Victorian Government’s Access to Justice Review report advocated for further expansion of the role of apologies as a

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109 Macfarlane, above n 8, 34-35.
110 Ibid 35.
111 Ibid.
112 Ibid 36.
114 Wrongs Act 1958 (Vic) s14I provides ‘apology’ means an expression of sorrow, regret or sympathy but does not include a clear acknowledgment of fault; and s 14J provides that an apology does not constitute an admission of liability.
meaningful way to offer redress and reduce litigation.\[^{115}\] In NSW similar provisions relating to apologies are far more expansive given in that jurisdiction an ‘apology’ includes an admission of fault, rather than merely an expression of regret. Further, in NSW the apology cannot subsequently be admitted into legal proceedings as evidence of fault or liability.\[^{116}\]

Participants in this study were not directly asked about apologies, yet nine participants discussed apologies and emphasised their importance in medical negligence claims. Some participants indicated that an apology can prevent litigation because in many circumstances a plaintiff is actually seeking an explanation, apology or expression of regret rather than damages:

> We often find that people are very aggrieved by the attitude of the doctors afterwards and there’s a real problem, I think, with a lot of doctors with communication and not wanting to deal with the consequences of their mistake and being honest about that. And I can’t tell you how many of our clients would say, ‘If he had come and explained to me what happened and apologised, I wouldn’t bother with this.’ (Plaintiff Lawyer 6)

Carroll contends that as a legal remedy, apologies can address the psychological needs of the parties and might redress the plaintiff’s loss better than an award of damages.\[^{117}\] While the participants thought the mediation process did not assist with the expression of emotion, some thought an apology was beneficial in offering emotional closure:

> Where I have seen the mediation process assist with the plaintiff’s emotions is when following the joint session, the hospital representative might say, ‘I would like to make a personal apology to the plaintiffs,’ and so then we’ll go and meet with them in their room and the hospital representative will convey an apology and I’ve seen that be of great assistance and provide closure to plaintiffs in some cases, but again it’s a rare occurrence. (Defendant Lawyer 3)

Another participant’s quote elucidated the devastation that can be felt by plaintiffs who not only experience a breach of trust when their doctor commits a medical error, but can feel abandonment when they do not receive an apology for the error:

In terms of the apology, yes absolutely. It is enormous and right from the beginning of getting a call from a new client the issue is ‘This has happened to me’, a sense of outrage, and ‘I don’t want it to happen to anyone else’. Medical cases in particular are emotional because people have such a faith in their doctor that they’ll be looked after and when that doesn’t happen the disappointment is enormous and the issue of getting a ‘sorry’ particularly in circumstances where the doctor has no doubt been told not to talk to them or to make any admissions for fear of voiding their insurance [policy]. Plaintiffs take that as they’ve just been abandoned by somebody who they thought cared about them and getting an apology is an important healing part, you know, and quite apart from the compensation to have a ‘sorry’ often is a main outcome. (Plaintiff Lawyer 3)

The quote also highlights the problems with the Victorian legislative provisions, where defendant doctors or hospitals may avoid apologising for fear of voiding their insurance policy. Another participant affirmed this and explained insurance companies are frequently reluctant to offer an apology, so plaintiffs should be encouraged to accept a financial offer of settlement as an admission of wrongdoing:

[O]ccasionally, our clients will say, ‘As part of this I want an acknowledgement or an apology,’ and in even less cases they’ll actually do it. It’s pretty rare, but occasionally it’s happened. Settlements at mediation always come with a denial liability, and it’s rare that the plaintiff gets any closure in terms of getting an acknowledgement, verbally, written, otherwise of what’s happened to them. The insurers are very, I think, quite opposed to that; and it’s, yeah, it’s not something that comes up. So generally it’s us saying, ‘Well, the acknowledgement is the fact that they’re willing to pay such a large amount of money and they wouldn’t be doing that unless they thought they’d done something wrong.’ (Plaintiff Lawyer 6)

The findings of this study indicate that apologies are a crucial part of the dispute resolution process, with nine out of 24 participants emphasising the significance of apologies following medical negligence. Further, participants thought that apologies may be particularly helpful in allowing plaintiffs to gain closure. Researchers have conducted an Australian qualitative study into the role that apologies and explanations play in medical negligence. Twenty-three individuals who were involved in adverse healthcare events were interviewed and the findings showed that open disclosure, apologies and offers of tangible support to the
aggrieved person were crucial in attaining complainant satisfaction.\textsuperscript{118} In a US study of mediations of law suits brought against New York hospitals, researchers found that apologies were offered in 25\% of the mediations studied.\textsuperscript{119} Significantly, the apologies were not delivered by physicians but by defendant lawyers, with the hospital representative or insurer echoing the apology. Direct apologies from physicians would have been difficult given that 25 plaintiffs (out of 31 cases) attended the mediation but not a single physician attended.\textsuperscript{120} The researchers concluded that the absence of the medical practitioners at mediation deprived the plaintiff of the opportunity for healing, understanding, forgiveness and repair of a broken relationship.\textsuperscript{121}

Vines contends that in order to be effective, an apology must include an acknowledgement of wrongfulness and responsibility, not simply acknowledgement that harm occurred.\textsuperscript{122} She distinguishes between a ‘full apology’ involving acknowledgement of fault, and a ‘partial apology’ consisting simply of an expression of regret.\textsuperscript{123} Vines contends that apologies occur in the context of moral communities within which civil norms exist, so that when an acknowledgement of fault occurs, the process validates the social norm that has been violated by the defendant.\textsuperscript{124} Consistent with the corrective justice approach adopted in this thesis, Vines contends that apologies operate within the parameters of corrective justice because they allow the wrongdoer to restore the equilibrium between the parties.\textsuperscript{125} Vines supports the approach used in NSW and contends their legislation is the most effective path to reducing litigation.\textsuperscript{126} Further, commentators have acknowledged that the law plays a vital role in encouraging dispute resolution, and that mediation is an ideal forum to facilitate authentic and meaningful apologies.\textsuperscript{127}

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\textsuperscript{120} Ibid 807.
\textsuperscript{121} Ibid 825.
\textsuperscript{123} Ibid 374.
\textsuperscript{124} Ibid 377-379.
\textsuperscript{125} Vines, above n 113, 502.
\textsuperscript{126} Ibid 505.
\end{flushleft}
Given the recent emphasis on apologies placed in the Victorian *Access to Justice* report, increased use of apologies in mediation of medical negligence disputes may assist to give greater procedural satisfaction to the parties by offering emotional closure and simultaneously reduce plaintiffs’ desire to pursue litigation. Nine participants in this study stressed the crucial role an apology can have in medical negligence disputes in allowing claimants’ non-legal needs to be met. Consistent with Vines’ views and recent endorsement of apologies in the *Access to Justice* report, use of a full apology with an acknowledgement of fault in medical negligence can assist to effect corrective justice between the parties in mediation, without the case having to reach trial. The participants in this study acknowledged that emotion is a factor in medical negligence disputes, particularly for plaintiffs, therefore apologies are arguably a key mechanism that should be used to assist the parties to gain emotional closure. Most importantly, apologies can restore the equilibrium between the parties and give effect to corrective justice at a much earlier stage of dispute resolution.

6.5 THE ROLE OF LAWYERS IN MEDIATION OF MEDICAL NEGLIGENCE DISPUTES

The role of lawyers in non-adversarial dispute resolution is increasingly being researched to ascertain lawyers’ attitudes and practices in these contexts. The way in which lawyers construct their role can influence the process and success of settlement. Direct participation in the mediation process by non-legal actors has been recognised as giving effect to intrinsic values of mediation such as self-determination and empowerment. Field describes self-determination as ‘the key fundamental element of mediation, particularly in terms of validating the process as a legitimate alternative to litigation.’ Self-determination lies at the core of mediation practice, and regardless of the level of involvement of the mediator, it is the parties who should ultimately remain responsible for consensually reaching an outcome. Yet giving effect to values such as self-determination can be compromised in court-connected

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130 Rundle, above n 128.


132 Ibid 181.
mediation processes, which are frequently dominated by lawyers who prevent their clients from speaking or expressing emotion. Unlike disputes involving close relationships, such as family law or estate matters, direct participation by parties in mediation is not as common in tort and commercial disputes. One of the reasons that lawyers dominate the process is to preserve their legitimacy as translators of the legal system and to maintain control of the dispute resolution process. By empowering their clients through familiarity with the process, lawyers reduce the mystery of the legal system and diminish their legitimacy.

Against the backdrop of increasing use of court-connected mediation to resolve civil disputes and the discussion of how lawyers can best contribute to mediation in the literature, it was pertinent to explore how lawyers in medical negligence disputes interact with their clients. Participants were asked how they saw the role of lawyers in mediation of medical negligence disputes, including the role of solicitors, barristers and mediators. Participants’ responses indicated a high level of lawyer involvement and control of the mediation process. None of the lawyers allowed their client to have free rein during negotiations. In many responses, the participants described their role as ‘legal advisor’, seeing their purpose as informing their clients on the merits of their case. Some participants described their role as a ‘translator’ of the legal system advising on the realistic parameters of settlement, while others saw their role as ‘protector’, shielding their clients from the stressful and emotional impact of dispute resolution.

When asked to reflect on their role in mediation, seven participants stressed that ‘proper preparation’ was a necessary aspect of their role, in order to make the mediation process meaningful and maximise the opportunity of settlement:

As a lawyer, I feel like my role is really to prepare the case for the mediation as best as I can and give it the best opportunity to resolve. (Plaintiff Lawyer 2)

My role is to make sure that I can attend fully prepared so that it’s not a waste of anyone’s time or money because they are expensive, they are time consuming and you have to acknowledge that there are plaintiffs who would be, you know, really building up to that experience… I think it’s imperative that you only agree to a mediation when you know you

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133 Rundle, above n 128, 84.
135 Ibid 207.
can make it a meaningful process. I refuse to participate in a mediation I think is going to be futile. It’s not good for my clients, it’s not good for the plaintiffs. (Defendant Lawyer 3)

One of the seven participants highlighted the importance of proper preparation in the medical jurisdiction which often involves technical medical terminology and complex evidence. This participant also explained that the art of persuasion is necessary in mediation of medical claims:

[T]he primary role is to advance the case in a compelling and persuasive manner. I don’t just rock up… Some people rock up to mediations and just say, ‘We want 500 grand; what are you going to do about it?’ In medical malpractice, that really doesn’t wash and people expect detail and they like to be persuaded, and I think the mediation open session, if you can put forward a compelling argument and the insurer is sitting in the room on the other side of the table, that can have an impact. (Plaintiff Lawyer 10)

Managing the client was also raised as an important aspect of a lawyer’s role, consistent with literature asserting that for many lawyers, management of their client’s expectations constitutes competent lawyering:

[O]n the day of the mediation itself, during the mediation I really see my role mostly as managing the client ensuring that I’m getting their instructions, that they’re feeling calm and in control about the process. (Plaintiff Lawyer 2)

So cases always involve parties identifying really what they need. Often they come to a lawyer in a medical case looking for answers because they don’t understand what happened and they want an explanation. They’re not interested in damages. But then what happens is when they start to get the explanation they get a bit angry about the fact that it’s never been made clear to them, and they’ve had to go through all this to find it out, and they’re told that compensation is not designed to punish it’s designed to restore them and that’s their right. So it opens their thought process to compensation and then, you know, managing that process in the sense of explaining to them that the compensation that you get invariably is inadequate because money making up for injury and pain – the two don’t work very well together. So all of that requires management and a lot of input. So it’s a huge process. (Court Lawyer 1)

When asked how they perceived their role at mediation, another participant offered the following response:

The master of fine detail. The organiser. The eye of the storm. [Laughs]. I mean, pick a cliché. You’ve got teenagers in grown up barrister bodies frantically panicking about this that and the other and you’re the one who’s got to stay calm, keep your client in control, keep the family in check and keep the barrister on point. Keep the mediator on side and keep the other side at a distance. (Plaintiff Lawyer 4)

These quotes show that the participants considered proper preparation as a key component of their role in mediation. However, another theme that emerged was an emphasis on ‘client control’, with the participants indicating that client management was a necessary task to be performed. The participants viewed themselves as experts in the legal field intent on dominating the mediation process with their legal expertise. They thought client control was necessary in order to restrain their client’s emotions which might be perceived to be a weakness if they disclosed information detrimental to the case outcome.

6.5.1 SPECTRUM OF LAWYERS’ INVOLVEMENT

In addition to proper preparation and client control, it was also necessary to explore the extent of lawyer involvement in the mediation process itself. When asked about the lawyer’s role in mediation, participants also provided responses about the extent of their involvement in mediation. While the participants were not expressly asked to address styles of mediation, their responses nevertheless gave an indication of the ‘adapted’ style of mediation that has developed in the Victorian medical negligence jurisdiction.

Olivia Rundle has created a five-category spectrum of lawyers’ level of involvement in mediation. One end of the spectrum represents less involvement and a lawyer can be either an ‘absent advisor’ who advises on substantive and procedural merits of the case but does not attend mediation or an ‘advisor observer’ who attends mediation to provide support and advice but will not interact with the other party or the mediator. In the centre of the

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138 Ibid 222.
139 Ibid 223-224.
spectrum is the ‘expert contributor’ who participates in mediation by providing their client with legal advice during the mediation. The other end of the spectrum represents more involvement by a ‘supportive professional participant’ who can negotiate on behalf of the client and reality test the workability of settlement. Finally, the ‘spokesperson’ is a lawyer who speaks for their client, negotiates for their client and provides legal advice but the client remains silent.

Echoing some of the characteristics of the expert contributor lawyer, one participant identified the need to construct an argument in mediation and emphasised the importance of persuasion:

As counsel for a plaintiff, you’ve got to construct an argument. You’ve got to have them condensed down but constructed so that’s easily appreciated and the other side understand exactly how you’re putting your case. You’ve got to draw on the bits of evidence that support you and ignore the ones that don’t. [Y]ou’ve got to present a scenario for a defendant that they can see that it’s a persuasive argument that can be made to the court and a jury might go for it. (Plaintiff Lawyer 7)

The participant’s response indicates the role of the lawyer is potentially far more adversarial than the expert contributor lawyer. Here, the participant has constructed a case that can persuade the opposing party’s lawyer of the likely successful outcome should the matter proceed to court. This approach fits with a lawyer’s role in the evaluative style of mediation with a focus on advocacy and persuasion.

In contrast to Rundle’s assertion that the spectrum of issues is determined by the parties themselves, the participants in this study highlighted that part of the lawyer’s role is working out the needs and interests of their clients:

Trying to work out what the client really wants and then providing the client with the advice that’s appropriate, and seeking to get a match between what the client really wants and what’s achievable. (Plaintiff Lawyer 11)

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140 Ibid 224-225.
141 Ibid 225-226.
142 Ibid 227-228.
143 Ibid 224.
In the above quote, the participant explains their role of reality testing the client’s expectations. In contrast, a different participant spoke about the lawyer’s role in formulating the thinking of their client and using their expertise to reality test the settlement:

So the lawyers have an incredibly important role in formulating the thinking of their client, getting their client to sort of look down the slot, making the client understand well look there are ranges and damages, that whole sort of picture which is terribly important to paint. And if they’ve got the confidence of the client and if they use that confidence correctly, they can say, ‘Listen, you know, look here are your risks, you’ve now been offered half a million dollars, your risks are now greater because the prospect is you might get a bit more but you might get a bit less, you’re in that grey area, you’re now at a greater risk’. Now if you’ve got the client’s confidence the client can say, ‘Yeah okay, I understand what’s going on. What do you think I should do?’ ‘I think you should settle.’

The participant’s quote reflects a distributive type of negotiation (otherwise known as zero-sum negotiation) rather than an interest based negotiation. In a distributive negotiation the parties hold opposing positions, and every gain by one party is equal to the other’s loss. \(^{144}\) Distributive negotiation is diametrically opposed to integrative negotiation which emphasises the parties’ interests. \(^{145}\) In interest-based negotiations, the parties are focused on exploring and satisfying their interests, rather than positions. \(^{146}\) By outlining the ‘zone of possible agreement’ affiliated with distributive negotiation, \(^{147}\) the participant is indicating the parameters of settlement which shifts the focus from interests to positions.

Rundle asserts that in medical negligence cases it is helpful for lawyers to adopt an expert contributor role, because in these cases legal analysis of liability is important, as are the non-legal needs of clients. \(^{148}\) In cases where a plaintiff is seeking an apology or a change in hospital procedure, Rundle suggests it is more appropriate that the plaintiff conduct the negotiations with the doctor or the hospital representative. \(^{149}\) However, as discussed earlier in this chapter, the participants in this study strongly discouraged their clients from participating in mediation for tactical reasons. This practice is reflected in a quote from a barrister:

\(^{144}\) Peter Condliffe, _Conflict Management: A Practical Guide_ (LexisNexis, 5th ed, 2016) 211.
\(^{145}\) Ibid 216.
\(^{147}\) Condliffe, above n 144, 211.
\(^{148}\) Rundle, above n 137, 225.
\(^{149}\) Ibid.
I tell people when I’m acting for plaintiffs that they are welcome if they wish to participate fully in the mediation but I would discourage that because the other side are likely to talk more frankly in their absence… It’s the role of the lawyers to encourage a resolution of the matter and to make sure the client fully understands each step of the process along the way. (Defendant Lawyer 1)

Discouraging or preventing clients from speaking at mediation is reflective of the ‘spokesperson’ lawyer who dominates the negotiation process. The client is a mere observer, who receives legal advice and provides instructions to the lawyer outside of the mediation session. This is consistent with the ‘shuttle-style’ approach described by the participants as being used in medical negligence mediations where parties are kept in separate rooms while the lawyers negotiate before a mediator. For instance, one participant stressed that mediation reflects the adversarial environment found in court where the lawyer’s role is to achieve the best possible financial result for their client:

[E]ach [lawyer] has to represent their side and it’s still an adversarial situation where the plaintiff’s counsel is duty bound to get as much as he reasonably can for his client and the defendant’s objective is to get out for as little as he possibly can… But we don’t like emotion because it blurs the judgment, and I know people say it’s good to let air out of the balloon and all the rest of it but that’s not our job, our job is to talk money, and there’s nothing very emotional about that. (Defendant Lawyer 7)

Here the participant explained that from his perspective, emotion can interfere with the ability to achieve a suitable settlement. The participants in this study frequently saw their role as getting the ‘right figure’ of compensation for their client or advancing their client’s case:

[T]he job of the legal advisors is to put their client’s case as best as it can be put, and to acknowledge the difficulties, and accentuate and emphasise the strengths. (Defendant Lawyer 6)

It’s really to try and maximise the outcome for your client. We go in there, try to convince the defendant why they should be paying a compensation sum, and then that’s really a question of them trying to – if we think that’s reasonable, then trying to convince our client if they don’t think it’s reasonable. Or sometimes you get the scenario where the client says, ‘I just want to grab the money and run,’ and we have to say, ‘Look, just hold onto your horses, there’s got to

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150 Ibid 227.
be some more there.’ So I suppose your role is just to try and maximise the best outcome.
(Plaintiff Lawyer 5)

When discussing their role at mediation, many participants spoke about achieving the ‘best outcome’ for their client in reference to fiscal objectives, reflecting that the parameters of negotiation occur within the shadow of the law:

My duty is to do the best I can for the client. And what I say to [clients] is also, you know, ‘What we want to do is to leave here today understanding what’s the last dollar they’re prepared to pay.’ You know, we don’t want to send them home without money in their pockets, you know. We might take their money, we might not, but what we want to do is get to the point where we know, ‘This is the most they’re prepared to pay.’ (Plaintiff Lawyer 8)

The above three quotes indicate that the lawyers in this study sidelined emotion in order to focus on achieving the ‘right figure’ or the ‘best outcome’ for their client. This indicates that the shadow of the law impacts upon the focus of mediation, turning the focus into a legal rights-based one, rather than heeding the non-legal needs of the parties. The participants voiced a preference to focus on quantitative financial objectives, upholding their client’s legal rights and attaining a settlement that they deem to be the best financial outcome for their client. The participants are sidelining non-quantitative and non-legal interests such as the capacity for the plaintiffs to have their story heard, to receive an acknowledgement of their injury and suffering, or to receive an apology from the medical practitioner. For defendants, there is also a missed opportunity to learn about the impact of their error or to explore changes in medical procedure. These quotes indicate medical negligence lawyers are adopting an evaluative mediation style, using a shuttle procedure to conduct the mediation. The participants showed empathy and care for their clients, but this translated into a goal of achieving a desirable financial settlement on behalf of their client.

When lawyers dominate the mediation process and thereby exclude direct disputant participation, such an approach can compromise parties’ self-determination in reaching a settlement. Confirming Menkel-Meadow’s concerns about lawyers colonising ADR, the findings of this study indicate that lawyers in the Victorian medical negligence practice group are sidelining their clients’ involvement in mediation in favour of rights-based settlement.

goals. By transferring adversarialism into the mediation room, lawyers risk robbing their clients of the ability to express themselves and pursue non-legal or non-financial objectives. This approach is consistent with an evaluative rather than a facilitative mediation style, and closely mirrors the traditional adversarial role of a lawyer in litigation.\textsuperscript{152} However, it may also be argued that the lawyers have shaped the mediation of medical negligence disputes into a unique process that assists rather than hinders the parties. Rundle contends that lawyers have significant influence in shaping how the dispute resolution process is conducted, as well as influencing their clients’ needs and expectations from dispute resolution.\textsuperscript{153} Alternatively, rather than perceiving the Victorian medical negligence lawyers as having colonised mediation, their adaptation of a model that fits this niche practice area may be viewed as practical and effective.

The participants’ responses indicated that the majority of the roles adopted by lawyers at mediation were that of ‘spokesperson’. The ‘spokesperson’ lawyer is highly interventionist, and this may be appropriate in circumstances where there is a power imbalance between the parties, or where direct participation may expose the more vulnerable party to disadvantage.\textsuperscript{154} Rundle contends that in such circumstances a highly interventionist approach may assist in rebalancing the parties and ensuring the mediation proceeds fairly.\textsuperscript{155} This approach can be particularly valuable to medical negligence claimants, likely inexperienced one-shot players, when opposed to repeat players in the form of insurance representatives and their lawyers. Two participants explained that taking on the spokesperson role at mediation was akin to acting as protector of their clients:

I suppose our role is to protect our clients. And that means a variety of things, I suppose. It means making sure that the settlement is a reasonable one, but it also means giving them very clear advice as to when the risks of proceeding and the potential outcomes outweigh the potential benefits. (Plaintiff Lawyer 6)

[F]rom the plaintiff’s perspective, the lawyers create for the client a protection, because the client goes into a mediation with a barrister, with a solicitor, with a big fat file and everyone’s sort of well-armed, and the client feels comfortable in that environment because he or she is

\textsuperscript{152} Douglas and Batagol, above n 128, 766.
\textsuperscript{153} Olivia Rundle, ‘Are We Here to Resolve Our Problem or Just to Reach a Financial Settlement?’ (2017)
\textsuperscript{141} Precedent 12, 14.
\textsuperscript{154} Rundle, above n 137, 227.
\textsuperscript{155} Ibid.
being protected, represented, and has confidence built and if that happens, the client’s going to listen. (Court Lawyer 2)

Lawyers acting as a ‘spokesperson’ may be beneficial in circumstances where there is a breakdown of an existing relationship, such as between a doctor and patient, and also where the client is suffering from a psychological disorder. Therefore in mental harm claims the client may benefit from having a spokesperson lawyer to shield them from emotional stress. However, by dominating the mediation process lawyers may deprive clients from a valuable opportunity to address emotional and psychological aspects of the dispute.

Non-adversarial justice approaches encompass the role of emotion in legal problems and advocate for resolution techniques that address the psychological aspects of disputes. For instance, the therapeutic jurisprudence movement advocates for legal professionals to recognise and incorporate emotions in problem-solving. In the medical negligence context, emotions can frequently be fuelled by painful injuries or a breach of trust with a doctor, so addressing emotion can be crucial in reaching a resolution. It may also be valuable for parties to be able to tell their side of the dispute in mediation as it provides the experience of procedural justice for court users. Procedural justice theory argues that giving parties voice, courtesy and respect in a court process can assist with the acceptance of court outcomes. This may be particularly true in medical negligence disputes as these disputes can be emotional due to claimants often wishing for an explanation of the negligence and potentially an apology.

Similarly, restorative justice recognises that harmful behaviour can have a negative impact on psychological or emotional wellbeing, so it promotes emotional healing through dialogue between the offender and victim. While restorative justice derives from the criminal justice system and primarily applies in victim-offender contexts, restorative practices can also be used in civil disputes. For instance, restorative justice approaches can address the harm

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156 Ibid.
158 Ibid 1118.
160 King, above n 157, 1098.
created by medical negligence, and hold the negligent parties accountable. The findings of this study thus indicate that mediation is potentially not being used to its fullest extent to address parties’ emotional needs and suggest that practices akin to restorative justice conferencing may offer a more suitable process to cater to parties’ emotional and psychological needs.

6.5.2 DISCUSSION

Analysis of the data indicates the participants in this research tended to dominate the mediation process, with the parties frequently absent from negotiations. This is supported by empirical research which has frequently found that lawyers have a tendency to restrict client engagement, limit discussion to legal issues and only involve clients in decision-making when it is absolutely necessary.\(^\text{162}\) The focus of the lawyers in this study was on achieving the best outcome for their client but this was constrained to quantum rather than encompassing what their client actually wanted. A focus on quantitative objectives meant that non-financial objectives were removed from the equation and non-legal objectives of the parties such as a desire for an explanation or an apology were sidelined.

This finding is consistent with a Canadian empirical study of legal and lay actors in personal injury disputes, which found that parties’ objectives in mediation are on emotional, psychological and extra-legal needs whereas the lawyers’ focus was on strategy, tactics and financial objectives.\(^\text{163}\) Relis argues that the findings of her study highlight important contradictions in legal policy and initiatives in the resolution of civil disputes, because the system is not serving disputants’ needs.\(^\text{164}\)

The approach taken by lawyers in this study was consistent with the findings of a different study of mediation use in the County and Supreme Court in Victoria, which found that mediation was conducted in a manner preferred by lawyers, as opposed to their clients.\(^\text{165}\) Further, the study found shuttle negotiations were most common with minimal party


\(^{163}\) Relis, above n 56, 10.

\(^{164}\) Ibid 5.

\(^{165}\) Tania Sourdin, Mediation in the Supreme Court and County Courts of Victoria (Department of Justice, Victoria, 2009) iv.
engagement. These findings are consistent with the evaluative mediation style adopted by participants who adopted a shuttle procedural method of conducting mediation. In contrast, one research study involving interviews with medical negligence claimants reported that the degree to which clients want involvement in their claims can vary, with none of the participants stating they wanted more control of the claim and many who were content to delegate that responsibility to their lawyer. However, most claimants in that study did report they initiated legal action for non-legal outcomes, such as an explanation or an apology, a fact that was not fully appreciated by lawyers who focused predominantly on financial outcomes.

The participants in this study favoured an evaluative, rights-based style of mediation or settlement approach and used advocacy skills to persuade the opposing party of the likely success of the case should the matter proceed to trial. Despite the tendency to adopt a ‘spokesperson’ role at mediation, the participants did not embody an adversarial culture. Rather, the participants exhibited a cooperative settlement culture in the medical negligence context.

The lawyers in this study were repeat players who were highly-experienced, had adapted their own mediation style to suit this niche jurisdiction and potentially their own preference to control negotiations in mediation. The participants had created a separate culture that was tailor made for the medical negligence context, with lawyers handling complex cases and managing clients fraught with emotion. The lawyers interviewed were highly-skilled and deeply concerned for their clients. They valued protecting their client from further harm, but that protection meant that lawyers colonised the mediation process and prevented their clients from expressing emotion. The mediation tended to focus on achieving the best financial outcome for the client, because lawyers viewed that as the primary remedy to help their client. Consequently they missed out on the opportunity to explore non-quantitative and non-legal interests of the parties.

166 Ibid 48.
168 Ibid 187.
169 Rundle, above n 137, 227.
170 Macfarlane, above n 33, 241; Macfarlane, above n 8.
171 Riskin and Welsh, above n 99, 864-865.
Analysis of the data indicates that lawyers largely colonised mediation as a vehicle for bargaining to achieve a desirable settlement, but by doing so they may have neglected significant benefits offered by the early promise of mediation, particularly the element of self-determination. Yet, it could also be said that the lawyers have arguably shaped the mediation process in this niche jurisdiction to a process that is best suited in the medical negligence context. Crucially, the process of court-connected mediation in medical negligence, doctors’ reluctance to attend mediation, and insurance representatives’ domination of the process to focus on financial objectives all make it difficult to alter the styles of mediation that have been adapted.

The lawyers practising in medical negligence showed a strong ethic of care, which Relis acknowledges is an important aspect of legal practice. Kimberlee Kovach has advocated for a shift in lawyers’ responsibilities to incorporate an ‘ethic of care’ which focuses more on human needs rather than legal rights and duties. Kovach stresses the importance of legal education towards non-adversarial practice for lawyers working in mediation and contends that, ‘if mediation is to survive as a formidable, unique process with the characteristics remaining that have made it a process resulting in party satisfaction, then practices and procedures with regard to lawyers’ conduct in the mediation process must change, commencing with legal education.’

Julie Macfarlane contends that legal education is an important site for reforming lawyers’ professional identity, especially in assisting a cultural shift towards non-adversarial practice. While the participants’ responses did not suggest legal education as a site for reform, analysis of the data about lawyers’ roles in mediation highlights the importance of educating lawyers about the benefits of ADR, both in law school and through continuing legal education. This may assist lawyers to recognise the importance of party self-determination in mediation and facilitate expression of emotion by parties in medical negligence disputes.

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172 Menkel-Meadow, above n 151, 34-35.
173 Rundle, above n 153, 14.
176 Ibid 972.
177 Macfarlane, above n 8, 223-224.
6.6 CONCLUSION

The findings relating to mediation indicate a range of important implications for mediation theory and practice, including the extent of engagement with the process and the role that lawyers play in mediation, particularly with respect to lawyers acting as gatekeepers of their clients’ emotions. Participants in this study showed a high level of engagement with mediation for resolution of medical negligence disputes which was undoubtedly assisted by legislative endorsement and court practice directions. The participants endorsed the classical attributes of mediation, including cost savings, speed and less emotional stress for their client.

Despite the majority of participants acknowledging that emotion was a significant factor for plaintiffs in the resolution of medical negligence disputes, parties were prevented from expressing emotion in the mediation process. Lawyers tended to dominate the mediation process and tended to transfer the adversarial culture from the court room to mediation. The focus tended to be on legal rights and financial objectives, with limited opportunities for apologies and expression of emotion. These findings relate to broader themes, including adversarialism and the culture of lawyers. With the advent of legislation and case management tools targeted at promoting greater use of ADR in dispute resolution, it may be timely to consider introduction of pre-action protocols in medical negligence. Further, the use of legal education can assist to foster a cultural shift in lawyers to the less adversarial spectrum. Evidently, the findings suggest there may still be a long road to travel before emotion will form part of the discourse of mediation in court-connected contexts.
CHAPTER 7 – CONCLUSION

7.1 INTRODUCTION

The purpose of this chapter is to discuss the research findings and consider the two central research questions of this doctoral study, which concern the challenges in litigation and mediation of medical negligence and mental harm claims in a post-Ipp era. Following a brief introduction, this chapter begins by presenting an overview of findings, then summarises those findings from the qualitative interviews undertaken and outlines the significance and the contributions of this research to medical negligence practice. Next, the discussion section outlines the potential for policy reform, both nationally and internationally, emanating from the findings of this study, and advocates strategies which could be adopted to effect reform. This is followed by an outline of the research limitations and recommendations for future research.

The ultimate objective of this research was to encourage policy reform to remove the barriers to compensation in meritorious claims, and to explore the operation of mediation in this practice context. Specifically, the two research questions were (1) Have the 2002-2003 amendments to the Wrongs Act resulting from the Ipp Reforms had any effect on the litigation and mediation of meritorious medical negligence claims? and (2) What impact are the 2015 amendments to the Wrongs Act likely to have on the litigation and mediation of medical negligence disputes? This research has captured insights from tort practitioners to better understand how legal processes and dispute resolution procedures operate in Victorian medical negligence and mental harm claims, and to highlight the challenges and shortcomings of these processes.

As indicated earlier in this thesis, the research approach adopted a qualitative methodology to gather the experiences of senior tort lawyers, barristers, and judicial officers in Victoria, specific to medical negligence reforms and the use of mediation in such processes. Despite many scholarly writings that critiqued the impact of the Ipp Reforms, this research represents the first study undertaking an exploration of the perceptions of legal actors in the Victorian medical negligence context. As the first study of its kind, this research is unique in that it
gathers the perceptions, and offers the perspectives of practitioners and judicial officers practising in the field.

The literature on medical negligence and mediation practice, together with theories of corrective justice and economic efficiency, were used as a lens to analyse the data for this research. Whilst data was gathered in Victoria, the findings are valuable in informing other Australian jurisdictions that have adopted similar or identical statutory restrictions stemming from the Ipp Reforms. The findings from this research study into mediation practice of medical negligence have the potential to inform the reform and practice in other Australian states, as well as in international jurisdictions.

The first part of this thesis, in Chapters Two and Five, focused on the challenges in litigating medical negligence claims. The most significant research finding from the study was an underlying theme of unfairness in the resolution of medical negligence disputes. A majority of participants highlighted that satisfying permanent injury thresholds for plaintiffs was the most significant challenge experienced by lawyers in medical negligence disputes, followed by restrictions imposed by caps on damages, and the restrictive test of causation. Unfairness was a dominant theme in the data relating to mental harm claims, as participants discussed their perception that the law discriminated between physical and psychiatric injuries by imposing higher barriers for the latter.

The majority of participants stressed that satisfying the causation test presented as a hurdle to plaintiffs. Some practitioners qualified this commentary by explaining that the test for causation is inherently difficult to satisfy for any negligence claim, and this difficulty does not emanate solely from the Ipp Reforms. The majority of research participants expressed a view that the 2015 reforms are likely to have some positive impact on the ability of plaintiffs to recover compensation, although participants acknowledged that the full nature and extent of that impact is difficult to determine so soon after the reforms.

When discussing their perceptions of litigation trends and compensation payments before and after the Ipp Reforms, most participants stated that they perceived the number of litigants was lower, as many claims that would have been viable prior to the introduction of injury thresholds were no longer sustainable. This is because plaintiffs with injuries that do not meet
the physical or psychiatric injury thresholds are excluded from claiming compensation for non-economic loss, therefore claims solely for non-economic loss that are unlikely to meet the threshold are simply not pursued.

Participants’ responses were divided on the issue of whether, in their experience, the reforms have resulted in changes to the compensation payments received by plaintiffs. Participants were unable to comment with certainty on an increase or decrease in payments for all Victorian claimants without relying on empirical data, but their responses were based on their experiences attaining compensation on behalf of their clients. The participants perceived that claimants who would have previously been able to attain compensation prior to the introduction of the thresholds were now unable to attain any compensation. The participants perceived that claimants who met the thresholds were receiving higher compensation, particularly in light of the 2015 increase to the non-economic loss damages cap. While the practitioners’ responses are helpful in offering an insight into their perception of litigation trends, an obvious limitation of the qualitative responses is that it does not provide objective empirical data based in fact.

Analysis of the interview data showed that the participants considered that significant injury thresholds, caps on non-economic loss damages and the principle of causation presented as unfair barriers to plaintiffs’ ability to attain compensation for meritorious claims. Research participants perceived the current regulatory framework as excessively restrictive, which adversely impacted injured plaintiffs, engendering unfairness and discrimination. This finding supports the need to explore alternative avenues for regulating entitlement to personal injury damages, including: amending significant injury thresholds; changing caps on damages and causation; or alternatively adopting a ‘no-fault’ compensation scheme, like those currently used in foreign jurisdictions, such as New Zealand.

The second part of this thesis, in Chapters Three and Six, focused on mediation practice in medical negligence. The focus of the study was on court-connected mediation, rather than dispute resolution mechanisms used by hospitals following medical error. The use of court-connected mediation to assist dispute resolution was endorsed by all research participants, who stated that mediation was speedier, offered confidentiality and less emotional stress, promised more certainty of an outcome, and was less expensive than trial. All participants
described their experiences of participating in mediation processes, either due to its compulsory, court-ordered nature, or because it was an ingrained dispute resolution process in their professional culture. The nature of the ‘role of the lawyer’ emerged as an important theme from the research, as the data indicated that practitioners in this field tend to dominate the mediation process on behalf of their client, often acting as an ‘advocate’ or ‘translator’. Participant responses indicated that lawyers tended to control the mediation process. None of the participant lawyers allowed their clients to have ‘free rein’ during negotiations, meaning they were reluctant to allow clients to have freedom of expression in mediation. Many participants described acting as an ‘advocate’ for their client, by presenting strong arguments to convince the opposing side of the merits of the plaintiff case. Some participants described their role as a ‘translator’ of the legal system, offering advice about realistic parameters for the settlement of claims.

The dominance of lawyers at mediation was shown to affect the mediation style and procedures used. Participants recorded use of an ‘evaluative’ rights-based mediation style that focused on legal rights and financial objectives, without including attention to the non-legal and non-financial objectives of the parties. Emotion in mediation emerged as another important theme, with the majority stating it was a factor in the mediation of medical negligence disputes, yet the expression of emotion was only permitted in limited circumstances. Participants indicated that ‘shuttle’ mediation was the preferred procedure for conducting mediation, where parties were kept in separate rooms, whilst the mediator moved between them. This finding suggests that lawyers may not be using mediation to its fullest potential to allow parties to explore issues including emotional and non-legal objectives, such as the need for an explanation, or an expression of regret or apology for the harm caused to them.

Further, the mediation culture of Victorian medical negligence lawyers favours an evaluative style which prevents the non-legal and non-financial interests of the parties being met. Whilst responses from medical negligence lawyers demonstrated that they value mediation, the findings of this study show that their actions in dominating the process meant that the ability of parties to fully maximise the benefits of mediation were curtailed. The potential for parties to tell their story of the dispute, and to be given a voice in the process was discouraged by the lawyers due to the fear that parties may inadvertently harm their own claim. This also meant
that parties were not given the opportunity within the conflict resolution process to achieve a level of emotional dialogue which may enhance the potential for closure. Practitioner participants adopted a style of mediation that favoured advocacy and persuasion. Prioritising the pursuit of monetary objectives diminished the opportunity for procedural justice through ‘party-voice’ and ‘self-determination’ during mediation. This finding supports the need to explore whether change in legal education, where a focus on valuing the emotional and non-legal needs of the parties during the mediation process, has the potential to shift the culture of lawyers and enhance their role in the mediation of medical negligence disputes.

7.2 THRESHOLDS, CAPS AND THE TEST FOR CAUSATION ARE RESTRICTIVE FOR PLAINTIFFS

The first research question explored whether amendments to the Wrongs Act, resulting from the Lpp Reforms, influenced the litigation and mediation of meritorious medical negligence claims. To address this, practitioner participants were asked about the challenges they experienced in managing medical negligence and mental harm claims. As discussed in Chapter Five of this thesis, the findings indicate that thresholds, caps on damages, and the test for causation presented barriers to successful recovery of compensation by injured plaintiffs. Participants were asked an open question regarding the challenges faced by claimants in medical negligence claims, followed by the same question with regard to mental harm claims. The participants were able to list more than one challenge faced by claimants. Fifteen lawyers reported that significant injury impairment thresholds were the predominant challenge in medical negligence claims. Nine of the participants considered that thresholds were the principal challenge in mental harm claims. Unfairness emerged as a recurrent theme. Many participants described harrowing circumstances where plaintiffs with a significant injury could not satisfy minimum permanent injury thresholds to qualify for compensation. When describing the thresholds, participants frequently used the word ‘unfair’ to describe the consequences of the current framework. Although some participants did not expressly use the word ‘unfair’, the theme of unfairness emerged. Explanations for this unfairness included discussion of the disparity between significant injury percentages for physical harm (more than 5 per cent) and psychological harm (10 per cent or more) demonstrating a divide in how the law treats different injuries in the legal system. Several participants believed this divergence represented discrimination by
the law between physical and psychological injury, which is a view echoed by leading academics.¹ Research participants indicated that unfairness emerged in the caps on non-economic loss damages that impact upon non-working parents, children and the elderly who could not claim for economic loss because they could not demonstrate ‘loss of earnings’. As a result, these claimants relied on damages for non-economic loss, which includes pain and suffering, and loss of amenity, however the monetary ceiling for this category is restrictive.

When asked about continuing challenges following the Ipp Reforms, six participants responded that the statutory test of causation was complex and unnecessarily restrictive. These six participants cited numerous reasons to explain this, including the complexity of satisfying this element of negligence when proving negligence; combined with the lack of clarity in interpretation and application of the statutory test. Participants were subsequently asked, ‘In your view, does the element of causation present as a hurdle to plaintiffs succeeding in a negligence case?’ Eighteen participants expressed the view that it does, stating that establishment of causation was the ‘largest hurdle’, a ‘massive hurdle’ or the ‘biggest issue’ in medical negligence proceedings. Participants elaborated that difficulties arose when plaintiffs needed to establish their injury was significantly worse due to a direct causal correlation with their doctor’s breach of duty. For example, where there is lack of treatment, incorrect treatment or failure to diagnose a terminal illness such as cancer, establishing the causal link can be difficult.

Many participants compared medical negligence cases to the schemes addressing workplace injuries or transport accidents, and suggested that these compensation schemes offered an easier mechanism for claimants to recover compensation. These findings show that under the fault-based common law system currently operating in Victoria, hurdles such as causation and significant injury thresholds pose substantial barriers to a plaintiffs’ ability to recover compensation.

Participants were also asked to reflect upon their perceptions about the changes in the number of litigants commencing medical negligence disputes, as well as the compensation payments received after the Ipp Reforms. Participants’ responses reflected their perceptions and were not informed by empirical data. For instance, participant commentary about the lower number

of plaintiffs commencing medical negligence claims was based on their observations of the number of new clients attending initial consultations with lawyers.² Thirteen participants perceived the number of litigants pursuing medical negligence claims as lower, and they attributed this change to the imposition of the significant injury thresholds introduced in the wave of the Ipp Reforms. However, practitioners qualified their statements by stating that litigation itself is complex and expensive. Regardless of the presence of thresholds and caps on damages for medical negligence claims, both before and after the Ipp Reforms, the practitioners perceived that there would always be claims that were not worth pursuing because these claims were not financially viable.

When asked whether they perceived compensation payments received by litigants was lower or higher after the Ipp Reforms, 10 participants stated that they had not observed a noticeable difference, despite the introduction of caps on damages. Six participants thought litigants were receiving higher sums of compensation because low quantum claims were no longer being pursued in courts. Four participants perceived that compensation payments were now lower. Ten participants did not observe a difference, whilst the remaining four participants were unable to comment without empirical data. When asked the same question about mental harm claims, notably 12 out of 24 participants thought that the thresholds and caps introduced by the Ipp Reforms had adversely affected the compensation in mental harm claims, attributing this to the law’s scepticism regarding psychiatric claims.

In view of the 2015 amendments to the Wrongs Act, particularly the increase to the caps on damages, and a lowering of the psychiatric and spinal injury thresholds, participants were questioned about whether the subsequent reforms would affect the ability of plaintiffs to recover compensation. Seven participants stated that the reforms were minimal, and unlikely to have a substantial impact. When discussing the increase in the upper ceiling for non-economic loss damages, participants explained that only a small proportion of the injuries (such as cerebral palsy or quadriplegia claims) would likely merit the maximum award. In their opinion, the amendment would have little practical significance to the majority of claims classified as within the ‘mid-range’ of the compensation spectrum. Eleven participants perceived that the reforms would have a substantial impact, and attributed this to the decrease in the thresholds. Participants explained that the decrease from ‘more than 5 per cent’ to ‘5

² Such as clients who had sustained an injury, but could not pursue a claim as they did not satisfy the threshold.
per cent or more’ for spinal injuries and ‘more than 10 per cent’ to ‘10 per cent or more’ for psychiatric injuries would likely permit many more claimants to qualify as eligible to recover compensation. The recent nature of the reforms means that their impact cannot be fully captured currently. It is envisaged that over time, the 2015 reforms will present a rich site for further empirical study.

7.2.1 SIGNIFICANCE OF THE FINDINGS

The findings outlined in Chapter Five of this thesis are significant, because they demonstrate that the effects of the restrictive Ipp Reforms continue to impact upon claimants who are dependent on compensation. The rigid nature of the thresholds, and their assessment per the AMA Guides and the GEPIC tool fail to adequately consider qualitative evidence of the impact of an injury on a person’s life. Victims of medical negligence who are dependent on non-economic loss damages are restricted in the sums of money they can receive even if they satisfy the thresholds.

Data analysis in this thesis pertaining to thresholds, caps and the test for causation was conducted through the lens of corrective justice theory, which imposes an obligation on the wrongdoer to repair the harm caused to the victim.3 In tort law, corrective justice theory requires a negligent person to repair an injured person’s loss through compensation. Contemporary academics support the use of corrective justice theory to explicate the foundations of negligence law.4 In contrast, distributive justice focuses on the equal distribution of resources across a community so that benefits and burdens are equally dispersed.5 The principle of causation conforms to corrective justice theory, by providing that claimants are only able to recover losses from a defendant wrongdoer who is responsible for the loss, and who caused that loss.6 Alternatively, economic efficiency theory centres on the economic welfare of the community by minimising costs.7 Economic efficiency theory has been discussed in Chapter One of this thesis as the theoretical model underpinning the reasons for the Ipp Reforms.

In the context of causation, liability does not fix onto a ‘single causal attribution’, but draws from a plethora of social, moral, political and economic considerations.⁸ Danuta Mendelson maintains that the Australian judiciary has tended to apply principles of economic efficiency in case law, whereas the reforms to the *Wrongs Act* have been influenced by corrective justice theory.⁹ Mendelson explains economic efficiency theory as being akin to distributive justice, by allowing judges to impose liability on defendants even when the plaintiff cannot satisfy causation, as the theory considers that the wrongdoer should be held responsible.¹⁰ In contrast, corrective justice theory requires the court to apply legal principles pertaining to breach of duty and causation, requiring the court to undertake a comprehensive factual analysis to reach a decision.¹¹

A fault-based tort system that requires plaintiffs to satisfy the elements of negligence to pursue a cause of action to attain damages, is consistent with corrective justice theory. This requires a plaintiff to demonstrate that a medical practitioner acted negligently, thus fault is attributed to justify the imposition of liability.¹² The findings of this doctoral study indicate that the current system of tort regulation does not give effect to corrective justice principles between the parties, as the combined effect of the statutory principle of causation, significant injury thresholds, and caps on damages are too restrictive. Therefore, the law cannot accommodate corrective justice principles between the parties because wrongdoers are not required to restore the harm suffered by the victim. In many circumstances in medical negligence claimants are unfairly denied access to compensation, thus preventing restoration of the equilibrium between the parties.¹³

The 2015 reforms were an acknowledgement by the Victorian government that the compensation system in Victoria was flawed as a result of the restrictions imposed through the Ipp Reforms. These recent reforms reflect positive action taken by the legislature to reduce barriers in obtaining medical negligence compensation. The responses of the

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⁸ Mendelson, above n 5, 457.
⁹ Ibid 458.
¹⁰ Ibid 457.
¹¹ Ibid 458.
participants demonstrated a desire for further refinement of existing laws. When questioned about further reform, most participants cited the removal of impediments to a plaintiff being able to sue in instances of negligent treatment, particularly the removal of permanent injury thresholds, as needing amendment. Many participants cited problems with the statutory test of causation, and the caps on non-economic loss damages, as the cause for limiting access to damages. Multiple participants emphasised that the claims process under the statutory work injury and transport accident injury schemes were simpler mechanisms, enabling victims to attain compensation. The data shows two opportunities for future reform:

1. Amending aspects of the existing system including lowering the minimum significant thresholds, increasing caps on damages, amending the statutory causation test, and adopting the narrative test; and
2. Replacing the common law fault system with a no-fault system such as the scheme operating in New Zealand.

7.2.2 REFORM 1 – AMEND THE EXISTING FAULT-BASED SYSTEM

The simplest and most cost-effective avenue for reform would be retaining the fault-based tort system presently operating in Victoria, and reducing restrictions through further legislative amendments to the Wrongs Act. Research participants perceived that the injury thresholds were the primary hurdle preventing claimants from recovering compensation in meritorious medical negligence and mental harm claims, as thresholds were the most common challenge cited by the participants. To succeed, claimants must have sustained a degree of impairment of the whole person resulting from the injury, which needs to be assessed by a medical practitioner as meeting the threshold level. The prescribed threshold level under the Wrongs Act means impairment of ‘10 per cent or more’ for psychiatric injury, impairment of ‘5 per cent or more’ for spinal injury and impairment of ‘more than 5 per cent’ for all other physical injuries.

Chu characterises the imposition of significant injury thresholds as ‘unethical’ and the ‘most controversial’ of the legislative changes affecting personal injury damages. Mullany

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14 Wrongs Act 1958 (Vic) s 28LF.
15 Ibid s 28LB.
contends that the thresholds and caps are ‘arbitrary and artificial’ and unsubstantiated by legal reasoning, manifesting in a mesh of principles devoid of any clarity. Criticisms that the current right to compensation is determined upon an arbitrary figure are warranted, because assessment of an injury under the present legislative framework is predominantly quantitative and does not consider the impact of an injury on a claimant’s life. Whilst each chapter of the AMA Guides addresses ‘pain’ as a component of injury, chapter 15 of the AMA Guides, which deals with ‘chronic pain’ is excluded. Lastly, the thresholds do not consider the personal circumstances of claimants, such as the extreme significance of a loss of a finger by a pianist, which would attract minimal compensation, despite having a drastic impact on the victim.

Mullany elaborates that thresholds do not remove the cost of injury from the community, but shift costs to the injured person, and therefore to the community more generally. From an economic efficiency theory perspective, thresholds do not reduce the costs of accidents to society. Restricting the compensation paid to claimants, forces injured members of the community to bear the cost of the injury, or seek alternative avenues of funding to support themselves whilst unable to continue working, which typically mean depending on social welfare payments for income or relying on the public health system to fund medical treatment.

The introduction of thresholds in 2002-2003 has been described as eroding common law rights, as injured claimants cannot recover compensation for non-economic loss without meeting minimum thresholds. King asserts that the thresholds breach human rights, particularly the right to the protection of the law without discrimination. This is evident where individuals, who are unable to seek economic loss damages, become reliant on non-economic loss damages (such as non-working parents, children and the elderly). The present system unfairly denies compensation to claimants who have legitimate injuries but cannot

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18 Wrongs Act 1958 (Vic) s 28LB.
20 Mullany, above n 17, 880.
21 Chu, above n 16, 156.
23 Charter of Human Rights and Responsibilities Act 2006 (Vic) s 8(3).
meet required thresholds. When asked about challenges in attaining compensation for medical negligence, 15 out of 24 participant responses indicated that significant injury impairment thresholds were the predominant challenge. While participants were invited to list multiple challenges, their responses emphasised the unfairness and injustice presented by the permanent injury thresholds in particular. For mental harm claims, nine participants believed the thresholds were the principal challenge.

At the time of implementation, former Victorian Premier Steve Bracks explained that the thresholds would reduce damages in small claims of $50,000 or less, and thus alleviate the pressure on businesses and professionals concerned about facing successive minor claims. Yet more than a decade later, Attorney-General Martin Pakula acknowledged that ‘the [Ipp] reforms have disproportionately affected the rights of claimants to access damages, and some deserving claimants have been denied compensation.’ Personal injury thresholds and caps on damages essentially relinquish tortfeasors from their responsibility to amend their wrongs, contrary to principles of corrective justice. While the 2015 reforms did reduce some restrictions, the failure to address all the issues identified in the report has meant that many of the restrictions have not been eliminated. For instance, individuals will risk missing out on compensation due to the continued operation of injury thresholds, and differences in outcomes for similarly injured individuals will continue to occur across the major injury compensation schemes in Victoria. Further, assessment of injuries will continue to be conducted on a predominantly quantitative basis, as VCEC did not recommend the adoption of a narrative test.

Injury thresholds also unfairly curtail the rights of claimants to recover compensation for psychological injuries. Not only are thresholds for psychological injuries set at double the percentage of impairment compared to physical injury but claimants pursuing a mental harm claim must also satisfy the hurdle requiring them to show ‘normal fortitude’ and a ‘recognised psychiatric illness’. Peter Handford contends that the statutory ‘codification’ of mental harm principles has had a detrimental effect on the law in two ways. First, the lack of

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24 Victoria, Parliamentary Debates, Legislative Assembly, 21 May 2003, 1782 (Steve Bracks, Premier).
25 Victoria, Parliamentary Debates, Legislative Assembly, 16 September 2015, 3281 (Martin Pakula, Attorney-General).
27 Wrongs Act 1958 (Vic) s 72.
consistency between states (as outlined in Appendix 6) could mean a plaintiff might succeed in one state, but not another because some states, such as Queensland and the Northern Territory, retain common law principles. \(^{28}\) Secondly, provisions exclude liability for some situations where the common law has recognised liability for psychiatric injury. \(^{29}\) Forster and Engel assert that the civil liability reforms have further reinforced the historic distinction between physical and mental harm injuries. They call for a more effective compensation framework which would reduce the direct and indirect costs of mental injury. \(^{30}\)

The first recommended option for reform is the removal of injury thresholds. In its place the Victorian Government could implement a graduated general damages system, akin to the legislative principles operating in Queensland and South Australia. Queensland uses a sliding scale between 0 and 100 to allocate a point value for injuries. \(^{31}\) The point value then determines the level of compensation payable. To illustrate, for a claimant who sustained a whiplash injury from a motor vehicle collision and experienced constant neck pain and headaches, as well as periodic pain in her mid to lower thoracic spine, the injury was deemed to be a 15 point value on the injury scale and the claimant received $23,700 for non-economic loss. \(^{32}\) By way of comparison, if a similar injury occurred in Victoria in a transport accident collision the claimant would be covered by the no-fault benefits operating through the TAC scheme. Yet, if the claimant had sustained the same injury through medical negligence in Victoria, they would be unable to recover non-economic damages unless they satisfied an independent medical practitioner their injury was both permanent and significant.

A similar system to that adopted by Queensland operates in South Australia, requiring a point value between 0 and 60 to be applied. \(^{33}\) In South Australia, claimants are required to show they have sustained an injury warranting non-economic loss damages (pain and suffering, loss of amenities of life, loss of expectation of life or disfigurement). \(^{34}\) The court then assesses severity of injury, and compensation is determined pursuant to a sliding scale.


\(^{29}\) Ibid 195-196. Handford questions whether a step-mother or friend would fall within the definition of ‘relative’, and whether witnessing the aftermath of an accident in hospital or through video technology would satisfy the test.

\(^{30}\) Forster and Engel, above n 1, 608.


\(^{33}\) Civil Liability Act 1936 (SA) s 52(2).

\(^{34}\) Ibid s 3.
Scaled measures of damages for non-economic loss are fairer than ‘significant injury thresholds’ because they do not automatically eliminate the awarding of damages for all smaller claims, and so they present as exemplar models that the Victorian jurisdiction could emulate.

Alternatively, if thresholds are retained, a second option could be the insertion of a provision into the Wrongs Act similar to the ‘narrative tests’ used in transport accident and workplace injury claims, allowing a court to award damages in circumstances that would otherwise be excluded. This provision could be used where the consequences of an injury negatively impact upon a claimant’s life, and where strict application of thresholds would be harsh and unjust, as with the earlier cited example of a pianist losing a finger. During the 2013 enquiry, VCEC received a number of submissions which criticised the thresholds, and the manner in which impairment was assessed using the AMA Guides.

Medical practitioners are informed by the AMA Guides which focus on objective medical criteria, but can fail to consider the impact of injuries on a person’s life, including their capacity to work and carry out the activities of everyday living. To remedy this flaw, three legal bodies made submissions to VCEC advocating for the introduction of a narrative test, modeled on the test used for assessing workplace or transport accident injuries. VCEC did not adopt this recommendation, likely due to risks of cost increases to the system. However, the narrative test is used under statutory schemes and allows consideration for qualitative factors impacting upon a claimant’s life following an injury. Although VCEC rejected the narrative test due to economic efficiency reasoning (related to an increase in insurance costs), it is imperative that economic arguments are balanced with the need to compensate injured members of society, giving effect to corrective justice objectives.

35 Ibid s 52(1). In SA a claimant is only required to demonstrate their ability to lead a normal life was significantly impaired by the injury for a period of at least 7 days or that their medical expenses meet the minimum prescribed threshold.
36 Transport Accident Act 1986 (Vic) s 93 and Accident Compensation Act 1985 (Vic) s 134AB.
38 The provision is modelled on the economic loss section relating to motor vehicle injuries in the Civil Liability Act 1936 (SA) s 56A(3).
39 Law Institute of Victoria, above n 37, 6–7.
40 Ibid.
41 Australian Lawyers Alliance, the Law Institute of Victoria and the Monash Law Students Society Just Leadership Program recommended introducing a narrative test.
42 VCEC Report, above n 26, xxvii and 41–42.
Adoption of a narrative test would benefit in two ways: firstly, by achieving regulatory consistency with workplace and transport accident injuries; and secondly, by ensuring claimants with substantial and painful injuries, who presently cannot satisfy the thresholds, have an increased possibility of recovering compensation. Whilst participants in this doctoral study did not expressly articulate the need for a narrative test, participants underscored the necessity for the legislative framework to consider individual circumstances. That said, narrative tests under the transport accident and workplace accident schemes are not a panacea for this problem. Jason Taliadoros describes these tests as creating voluminous litigation that burdens public resources, however he acknowledges this may emanate from legal uncertainty regarding the wording of legislative provisions.

The narrative tests under transport accident and workplace accident schemes incorporate a two-limb test: first, the injury must fall into categories prescribed by the legislation; and second, three reference points must be satisfied. These reference points are: (1) assessing the ‘seriousness’ as judged with respect to the pain and suffering, or loss of earning capacity of a worker because of the injury (2) evaluating these consequences of the injury with other cases in a range of impairments; and (3) when judging these consequences the impairment or disorder ‘shall not be held to be serious’ unless the pain and suffering consequence, or the loss of earning capacity consequence meets a semantic threshold of seriousness. Thus, merely interpreting the narrative test is convoluted for plaintiffs and practitioners. A simpler solution for medical negligence claims may be inserting a provision into the Wrongs Act which mirrors a provision used in the South Australian (‘SA’) civil liability legislation:

> a court may award damages in a case that would otherwise be excluded if satisfied—
> (a) that the consequences of the personal injury with respect to loss or impairment of future earning capacity are exceptional; and

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44 Taliadoros, above n 43, 244.

45 For instance, some of the criteria are that the serious injury is a loss of a foetus, a permanent serious disfigurement, severe long-term mental or severe long-term behavioural disturbance or disorder, an impairment or loss of a body function that is ‘serious long-term’ or a ‘permanent serious’ impairment or loss of a body function.

46 Taliadoros, above n 43, 247.
(b) that the application of the threshold set by that subsection would, in the circumstances of the particular case, be harsh and unjust.47

While this SA provision relates to economic loss in the context of motor vehicle claims, it can be tailored to apply in the non-economic loss context. This approach would privilege judicial discretion by allowing consideration of plaintiffs’ individual circumstances in determining an outcome, and would assist plaintiffs who would not otherwise attain compensation if they did not meet the prescribed threshold. Such an approach would require judges to apply corrective justice principles to the facts of each case, as opposed to matters of policy normally affiliated with economic efficiency theory. The wording of the SA provision is clear, compared to the convoluted narrative tests applied under Victorian schemes. Additionally, practice notes utilised in the Medical List in the County Court could be amended to provide guidance on the criteria needed to satisfy the medical negligence narrative test, to ensure consistency of application.

Another option to consider is the overhaul of the legislative framework. In the context of public liability claims (which have been subjected to a similar type of restrictions as medical negligence), Bell-James and Barker assert that liability questions in cases involving public authorities should revert to the common law that provides clarity and consistency over the current statutory framework.48 This proposition advances the repeal of existing legislative provisions, with a reversion to common law principles.

An alternative solution is the adoption by all Australian states of uniform legislation, akin to the uniform defamation statutes.49 Bell-James and Barker highlight that anomalies experienced in the post-Ipp era indicate that if uniform legislation is adopted, it needs careful consideration, clear drafting and consideration of the principles and protections which the

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49 Defamation Act 2005 (NSW); Defamation Act 2005 (Qld); Defamation Act 2005 (SA); Defamation Act 2005 (Tas); Defamation Act 2005 (Vic); Defamation Act 2005 (WA); Civil Law (Wrongs) Amendment Act 2006 (ACT) amending the Civil Law (Wrongs) Act 2002 (ACT); Defamation Act 2005 (NT) collectively referred to as the ‘Uniform Defamation Acts’.
common law offers.\textsuperscript{50} One participant articulated the need for uniformity in medical negligence law across Australian jurisdictions, echoing academics’ criticisms about the lack of uniformity stemming from the Ipp Reforms.\textsuperscript{51}

When considering the avenues of reform listed above, the simplest and most pragmatic initiative would be amending existing provisions in the \textit{Wrongs Act} to reduce threshold restrictions. This could be achieved by either lowering the thresholds or introducing the sliding scale system operating in Queensland and South Australia which ensures all meritorious claims are compensated. If caps on damages are retained, this would stifle excessive damages awards, alleviating fears of another insurance ‘crisis’. Also, if the thresholds are retained, the introduction of a legislative provision allowing for the use of a narrative test would restore \textit{some} fairness to the present framework, by considering the adverse effect of injuries on claimants’ lives.

Other avenues of reform include repealing Part VB and VBA of the \textit{Wrongs Act} legislation relating to caps on damages and injury thresholds and reverting to common law principles. A third alternative would be adopting uniform tort legislation to achieve clarity and consistency in an otherwise fragmented federal framework. An objective of the Ipp Reforms was to implement consistency across the Australian jurisdictions, yet this aim has evidently not been achieved. Uniform legislation would solve this dilemma, but only if its implementation is underpinned by independent and thorough empirical research, rather than as a reactionary political response to scant evidence of an insurance ‘crisis’.\textsuperscript{52}

\subsection*{7.2.3 CAUSATION}

When asked directly about causation, 18 out of 24 participants thought the statutory test of causation presented as a hurdle to successful recovery. Participant responses indicate that the statutory provisions regarding causation are a potential site for reform.

\textsuperscript{50} Bell-James and Barker, above n 48, 41.
\textsuperscript{52} This is supported by Edmund Wright, ‘National Trends in Personal Injury Litigation: Before and After ‘Ipp’’ (2006) 14(3) \textit{Torts Law Journal} 233, 249. Professor Wright’s research shows a stable trajectory of claims with a sudden increase in claims leading to the Ipp Reforms. Following the Ipp Reforms, the rate of claims decreased in all Australian jurisdictions.
The first potential solution is to codify the law with respect to causation. Codification involves a comprehensive statement of the law in one statute. If negligence principles were to be codified, such codification would require a broad wording and would need to be subject to judicial interpretation because of the sheer number of factual situations that could arise. Yet codification in itself does not offer a comprehensive solution. In the negligence context, it would require a re-statement of the common law principles, and the codified law would continue to require judicial interpretation. One commentator contends that the insertion of a two-part statutory test in 2003 was effectively a codification of the common law.

A second possible solution is to alter the statutory provisions relating to causation, particularly the scope of liability element. The participants in this study highlighted that factual causation is relatively straightforward to satisfy, however the scope of liability element is nebulous. If the vagueness of the scope of liability element is the root of the problem, then the solution should focus on inserting specific criteria which need to be satisfied. A solution could be achieved by inserting a list of factors that the courts must consider, analogous to Chief Justice Allsop’s ‘salient features’ which are considered when assessing novel duty of care categories.

A third avenue of law reform for consideration is the reversal of the onus of proof for causation in medical negligence cases. The plaintiff would be required to prove duty of care and breach of duty, but the onus would then shift to the defendant, if the adverse outcome sustained by the plaintiff is one that is a recognised risk with that medical procedure. For example, if the medical practitioner does breach their duty of care then the law should presume (in the absence of proof to the contrary) that the cause of the negative outcome is a breach of duty on the part of the medical practitioner.

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53 An example is the Criminal Code 1899 (Qld).
54 An example is the wording of the credibility evidence rule in s 101A of the Evidence Act 2008 (Vic).
55 See for instance Justice Michael McHugh, ‘Introduction: Sydney Law Review Torts Special Edition’ (2005) 27(3) Sydney Law Review 385, 389 who refers to section 51 and states, ‘[t]hat section follows recommendation 29 of the Ipp Report, which suggested that a statutory codification of the issue of causation entail two elements, namely ‘factual causation’ and ‘scope of liability’. The Ipp Report made this recommendation so that the statutory provision ‘will suggest to courts a suitable framework in which to resolve individual cases.’
56 Caltex Refineries (Qld) Pty Ltd v Stavar (2009) 75 NSWLR 649, 676 [102] – [104] Allsop P (as he then was).
The implementation of a reversal of onus of proof would result in the creation of a hybrid compensation scheme, similar to New Zealand’s no-fault statutory scheme. Consistent with economic efficiency theory, the operation of a no-fault statutory scheme risks placing too harsh an economic burden on the legal system. However, requiring a plaintiff to satisfy duty of care and a breach of duty but not causation (if the outcome was one of the recognised adverse risks) is effectively a hybrid system of compensation. The hybrid system could alleviate some of the injustice faced by plaintiffs who have meritorious claims and ought to have received some compensation for breach of duty, but failed at the causal hurdle.

7.2.4 DISCUSSION OF CORRECTIVE JUSTICE THEORY

As outlined in Chapter One of this thesis, the purpose of corrective justice is to restore the balance, or the equilibrium, between the victim and the tortfeasor. Erbacher describes corrective justice as a ‘rights-based instrument’ which is ‘designed to rectify wrongs committed by one person against another in a relationship.’ Pursuant to this view, disputes should be determined on a case-by-case basis between the parties, rather than being based on public policy considerations or a particular economic rationale. In a medical negligence context, corrective justice theory would require a negligent doctor to restore any harm they have caused to the patient through payment of compensation.

In an analysis of the theoretical lens underpinning the negligence principles of this thesis, a strong case has been made through the analysis of the work of Weinrib, Schwartz, Coleman and Erbacher for the appropriateness of corrective justice theory. The restrictions imposed in the Wrongs Act through tort reforms are consistent with corrective justice principles, insofar as they impose clear rules for determining liability amongst individuals. Commentators have also argued that restorative tools of the law, such as apologies, are consistent with corrective justice.

Ernest Weinrib’s description of tort liability focuses on the bipolar relationship between the wrong-doing conduct of defendant and the harm sustained by the plaintiff. Two primary

58 Coleman, above n 13, 350.
59 Erbacher, above n 4, 17.
aspects of corrective justice articulated by Weinrib are correlativity and personality. He describes correlativity as ‘the connection that exists between the parties in a regime of liability’, while personality encapsulates ‘what is normatively significant about the parties for purposes of liability’. Correlativity refers to the organisation of private law through bilateral relationships between individuals. In private law this means that ‘one person’s right is always a function of another person’s duty.’ Therefore, a patient’s right to compensation for breach of duty while receiving medical treatment directly correlates to the doctors’ legal duty to adhere to the standard of care reasonably expected of medical practitioners. Correlativity in tort liability focuses on considerations that affect both parties. Erbacher explains that ‘it is inconsistent with the correlative structure of corrective justice to decide liability and entitlements by reference to considerations that focus solely on the conduct of one party.’

Causation is highly relevant from the perspective of corrective justice theorists because it ‘supplies the particular feature about the defendant that singles him out from the generality of those available for the shifting of the plaintiff’s loss.’ Consistent with principles of corrective justice, claimants can only recover compensation if their injury was caused by the defendant’s negligent conduct. In contrast, distributive justice and economic theories do not focus on a ‘singular causal attribution’ but rather ultimate attribution of liability is based on social, moral, political and economic considerations. Mendelson contends that the tort reform legislation has been heavily influenced by corrective justice theory by emphasising the need for a plaintiff to establish that the defendant’s negligence has caused the harm.

Corrective justice theory supports the legal requirement to establish a causal link in negligence. Gemma Turton stresses that causation is a central feature of corrective justice and the centrality is ‘unaffected by the argument that the distributive effects of liability ought

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63 Erbacher, above n 4, 26.
66 Ibid 640.
67 Mendelson, above n 5, 458.
68 Ernest J Weinrib, ‘Towards a Moral Theory of Negligence Law’ (1983) 2(1) Law and Philosophy 37, 38. Weinrib contends that, ‘the requirement of factual causation establishes the indispensable nexus between the parties by relating their rights to a transaction in which one has directly impinged upon the other.’
to be taken into account in order to balance coherence and morality." Turton relies on the case of Chester v Afshar [2005] 1 AC 134, where a doctor failed to warn their patient of a small risk associated with a medical procedure. The risk materialised and the patient suffered an injury. Yet the patient admitted that had she been warned of the risk, she would nevertheless have proceeded with the procedure. While the court decided that the ‘but for’ test was satisfied and the defendant doctor should be held liable in the circumstances, Turton asserts that imposition of liability should be questioned when made without a clear causal link. In other words, the provision of information or warning of the risk would ultimately not have made a difference in the patient’s decision to proceed with the surgery, therefore imposition of liability in the circumstances was not warranted.

Despite corrective justice offering the best explanation for tort liability, analysis of the data in this study had demonstrated that by imposing numerous means of restricting access to compensation (such as thresholds, caps on damages and causation), the balance between individuals is shifted too extensively in favour of defendants. Thus, the current legislative framework does not embody corrective justice between parties because in many instances the equilibrium is not restored between the wrong-doer and the victim. Paul de Jersey, former Chief Justice of Queensland, argues that restrictions arising out of the civil liability reforms in Queensland regarding calculation of damages:

‘[create] an inflexibility which eschews much of the evaluative process previously carried out by judges fully informed of the relevant circumstances of the individual plaintiff before them. This inflexibility diminishes the scope for individual corrective justice and reduces the chances of restoring a plaintiff to the pre-accident position; amends are not made.’

While the framework of tort liability is embedded in corrective justice, the operation of such a system must be questioned where it fails to effect actual justice between the parties. For instance, Richardson and Gillett contend that no single form of justice can suitably account for medical error and that myriad justice approaches are necessary in the healthcare context. Richardson and Gillett accept that pursuant to corrective justice theory, a fault-based tort

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69 Turton, above n 4, 20.
70 Ibid.
72 Richardson and Gillett, above n 12, 785.
system involves a two-party transaction where the plaintiff must prove the doctor’s negligence and establish fault. Only once this has been established can the doctor pay damages to ‘put-right’ the wrong that has been caused. However, problems emerge where ‘no clearly negligent or faulty party’ can be identified and held responsible, resulting in an outcome that is ‘potentially unjust’. Further, even if a negligent party can be identified, the injury may not be of sufficient gravity to satisfy legal responsibility. In such circumstances ‘satisfying the duty of repair under normative principles of corrective justice may be somewhat arbitrary’. Richardson and Gillet contend that:

Such a state of affairs is intuitively unfair to victims who have suffered the same loss given that the resolution or failure to resolve is not within the patients’ control. Therefore, schemes that rely only on corrective justice do not provide sufficient coverage to victims and often do not satisfy our sense of natural justice, factors that render them, by and large, inappropriate to deal with medical error.

In circumstances where the current fault-based system is failing to effect actual justice between the parties, it may be appropriate to look to no-fault schemes as an alternative system. A no-fault scheme transfers the burden of error collectively to a community and is a form of distributive justice. Under a no-fault scheme, recognition is given to the need for patients who have suffered injury due to medical error to receive financial support, regardless of the ability to satisfy the causal relationship between breach of duty and harm. Richardson and Gillett assert that an argument for a no-fault scheme is convincing, when contrasted against corrective justice principles which require ‘significant fictions to be maintained to conform to our intuitive sense of justice.’ Various benefits and drawbacks of a no-fault scheme is discussed in the next section.

7.2.5 REFORM 2 – NO-FAULT SYSTEM

An alternative to amending the existing Victorian fault-based tort system would be assuming a form of the no-fault compensation systems that currently operates in NZ, Sweden, Finland and Denmark for medical negligence claims. In the NZ no-fault system, claimants are not required to prove fault in a civil justice court system to recover compensation. Instead, an
injured person is required to complete a claim form, consult with a healthcare provider to verify their injury, and lodge the claim with the NZ Accident Compensation Corporation. The ‘no-fault system’ has been widely accepted in Australia through its operation in transport accident and workplace injury compensation schemes, therefore it is not a foreign process in this jurisdiction and it is timely to seriously contemplate whether it can be implemented as a better system to manage medical injury claims.

During the Ipp Reforms, former government minister, the Hon. Joe Hockey, intended to introduce a no-fault scheme similar to the New Zealand scheme, but faced vehement opposition due to fears of the exorbitant cost and liability such a system could attract. However, Andrew Field posits that most of these arguments were untethered to any justification and lacked evaluation of the true cost of such a model. Field purports that the arguments countering a no-fault scheme carried significant political weight prior to the introduction of thresholds, and prior to the removal of common law protections. In light of the current restrictions, it might be worthwhile considering alternatives.

Weisbrot and Breen support the introduction of a no-fault scheme, asserting the current fault-based system is slow, expensive, inefficient, stressful, inequitable and unpredictable in helping people injured through medical care. They concede elements of opponents’ arguments are legitimate, regarding the social costs of the no-fault scheme, but Weisbrot and Breen emphasise that funding can be sought from the community through taxpayers funds, rather than being limited to compulsory medical indemnity cover.

A recent example of the adoption of a no-fault scheme in Australia is the National Disability Insurance Scheme (NDIS), introduced in response to a 2011 Productivity Commission inquiry which recommended a no-fault national scheme for ‘catastrophic’ injury (including medical injury). The NDIS is similar to New Zealand’s no-fault scheme, as it provides a

78 Accident Compensation Corporation, What to do if you’re injured <www.acc.co.nz/im-injured/what-to-do/>
79 The Transport Accident Act 1986 (Vic) s 93 allows a common law action to be initiated if the injury is 'serious'.
80 Field, above n 57, 92.
81 Ibid 93.
82 Ibid 95-97.
84 Ibid 297.
level of compensation to people with disabilities for support services deemed reasonable and necessary, but it does not compensate for lost income. Weisbrot and Breen argue that the 2011 Productivity Commission inquiry represents a missed opportunity for introducing a no-fault system for medical injuries, and they recommend a further inquiry into this matter.⁸⁶

Adopting a no-fault system of liability for medical negligence claims obviates the need for litigation, which eliminates the social costs and plaintiff costs of trial. It is well-known that litigation in court is stressful for injured people,⁸⁷ and the protracted process can deleteriously affect both finances and mental well-being, including relationships. In New Zealand, an injured person is entitled to claim no-fault benefits for a ‘treatment injury’, if such injury was sustained during medical treatment. The injured person is not required to prove negligence and demonstrate in court that the medical practitioner made an error.⁸⁸ In New Zealand, funding for the no-fault scheme is sourced from employment taxes, government revenue and taxes on petrol and vehicle registrations.⁸⁹

In Australia, the NDIS provides a useful model on which to base a potential no-fault scheme. The NDIS was funded through government revenue (including a diversion of all usual disability services funding to the NDIS) and an increase to the Medicare levy.⁹⁰ The increase to the Medicare levy is one avenue of pooling resources to fund a no-fault scheme and the NDIS evidences that the Australian government is willing and able to take this course of action. Another example is the proposed National Injury Insurance Scheme (NIIS) for medical treatment injuries.

In their 2011 final report regarding the disability sector, the Productivity Commission dedicated two chapters to creation of the NIIS and the inadequacies of the common law to

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⁸⁶ Weisbrot and Breen, above n 83, 296.
⁸⁸ Accident Compensation Act 2001 (NZ) ss 32-33.
provide necessary support to injured individuals. The recommendation proposed a scheme that would support individuals living with catastrophic injuries due to accidents or arising out of medical treatment. The response to this recommendation has somewhat stalled, save for the introduction of a limited scheme in Queensland for injuries arising out of motor vehicle accidents. In July 2015, the Commonwealth Treasury released a draft medical treatment injury discussion paper suggesting that establishment of the NIIS is proceeding. The Government proposed a funding model based on premiums on medical practitioners’ and hospitals’ medical indemnity insurance. The scheme would cover spinal cord injury, brain injury, multiple amputations, burns and permanent blindness, but would exclude birth defects, injuries caused wholly or substantially through unreasonably withholding or delaying of treatment and individuals injured when 65 years old or older. The NIIS would be modelled on New Zealand’s no-fault scheme and would cover all unintended injuries that occurred as a result of medical treatment. While progress on the introduction of the NIIS remains slow, the policy considerations and implementation must be subjected to proper scrutiny.

In its current form, the Wrongs Act curtails corrective justice, as the compensatory pendulum has swung too far in favour of insurance companies to the detriment of plaintiffs seeking redress for harms caused to them by others. This view is supported by the discussion of the participants in this study who thought that restrictions in the current framework unfairly curtail the right of injured individuals to attain compensation. Pursuant to corrective justice, a tort compensation system should be able to facilitate the wrongdoer restoring justice to an aggrieved individual, yet in practice, corrective justice is not effected when individuals are unable to access justice due to legislative restrictions. Further, the principles of corrective justice, in practice, have limitations. It represents the balance of what a society can pay. The no-fault scheme represents a form of distributive justice as it allows justice between the parties to be effected within a statutory framework. The no-fault system ensures that all individuals have equal access to a compensation system that can assist them to attain some

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91 Productivity Commission, above n 85, 851-937.
92 National Injury Insurance Scheme Act 2016 (Qld).
94 The definition would exclude personal injury that is wholly or substantially caused by a person’s underlying health condition; personal injury that is solely attributable to a resource allocation decision; or personal injury that is a result of a person unreasonably withholding or delaying consent to undergo treatment.
95 Emily Mitchell, ‘The National Injury Insurance Scheme: The Details Revealed’ 125 Precedent 18, 23.
compensation for treatment or rehabilitation, weekly compensation for lost income, or lump sum payment for permanent disabilities, without having to prove negligence in court.

7.3 MEDIATION FINDINGS

The appetite for ADR mechanisms has transformed the landscape of the way general negligence claims are managed. ADR is now a much used case management tool in Victorian court proceedings. Due to the rise in court-connected mediation, it was valuable in this research to explore how mediation operates for medical negligence claims. A large part of this doctoral research has explored how mediation of medical negligence disputes operates in the Victorian jurisdiction. Particular focus was paid to the level of lawyers’ engagement with the mediation process, and to the suitability of mediation as a process for resolving medical negligence disputes. As indicated previously in this thesis mediation has myriad benefits compared with litigation, including cost savings, expediency, confidentiality, and it also offers unique value in practice areas where parties have extra-legal, emotional, or non-financial needs. For victims of medical negligence, this may include the plaintiff’s desire for an explanation of medical error, or an expression of apology or sympathy from the defendant. Lawyers are a key player in the mediation of medical negligence disputes as they directly impact upon the conduct of mediation, and influence the outcomes secured for their clients. As such there was a fundamental need for this research to explore the use of mediation in medical negligence practice.

Participants’ responses regarding engagement with the mediation showed a cultural shift toward embracing non-adversarial practice. When questioned whether participants engaged with mediation to resolve medical negligence disputes, 16 of the 24 participants stated they did so and described their involvement as ‘mandated’ by courts, clients, or accepted norms. Eight out of the 16 participants explained that their involvement was due to ‘court-ordered’ processes, whilst the other eight used language describing a state of compulsion or inability to avoid mediation because of enduring legal industry practices. Participants viewed mediation as a process which all litigants and lawyers must undertake, though they described participating in mediation as a positive necessity.

In contrast, the remaining eight participants expressed insights regarding the positive benefits of mediation, stating that legal actors and disputants engage willingly, showing a cultural
shift towards non-adversarial practice. The language expressed by participants demonstrated genuine willingness to participate in mediation, demonstrating a shift in legal culture in this practice area, rather than mere compliance with legislative requirements. Three participants expressly cited the Civil Procedure Act 2010 (Vic) and the expectation of judges that parties and lawyers should ‘genuinely attempt’ mediation prior to trial. While some commentators remain cautious about public policy legislation and ADR, the willingness of all 24 participants to partake in mediation strongly indicates a cultural shift toward non-adversarial practice; a shift that was undoubtedly spurred by legislative intervention.

Participants were asked about the suitability of mediation as a dispute resolution mechanism for medical negligence claims. Research participants unanimously endorsed mediation as the preferred form of dispute resolution for medical negligence disputes, speaking favourably about the process. Participants endorsed the classical features of mediation, including expediency, cost savings, certainty, control over the process and outcome, as well as less emotional stress for the parties. The most common benefit cited as a result of adopting mediation were the saving in expenses, with all but one participant stressing that its lower cost was a major benefit reaped from undertaking mediation. This finding mirrors the medical dispute literature, which highlights that cost is a significant factor as medical negligence disputes involve complex medico-legal issues and expert evidence. Six participants expressed the view that the less adversarial nature of mediation meant it was a desirable dispute resolution process when compared to trial, which was described as a ‘gut-wrenching’ and ‘traumatic’ process. These perceptions are consistent with Menkel-Meadow’s assertion that the adversarial system is inadequate in meeting parties’ needs and it is imperative that parties are permitted greater choice in deciding how to resolve their disputes.

99 Plaintiff Lawyer 11.
100 Defendant Lawyer 2.
Extant literature emphasises that emotion is a key aspect of conflict and in dispute resolution and that addressing the emotional needs of the parties can be critical in resolving disputes.\textsuperscript{102} Bogdanoski contends that mediation, particularly the facilitative mediation style, can cater to medical negligence plaintiffs’ emotional needs and interests.\textsuperscript{103} With studies increasingly paying attention to the role of emotion in mediation,\textsuperscript{104} it was valuable to explore whether participants considered that emotion is indeed a key factor for medical negligence parties, and if so, whether the mediation process allows for the emotional needs of parties to be addressed.

In this study 18 out of 24 participants thought that emotion was a critical factor in medical negligence disputes, due to claims in medical negligence arising out of a breach of trust between a medical practitioner and a patient. In medical negligence disputes, parties’ loss may involve physical injury, permanent disability or death of a loved one (as opposed to a breach of contract which tends to involve purely financial loss), heightening plaintiffs’ emotional investment in the claim. Therefore, it was unsurprising that 15 participants indicated that emotions were predominantly plaintiff-orientated, with participants indicating doctors were largely kept out of medical negligence mediation. In fact, the responses from the participants revealed that doctors rarely attend mediation in Victoria. This finding is consistent with Tamara Relis’ study of Canadian medical malpractice disputes where the majority of lawyers indicated they had little or no experience with doctors in attendance at mediation.\textsuperscript{105}

Despite acknowledging the critical role of emotion for plaintiffs, 20 participants in this study indicated that parties’ emotional needs are not being met during mediation. The participants stated that the predominant focus in mediation was on legal rights, fiscal objectives and achieving settlement, therefore no attention was given to disputants’ non-legal needs. In elucidating the process adopted by lawyers in Victorian medical negligence mediations, participants explained that parties rarely receive an opportunity to address emotional needs

\textsuperscript{103} Tony Bogdanoski, ‘Medical Negligence Dispute Resolution: A Role for Facilitative Mediation and Principled Negotiation?’ (2009) 20(2) Australasian Dispute Resolution Journal 77.
\textsuperscript{104} Kathy Douglas and Clare Coburn, ‘Attitude and Response to Emotion in Dispute Resolution: The Experience of Mediators’ (2014) 16(1) Flinders Law Journal 111.
\textsuperscript{105} Tamara Relis, Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties (Cambridge University Press, 2009) 89.
because joint sessions are rarely held. Parties drew a distinction between theory and practice, highlighting that lawyers in mediation of medical negligence disputes largely used a ‘shuttle’ approach, meaning that parties and lawyers are kept in separate rooms,106 with the mediator moving between rooms to conduct the mediation.

Participants also stressed that plaintiffs were constrained by lawyers from participating in the negotiation process for tactical reasons. Even if plaintiffs wished to speak, or confront the doctor, they could rarely do so due to the lack of attendance by doctors. Yet nine participants, without prompting, highlighted the effectiveness of apologies by doctors to plaintiffs in mediation when such apologies were able to be facilitated. This is consistent with Carroll’s view that apologies can be a powerful legal remedy, addressing parties’ psychological needs more satisfactorily than an award of damages.107

A theme evident from participants’ responses about the lack of client involvement in mediation, and the focus on legal and financial objectives, is that lawyers have a significant capacity to influence the mediation process.108 Participants were asked how they saw the role of lawyers in mediation of medical negligence disputes, including the role of solicitors, barristers and mediators. Participants’ responses indicated a high level of lawyer involvement and control of the mediation process. None of the participants permitted their clients to have complete involvement in negotiations. This finding is consistent with Relis’ research which found that lawyers dominated the mediation process and frequently ignored their clients’ emotional or non-legal needs.109 While the participants in this doctoral study acknowledged that emotion was a factor for clients, particularly plaintiffs, this awareness did not motivate them to reduce their domination of the mediation process.

A theme that arose out of participants’ responses related to lawyers ‘managing the client’ or achieving ‘client control’ during mediation, particularly for tactical reasons. The lawyers in this study resembled Rundle’s ‘spokesperson’ lawyer who dominates the negotiation process. The client remains a mere observer, who receives legal advice and provides instructions to

106 Mieke Brandon, ‘Use and Abuse of Private Session and Shuttle in Mediation and Conciliation’ (2005) 8(3) ADR Bulletin 41.
109 Relis, above n 105, 237-238.
the lawyer outside of the mediation session.\textsuperscript{110} Further, emotional plaintiffs were perceived as a liability if they divulged information that could be used by the opposing side in subsequent court proceedings. Despite confidentiality of mediation, the defendant could gather insights into the plaintiff’s likely presentation in the witness stand and many plaintiff lawyers perceived that as a tactical disadvantage. Again, these findings are consistent with Relis’ Canadian study where lawyers had a tendency to focus on strategy, tactics and financial objectives in dispute resolution, as opposed to disputants whose focus was on emotional, psychological and extra-legal needs.\textsuperscript{111} This indicates a possible international trend, at the very least in common law jurisdictions, in the framing of lawyers’ role in medical negligence disputes.

Participants’ responses indicated they used an evaluative, rights-based mediation model which focused heavily on legal rights rather than non-legal interests and included incremental bargaining. The responses reflected distributive negotiation rather than an interest based negotiation style.\textsuperscript{112} The focus was on achieving the ‘right figure’ or the ‘best outcome’ for the client at mediation, rather than on addressing any non-legal needs of clients. Seven participants highlighted the importance of ‘proper preparation’ for mediation of medical negligence disputes, because these disputes often involve technical medical terminology and complex expert evidence. Lawyers saw themselves as experts in the law and described their role as ‘legal advisor’, their purpose to inform their clients on the merits of their case. Some participants described their role as a ‘translator’ of the legal system, advising on the realistic parameters of settlement. Others perceived their role as ‘protector’, shielding their clients from the stressful and emotional impact of dispute resolution.

The participants were aware of the shadow of the law influencing settlement negotiations, and used advocacy skills to persuade the opposition of the merits of their case. Despite the focus on legal rights and financial objectives, the participants were not excessively adversarial in their approach. Rather, this community of lawyers have developed a cooperative settlement culture and also exhibited awareness of their clients’ needs and showed sympathy towards their clients. The lawyers did not adopt the facilitative model of mediation but instead had developed a tailored and unique process to the resolution of

\textsuperscript{111} Relis, above n 105, 10.
\textsuperscript{112} Peter Condliffe, Conflict Management: A Practical Guide (LexisNexis, 5\textsuperscript{th} ed, 2016) 211.
medical negligence disputes in the Victorian jurisdiction. The participants recognised their adapted model differed from the ‘textbook’ mediation approach and it also differed from the highly adversarial attitude of NSW lawyers.113 The approach of this group involved speaking on clients’ behalf at mediation, advising them on realistic parameters of settlement and shielding their clients from the emotional stress of the dispute. The lawyers in this study dominated the discourse of the mediation in order to bargain and achieve settlement. By doing so the lawyers showed an approach to practice that diminished party voice and control in the process that also compromised party self-determination. The lawyers’ approach means that parties had little opportunity to directly contribute to the mediation process, achieve emotional expression, or gain a sense of procedural justice.114

7.3.1 SIGNIFICANCE OF THE FINDINGS

The findings outlined in Chapter Six of this thesis relating to mediation of medical negligence disputes are important because they show insights into the dispute resolution culture of this legal practice group. The findings regarding suitability of mediation for medical disputes, engagement with the process, the role of emotion in dispute resolution and the role of lawyers in dispute resolution have significant impact for mediation theory and practice. Data analysis of participants’ discussions culminated in two overarching themes: the culture of lawyers, and the heritage of adversarialism. The findings showed that lawyers in this study dominated the mediation process, discouraging their client from speaking and largely acted as a spokesperson. This finding endorses Menkel-Meadow’s concerns that lawyers colonise mediation.115

However, the participants showed signs of Macfarlane’s evolving practitioner,116 because they spoke positively about mediation and non-adversarial practice, and exhibited genuine desire to engage in the mediation process. This is consistent with the increase in the use of mediation through public policy legislation, which can be used as a tool to shift the culture of

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lawyers. Combined with judicial case management and the Civil Procedure Act 2010 (Vic) requirements, Victorian lawyers are no longer able to litigate in court without having attempted some form of ADR, most likely mediation. This cultural shift was a policy initiative of the then Victorian parliament, with former Attorney-General Hulls describing the reforms as a ‘generational change in the way civil litigation will be managed’, with a key objective of the reforms to ‘change litigation culture itself’ by adopting a ‘less adversarial approach’ to dispute resolution.117 The findings of this study show that in spite of this aim, the culture of lawyers in this particular area of practice has failed to fully embrace a more non-adversarial approach.

While the participants in this study were positive about mediation, their views reflected experiences in the adapted mediation process these Victorian lawyers have created for medical negligence disputes. Further investigation is needed to explore the precise characteristics of this model, though participants’ responses revealed that an evaluative or settlement model is at the centre of mediation practice in the Victorian medical negligence jurisdiction. This finding reflects a community of practice and shows how these lawyers have constructed their professional identity in medical negligence, with its unique dispute characteristics which differ to other practice areas. As Macfarlane’s research has demonstrated, a range of legal cultures can develop in mediation practice.118 While the participants showed an ethic of care for their clients,119 the adapted process strays from the purely facilitative model of mediation, as participants acknowledged it did not follow the model taught in mediation training. Rundle acknowledges that lawyers will ultimately shape dispute resolution processes, including their role and their clients’ expectations.120 However, the adaption risks losing many benefits of mediation, such as party self-determination, expression of emotion and the ability to meet parties’ non-legal needs.

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118 Macfarlane, above n 113, 241.


120 Olivia Rundle, ‘Are We Here to Resolve Our Problem or Just to Reach a Financial Settlement?’ (2017) 141 Precedent 12, 14.
This finding raises the issue as to whether other practice areas might also have shifted from the traditional litigious culture of lawyers. It seems likely that the medical negligence practice area is not alone in making this shift. Arguably, a cultural shift may be evident more widely in the various practice groups that experience mediation as part of case management, at least at the procedural level if not in intention or implementation. Such a shift in practitioners’ approaches to value the legal requirement for mediation would demonstrate that the intended objective of the Civil Procedure Act 2010 (Vic) has been achieved. Yet the participants primarily valued mediation for its expediency and costs savings, demonstrating the participants have not yet truly shifted their culture towards non-adversarial practice. The data also shows that the widely accepted facilitative model of mediation that values self-determination and meeting parties’ non-legal needs is not used by the members of this study.

In the medical negligence context, lawyers are clearly less adversarial in mediation but they are still not open to using a process and involving parties in ways that may meet the emotional needs of the clients in the process. Lawyers in this study saw the significance of emotional concerns for their clients but they did not recognise the value of emotional dialogue in mediation. Lawyers tend to be rationally-minded in mediation, focusing on the expediency of the process, cost savings and protecting their clients from further stress associated with dispute resolution. Thus the emotional aspects of conflict and the potential for emotional closure are not being addressed, other than lawyers acting protectively to shield their clients from stress. This approach to mediation is evident from other studies in Australia, such as Sourdin’s study into practice at the Victorian Supreme and County courts. Relis, in her Canadian study, also found that lawyers did not allow dialogue relation to emotion medical negligence disputes.121

The tendency to control is not limited to the personal injury context, but in other disputes where lawyers dominate the processes.122 The lawyers in Rundle’s study of litigation in Supreme Court in Tasmania also adopted a rights-based style, with a focus on settlement bargaining. Such an approach to mediation has resulted in reduced party participation in the process and a curtailment of the opportunity to address the emotional repercussions of injury.

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121 Tania Sourdin, Mediation in the Supreme Court and County Courts of Victoria (Department of Justice, Victoria, 2009) iv; Relis, above n 105, 10.
Repeat players in medical negligence mediation, the lawyers and insurance representatives, are reducing plaintiff involvement in mediation. This fact, coupled with the trend for doctors not to attend mediation, means any real opportunity to engage directly is limited. Substantial reform to legal culture and procedure would need to occur to shift the approach of lawyers. This suggests that there is a need for lawyer education to understand the benefits of emotion as part of the discourse of mediation in the court-connected context.

This doctoral research demonstrates that parties have little opportunity to contribute in medical negligence mediation and are limited in experiencing procedural satisfaction. PJ research and theory demonstrates that procedural satisfaction is associated with the ability of participants to be heard in the dispute resolution process, to be allowed to tell their story, and to be treated with respect.123 Likewise, RJ theory privileges the emotional needs of parties and focuses on repairing harm caused by one party to another, by bringing together the victim and offender in conferencing.124 The balance between the wrongdoer and the victim can be restored through dialogue between the parties, which may be particularly valuable in medical negligence mediation, allowing individuals the opportunity to speak and be heard, to be respected and to have their emotional needs validated. Despite originating in the criminal context, RJ conferencing can be influential in the medical context to assist parties to attain procedural satisfaction.125

Mediation of medical negligence can also be analysed through the lens of corrective justice theory, as mediation is an earlier alternative to trial that has the potential to afford corrective justice. It operates in the shadow of the law and influences the substance of disputes at mediation. For instance, the use of apologies in mediation can assist the parties to attain corrective justice, as they allow the wrongdoer to correct the imbalance by addressing the harm they have caused. Vines asserts that apologies operate within the parameters of corrective justice.126 Mediation has an interpersonal aspect but the opportunity to use

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126 Vines, above n 60.
mediation as a process to address emotional needs that may include an apology is not exploited by lawyers.

7.4 MEDIATION REFORM

7.4.1 TRIPARTITE APPROACH TO DISPUTE RESOLUTION

If mediation does have the potential to allow parties to attain corrective justice, questions arise as to what point in time mediation is most useful? The participants in this study indicated that in medical negligence disputes mediation often occurs far too late in the dispute, when parties are deeply ingrained in their positions and when excessive financial resources have been expended. This led participants to advocate for mediation earlier in the process. In South Australia, the *Supreme Court Fast Track Rules 2014 (SA)* requires parties to satisfy a number of requirements before commencing court proceedings, including exchange of evidence relating to liability and causation. In Victoria, the County Court practice directions require all proceedings in the Medical List to be subjected to mediation, although by that stage parties may already have become entrenched in their positions. In the US, the Florida Patient Safety and Pre-Suit Mediation Program requires patients to sign a pre-suit mediation agreement before receiving medical care, obliging them to mediate before commencing court proceedings.

In Victoria, mediation could be introduced as a mandatory pre-action protocol or alternatively as a contractual obligation between hospitals/doctors and patients. A potential solution is the adoption of a tripartite approach to dispute resolution to encourage early resolution of medical negligence disputes. Firstly, legislation endorsing ADR, such as the *Civil Procedure Act 2010* (Vic) which is already in effect, provides a necessary framework within which mediation can operate. Secondly, a desirable reform is court endorsement of pre-action mediation through court rules and practice directions. Several participants raised the issue of pre-action mediation, stressing that by the time a case reaches court-connected mediation it may be too late for it to be successful. Requiring parties to attempt ADR prior to filing court proceedings, akin to the approach in South Australia, would implement pre-action mediation. Thirdly, introduction of contractual pre-action mediation requirements, akin to the Florida

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127 County Court of Victoria, *Practice Note: Common Law Division – Medical List No 1 of 2015*, 24 July 2015, [66].

program, may be used in hospitals and clinics. A pre-action mediation clause could be introduced contractually and would operate similarly to a dispute resolution clause in commercial contracts.

7.4.2 LEGAL EDUCATION

Education can be a catalyst for shifting the culture of the legal profession. The findings of this study give rise to important questions about whether reform to legal education is required to educate lawyers about non-adversarial practice. Corbin, Baron and Gutman propound that reform to legal education and directive professional rules are key tools in shifting lawyering culture. They propose that Threshold Learning Outcomes in law school standards should prioritise ADR, and they also advocate for the inclusion of ADR as a core subject in law schools. This suggestion is supported by several academics, and endorsed by NADRAC who contend that ADR should be a compulsory subject in legal education. In December 2016, the Law Admissions Consultative Committee revised the Model Admission Rules for legal practice, altering Civil Dispute Resolution (formerly Civil Procedure) to include teaching of ADR. Civil Dispute Resolution is part of the ‘Priestley 11’ core units law students must complete to gain admission to practice, hence this reform represents a significant shift in the acceptance of ADR in the training and education of lawyers.

129 Ibid 1.
130 Such a clause would oblige the parties to attempt to resolve the dispute by mediation prior to resorting to litigation.
131 Macfarlane, above n 116, 223-224.
133 The Threshold Learning Outcomes were developed in 2010 and represent a set of six knowledge and skills outcomes expected of Australian law graduates: Laurence Boulle and Rachael Field, Australian Dispute Resolution: Law and Practice (LexisNexis, 2017) 27-30.
134 Corbin, Baron and Gutman, above n 132, 511-512.
While the participants in this study did not discuss legal education as a site for reform, the academic literature on legal education and adversarialism, coupled with the findings of this study suggest the need for ongoing legal education on the benefits of ADR and non-adversarial practice. The findings of this study support the assertion that ADR education throughout law school is by itself insufficient to ensure lawyers continue adopting non-adversarial approaches in dispute resolution. Rather, ongoing training about the benefits of ADR is needed through continuing professional development of lawyers, combined with the need to educate lawyers to fully take advantage of the opportunity of mediation as a process where the emotional and non-legal needs of parties can be addressed. Ongoing professional development of lawyers and education about the role of emotion in dispute resolution will ensure that lawyers are empowered with problem-solving skills and are better equipped to respond to emotional conflict.

7.4.3 MEDICAL NEGLIGENCE RESTORATIVE CONFERENCE AND MANDATORY ATTENDANCE BY DOCTORS

The findings of this study show that there is a lack of opportunity for plaintiffs to meet non-legal objectives in mediation (such as apologies or an explanation for the medical error), as medical practitioners rarely attend mediation. This finding is consistent with research in the US and Canada which also found that doctors are neither attending nor participating in medical negligence mediations. The findings in this study are consistent with international research, which found that lawyers tend to dominate the mediation process and fear the risk of allowing their client to fully participate in the mediation process, so no real opportunity arises for plaintiffs to experience emotional closure.

Therapeutic jurisprudence, procedural justice and restorative justice theories acknowledge the role of emotion in conflict and the importance of addressing the non-legal needs of parties in dispute resolution. Therapeutic jurisprudence encourages lawyers not only to recognise but to

incorporate emotions in problem-solving. Procedural justice provides that parties are more likely to accept the outcome of a decision, whether in court or ADR, if they are to perceive the dispute resolution process as procedurally fair. It would seem particularly necessary in medical negligence disputes for parties to have their voice heard about their experience of negligence. This opportunity for expression is thwarted by lawyers and thus parties are unlikely to experience procedural fairness. Restorative justice practices also value the role of emotions in disputes, and encourage emotional healing through dialogue between the parties and provide a template for the potential benefits of such a focus.

The findings of this study support the recommendation that emotional dialogue between the parties, including the opportunity for an apology, explanation or statement of impact of an injury on an individual’s life, should be facilitated. To allow this to occur, doctors must be required to attend mediation. Carol Liebman asserts that doctors’ lack of participation has resulted in lost opportunities to learn from error and a missed opportunity to experience procedural justice for doctors. Liebman argues that doctors should attend mediation of medical negligence disputes to allow both parties to meaningfully participate in the process.

The findings of this study also support the recommendation that doctors should be encouraged to attend mediation, and one manner in which this may be achieved is through the introduction of new practice directions in the Medical List of the County Court of Victoria. At present these practice notes only require proceedings to be subject to mediation, but do not mandate doctors’ attendance. A new practice direction mandating the presence of parties themselves would ensure doctors attend. A process similar in nature to restorative justice conferencing used in criminal matters, could allow the aggrieved party (the plaintiff) to invite the opposing party (the defendant doctor) to a ‘medical negligence restorative conference’

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142 Hollander-Blumoff and Tyler, above n 114, 1.
143 King, above n 141, 1098.
145 Ibid.
146 County Court of Victoria, Practice Note: Common Law Division – Medical List No 1 of 2015, 24 July 2015; [66].
where the parties are given an opportunity to seek an explanation, make a statement expressing regret or offer an apology.\textsuperscript{147}

7.5 RESEARCH LIMITATIONS AND FURTHER RESEARCH

While this study has made a meaningful contribution to policy and practice, the research inevitably has several limitations. The research objectives limit the scope of the study specifically to medical negligence practice in the Victorian jurisdiction. Given that all Australian states implemented reforms stemming from the Ipp Report, it would be valuable to explore insights from practitioners in other Australian states to ascertain whether similar or different challenges impact upon plaintiffs’ ability to attain compensation in meritorious medical negligence claims. This research used an interpretive methodology to gather rich insights and understandings of the impact of the Ipp Reforms from the perspective of Victorian legal practitioners. Unlike quantitative research, the study is not easily generalisable to all Australian states. A comprehensive empirical study of the litigation trends before and after the Ipp Reforms in all Australian jurisdictions, particularly on the number of litigants commencing medical negligence actions and the quantum of damages paid in successful claims, is desirable.\textsuperscript{148}

Further, this study gathered insights from lawyers about challenges faced by claimants in attaining compensation, as they were best positioned to comment on the legal aspects of such challenges. There is scope to conduct further research interviewing plaintiffs and doctors, to gather perspectives from the parties about their aims and objectives in pursuing medical negligence action, as well as the role of parties in partaking in mediation of such disputes. If pursued, this research would resemble Tamara Relis’ Canadian study of legal and lay actors’ perceptions in litigation and mediation of medical malpractice suits.\textsuperscript{149}

Based on views of participants in this study espousing the benefits of no-fault schemes, combined with views of esteemed scholars, a recommendation was made to adopt a no-fault compensation akin to that used in New Zealand. However, further research is needed to explore the benefits of such a scheme in medical negligence cases. A comparative study between Australia’s fault-based compensation system and New Zealand’s no-fault

\textsuperscript{147} Todres, above n 125, 672.
\textsuperscript{148} Wright, above n 52, 233.
\textsuperscript{149} Relis, above n 105, 26-32.
compensation system is warranted, with a qualitative component gathering insights from lawyers practicing in both jurisdictions.

In relation to mediation, this doctoral research project focused on court-connected mediation rather than dispute resolution mechanisms at hospital, following medical error. A site for future research could explore dispute resolution in the healthcare context through a two-part process. The first would focus on the site of the medical error, namely hospitals, and the mechanisms employed by healthcare providers to communicate with patients following error. The second site is the court-connected environment when disputes proceed past the initial hospital stage and into the legal sphere.

Finally, a theme that arose from this study was the role of lawyers in mediation of medical negligence giving rise to unique practice groups. The findings indicated that lawyers practicing in medical negligence in the Victorian jurisdiction have accepted mediation as a legal requirement but are not yet fully embracing non-adversarial practice. Studies have shown that practice groups can exhibit unique characteristics and varying degrees of adversarialism across different cities. Therefore, it would be beneficial to undertake a comparative study of the role of lawyers in medical negligence dispute resolution in Victoria and NSW to explore levels of adversarialism within these legal cultures. Further, the participants indicated they were using an adapted model of mediation in medical negligence. Therefore, it would be beneficial to undertake further empirical research to explore the precise characteristics and use of this adapted model.

7.6 CONCLUSION

When individuals are injured as a result of medical negligence, they turn to the legal system to attain compensation that can provide critical financial support for the rest of their lives. The aim of this study was to explore whether the Ipp Reforms and subsequent 2015 reforms continue to present legal challenges to the attainment of compensation in medical negligence claims. The findings of this study demonstrate that the Victorian legal system continues to deprive injured individuals of compensation where they are unable to satisfy arbitrary threshold criteria. The results of this study show that participants considered injury

151 Macfarlane, above n 113, 241; Sourdin, above n 113, 19.
thresholds, caps on non-economic loss damages and causation as barriers faced by claimants in attaining compensation, particularly for the non-working, elderly or children. For these injured individuals, this is a major barrier preventing access to justice; hence reform of the current fault-based system is needed to provide clarity and consistency in compensation. Alternatively, the adoption of a no-fault system akin to that operating in New Zealand should be evaluated and implemented in Australia. A no-fault system provides greater fairness and speed than a fault-based system in delivering compensation to those who need it most.

If the current fault-based system is retained, all claimants pursuing a medical negligence will have their case subjected to mediation prior to trial. This study shows that mediation is an effective addition to the litigation of disputes in the medical negligence context. Bolstered by legislation and a shift in the traditional adversarial culture, mediation was valued by the lawyers in this study. However, this shift in culture does not yet extend to allowing the full engagement of clients in the mediation process. For many individuals, a medical negligence claim is highly emotional and they seek non-legal remedies such as an explanation or apology. Thus the opportunity to use mediation to meet non-legal needs is a critical component of dispute resolution and one that must be recognised by lawyers to allow parties to experience a sense of procedural satisfaction.

The findings of this thesis showed that participants recognised that medical negligence proceedings were emotional for plaintiffs, yet the participants did not facilitate expression of emotion in mediation. They used an adapted form of mediation that resembled an evaluative or settlement model, allowing lawyers to default to a model they were comfortable with rather than a model that would meet the needs of the clients they represented. Indeed, without the presence of doctors at mediation the discussion centred on compensation. The findings highlight that reform is needed to assist lawyers to understand the potential of mediation for the canvassing of non-legal elements of a dispute in medical negligence. This thesis has recommended a tripartite approach to dispute resolution, combined with ongoing legal education about ADR, to embed and prioritise the true benefits of mediation for medical negligence.
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Appendix 1 – Ethics Approval Letter from RMIT University dated 15 October 2015

Notice of Approval

Date: 15 October 2015
Project number: 19616
Project title: Causation in Medical Negligence: Challenges in Litigation and Mediation
Risk classification: Low Risk
Chief Investigator: Dr Kathy Douglas
Student Investigator: Martina Popa
Other Investigator: Dr Andrew Vatikunas

Project Approved: From: 6 October 2015 To: 2 March 2019

Terms of approval:

Responsibilities of the principal investigator

It is the responsibility of the principal investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by BCHEAN. Approval is only valid while the investigator holds a position at RMIT University.

1. Amendments
   Approval must be sought from BCHEAN to amend any aspect of a project including approved documents. To apply for an amendment submit a request for amendment form to the BCHEAN secretary. This form is available on the Human Research Ethics Committee (HREC) website. Amendments must not be implemented without first gaining approval from BCHEAN.

2. Adverse events
   You should notify BCHEAN immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

3. Participant Information and Consent Form (PICF)
   The PICF must be distributed to all research participants, where relevant, and the consent form is to be retained and stored by the investigator. The PICF must contain the RMIT University logo and any complaints clause including the above project number.

4. Annual reports
   Continued approval of this project is dependent on the submission of an annual report.

5. Final report
   A final report must be provided at the conclusion of the project. BCHEAN must be notified if the project is discontinued before the expected date of completion.

6. Monitoring
   Projects may be subject to an audit or any other form of monitoring by BCHEAN at any time.

7. Retention and storage of data
   The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Regards,

[Signature]

Associate Professor Penny Weller
Chairperson
RMIT BCHEAN
Appendix 2 - Ethics Approval Letter from RMIT University dated 24 December 2015

Notice of Project Amendment Approval

Date: 24 December 2015
Project Number: 19616
Project Title: Causation in Medical Negligence: Challenges in Litigation and Mediation
Risk Classification: Low Risk
Principal Investigator: Dr Kathy Douglas
Student Investigator: Miss Martina Popa
Other Investigator: Dr Andrew Valiukunas
Project Approved: From: 6 October 2015 To: 2 March 2019
Project Amendment Approved: From: 22 December 2015

Amendment Details:

1. Include judges with medical negligence experience as interview participants (in addition to lawyers). This amendment is approved with the condition that only County Court judges are interviewed until the ethics process for interviewing Supreme Court judges is known.

2. Expand recruitment method to include a snowball sampling technique for all participants.

Terms of approval:

1. **Responsibilities of the principal investigator**
   
   It is the responsibility of the principal investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by BCHEAN. Approval is only valid while the investigator holds a position at RMIT University.

2. **Amendments**
   
   Approval must be sought from BCHEAN to amend any aspect of a project including approved documents. To apply for an amendment submit a request for amendment form to the BCHEAN secretary. This form is available on the Human Research Ethics Committee (HREC) website. Amendments must not be implemented without first gaining approval from BCHEAN.

3. **Adverse events**
   
   You should notify BCHEAN immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. **Participant Information and Consent Form (PICF)**
   
   The PICF must be distributed to all research participants, where relevant, and the consent form is to be retained and stored by the investigator. The PICF must contain the RMIT University logo and a complaints clause including the above project number.

5. **Annual reports**
   
   Continued approval of this project is dependent on the submission of an annual report.

6. **Final report**
   
   A final report must be provided at the conclusion of the project. BCHEAN must be notified if the project is discontinued before the expected date of completion.

7. **Monitoring**
   
   Projects may be subject to an audit or any other form of monitoring by BCHEAN at any time.

8. **Retention and storage of data**
   
   The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Regards,

A/Prof Penelope Weller
Chairperson
RMIT BCHEAN
Notice of Project Amendment Approval

Date: 31 March 2016
Project Number: 19618
Project Title: Causation in Medical Negligence: Challenges in Litigation and Mediation
Risk Classification: Low Risk
Principal Investigator: Dr Kathy Douglas
Student Investigator: Miss Martina Popa
Other Investigator: Dr Andrew Vaitiekunas
Project Approved: From: 6 October 2015 To: 2 March 2019
Project Amendment Approved: From: 31 March 2016
Amendment Details:
Expand research to include Supreme Court of Victoria Justices with medical negligence experience as interview participants.

Terms of approval:
1. Responsibilities of the principal investigator
   It is the responsibility of the principal investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by BCHEAN. Approval is only valid while the investigator holds a position at RMIT University.

2. Amendments
   Approval must be sought from BCHEAN to amend any aspect of a project including approved documents. To apply for an amendment submit a request for amendment form to the BCHEAN secretary. This form is available on the Human Research Ethics Committee (HREC) website. Amendments must not be implemented without first gaining approval from BCHEAN.

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5. Annual reports
   Continued approval of this project is dependent on the submission of an annual report.

6. Final report
   A final report must be provided at the conclusion of the project. BCHEAN must be notified if the project is discontinued before the expected date of completion.

7. Monitoring
   Projects may be subject to an audit or any other form of monitoring by BCHEAN at any time.

8. Retention and storage of data
   The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

Regards,

A/Prof Penelope Weller
Chairperson
RMIT BCHEAN
INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

PARTICIPANT INFORMATION

Project Title: Causation in Medical Negligence: Challenges in Litigation and Mediation

Investigators:
- Martina Popa
- Dr Kathy Douglas
- Dr Andrew Vaitiekunas

Dear ____________________

You are invited to participate in a research project being conducted by RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

- This project is being conducted by Martina Popa, a PhD candidate of RMIT University as part of research into the challenges experienced in litigation and mediation of medical negligence proceedings.
- The project has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

You have been invited to participate in the research as a lawyer practising in medical negligence in Victoria.

What is the project about? What are the questions being addressed?

- The aim of this research is to critically evaluate whether the 2003 amendments to the Wrongs Act 1958 (Vic), specifically to the principles of causation in medical negligence disputes, have presented challenges to successful recovery of compensation in negligence proceedings. The research objectives are to establish what effects (if any) the 2003 law reforms have had on the litigation and mediation of meritorious medical negligence claims from the perspective of lawyers practising in the field.
- It is expected that approximately 36 people will be interviewed as part of this project.
If I agree to participate, what will I be required to do?

You will be required to participate in an interview of approximately 45 minutes in duration with the researcher. The interview can be undertaken at your place of work or a nearby location. The interview will consist of questions similar to the following:

- ‘What are the challenges (if any) experienced by medical negligence lawyers in litigation post the Ipp reforms?’
- ‘Based on your experience, what are your perceptions about the changes (if any) experienced in the compensation payments received by victims of medical negligence?’

The interview will be audio recorded, however, you may request at any time for audio recording to cease. If this occurs, the interviewer will make written notes of the interview content.

What are the possible risks or disadvantages?

There are no perceived risks or disadvantages of participating in the study. However, if you are unduly concerned about your responses to any of the interview questions or if you find participation in the project distressing, you should contact Dr Kathy Douglas as soon as convenient. Kathy will discuss your concerns with you confidentially and suggest appropriate follow-up, if necessary.

What are the benefits associated with participation?

There is no direct benefit to the participant from participating in this study. Participation in this project is not required as part of your employment, and you will not be advantaged or disadvantaged in your employment if you agree or decline to participate.

What will happen to the information I provide?

- Your identity will be removed from records of the interview, and will not be revealed in publication of the results of the project.
- All research data (audio recordings and notes) created by the interview will be securely held by the researcher for a period of 5 years after publication before being destroyed.
- Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) if specifically required or allowed by law, or (3) you provide the researchers with written permission.
- The results of this project may be used in papers for publication, conferences, books and as an Appropriate Durable Record (ADR) in the RMIT Online Repository, which is a publically accessible online library of research papers.

What are my rights as a participant?

- The right to withdraw from participation at any time
- The right to request that any recording cease
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.
Whom should I contact if I have any questions?

- Martina Popa
- Dr Kathy Douglas
- Dr Andrew Vaitiekunas

Yours sincerely

Dr Kathy Douglas

Dr Andrew Vaitiekunas

Martina Popa

If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University.

PARTICIPANT CONSENT

1. I have had the project explained to me, and I have read the information sheet

2. I agree to participate in the research project as described

3. I agree:
   - to be interviewed
   - that my voice will be audio recorded

4. I acknowledge that:
   
   (a) I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
   
   (b) The project is for the purpose of research. It may not be of direct benefit to me.
   
   (c) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   
   (d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to participants upon request. Any information that will identify me will not be used.

Participant’s Consent

Participant: ___________________________ Date: __________________

(Signature)
Appendix 5 – Interview Schedule

Questions

Participant Characteristics

  a) How long have you practised in medical negligence litigation?
  b) Do you mainly represent plaintiffs or defendants in medical negligence litigation?

Prompt Questions

Litigation

  1. (a) Are you familiar with the 2003 Ipp Reforms?
     (b) Are you familiar with the legal community’s response to the reforms?
  2. Following the Ipp Reforms, what are the challenges experienced by lawyers in medical negligence litigation? Do these challenges apply to mental harm claims as well?
  3. In your view, does the element of causation present as a hurdle to plaintiffs succeeding in a negligence case?
  4. Based on your experience, what are your perceptions about the changes (if any) experienced in the number of litigants commencing medical negligence disputes after the Ipp Reforms?
  5. Based on your experience, what are your perceptions about the changes (if any) experienced in the compensation payments received by plaintiffs in medical negligence proceedings, following the Ipp Reforms? Do these changes apply to mental harm claims as well?
  6. In your view, what impact do you see the recent 2015 amendments to the Wrongs Act having on the ability of plaintiffs to recover compensation?

Mediation

  7. In your experience, to what degree do parties engage in mediation for medical negligence disputes? If they do, are emotional issues a relevant factor in participating in mediation?
  8. Do you think the mediation process assists participants to express their emotions associated with the medical negligence dispute?
  9. What do you see as the role of the lawyers in the mediation of medical negligence disputes?
 10. Following the Ipp Reforms, what are the challenges (if any) experienced by lawyers in mediation of medical negligence disputes?
 11. In your experience is mediation a more suitable dispute resolution avenue than litigation for medical negligence claims?
 12. Based on your experience, what benefits or disadvantages does mediation (as opposed to litigation) have on medical negligence clients (either plaintiff or defendant)?
13. In your opinion, are there any aspects of the medical negligence dispute litigation or mediation process in need of further reform?
## Appendix 6: Negligence Comparison Table – Causation, Thresholds, Caps and Mental Harm

<table>
<thead>
<tr>
<th>Legislation</th>
<th>Victoria</th>
<th>New South Wales</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Northern Territory</th>
<th>ACT</th>
<th>WA</th>
<th>TAS</th>
</tr>
</thead>
</table>

### Causation

<table>
<thead>
<tr>
<th>Victoria</th>
<th>New South Wales</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Northern Territory</th>
<th>ACT</th>
<th>WA</th>
<th>TAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>s 51(1) Factual causation and scope of liability.</td>
<td>s 5D(1) Factual causation and scope of liability.</td>
<td>s 11(1) Factual causation and scope of liability.</td>
<td>s 34(1) Factual causation and scope of liability.</td>
<td>No statutory provision on causation.</td>
<td>s 45(1) Factual causation and scope of liability.</td>
<td>s 5C(1) Factual causation and scope of liability.</td>
<td>s 13(1) Factual causation and scope of liability.</td>
</tr>
</tbody>
</table>

### Thresholds for non-economic loss

<table>
<thead>
<tr>
<th>Victoria</th>
<th>New South Wales</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Northern Territory</th>
<th>ACT</th>
<th>WA</th>
<th>TAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>s 28LE Requires a ‘significant injury’.</td>
<td>s 16(1) No damages may be awarded for non-economic loss unless the severity of the non-economic loss is at least 15% of a most extreme case.</td>
<td>s 61 Court must assess injury scale between 0 and 100 (sliding scale)</td>
<td>s 52(1) The injured person must experience at least 7 days impairment or incur the prescribed minimum in medical expenses.</td>
<td>s 27(2) A court must not award damages for non-pecuniary loss if the court determines the degree of permanent impairment to be less than 5% of the whole person</td>
<td>No threshold.</td>
<td>ss 9-10 Western Australia uses ‘deductible thresholds’ where a deductible amount is set ($12,000 indexed annually). If the damages are less than this amount, no compensation is paid. If the loss is between $12,000 and $36,500, a percentage is paid per prescribed formula.</td>
<td>s 27 Tasmania uses ‘deductible thresholds’ where a deductible amount is set ($4,000 indexed annually) and the payment is calculated pursuant to the prescribed formula.</td>
</tr>
<tr>
<td>Caps on damages</td>
<td>Victoria</td>
<td>New South Wales</td>
<td>Queensland</td>
<td>South Australia</td>
<td>Northern Territory</td>
<td>ACT</td>
<td>WA</td>
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<td>-----------------------</td>
</tr>
<tr>
<td>Maximum amount for non-economic loss</td>
<td>ss 28G–28H</td>
<td>ss 16-17</td>
<td>s 62</td>
<td>s 52(2)</td>
<td>ss 27-28</td>
<td>No cap on general damages.</td>
<td>No cap on general damages.</td>
</tr>
<tr>
<td>$577,050 (indexed).</td>
<td>$350,000 (indexed).</td>
<td>$551,500 now, percentage of 'most extreme case')</td>
<td>Must refer to Queensland Civil Liability Regulations 2003 (Qld) awards general damages (damages for non-economic loss) based on an injury scale to a maximum of $337,300 (r 6A(5))</td>
<td>The court assesses the level of severity of the injury. The court then compares the severity of the injury with 'the most serious and least serious non-economic loss a person could suffer, a scale of 0 to 60. Maximum is $274,200.</td>
<td>$350,000 indexed.</td>
<td>A court may refer to previous decisions to assess payment: s 99</td>
<td>Uses deductible thresholds.</td>
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<tr>
<td>Legislation</td>
<td>Victoria</td>
<td>New South Wales</td>
<td>Queensland</td>
<td>South Australia</td>
<td>Northern Territory</td>
<td>ACT</td>
<td>WA</td>
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<tr>
<td>Mental Harm</td>
<td>ss 72-75</td>
<td>ss 27-33</td>
<td>ss 30 - Limitation on recovery for pure mental harm arising from shock</td>
<td>ss 33, 53</td>
<td>ss 34(1) – Duty of care, normal fortitude requirement and recognised psychiatric illness requirement</td>
<td>ss 33-35</td>
<td>ss 5S, 5T</td>
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<td></td>
<td>s 72(1) – Duty of care, normal fortitude requirement and recognised psychiatric illness requirement</td>
<td>s 32(1) – Duty of care, normal fortitude requirement and recognised psychiatric illness requirement</td>
<td>s 34(1) – Circumstances of the case</td>
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<td>s 72(2) – Circumstances of the case</td>
<td>s 32(2) – Circumstances of the case</td>
<td>s 35(1) – Damages for mental harm, including the recognised psychiatric illness requirement</td>
<td>s 53(2) – Circumstances of the case</td>
<td>s 34(1) – Circumstances of the case</td>
<td>s 53 – Damages for mental harm, including the recognised psychiatric illness requirement</td>
<td>s 5T – Damages for pecuniary loss for consequential mental harm, including the recognised psychiatric illness requirement</td>
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<td>s 73 – Limitations on recovery of damages for pure mental harm</td>
<td>ss 33</td>
<td>s 53 – Damages for mental harm, including the recognised psychiatric illness requirement</td>
<td>ss 33(2) – Circumstances of the case</td>
<td>s 34(1) – Circumstances of the case</td>
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<td>ss 53</td>
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