TRANSCRIPT OF PROCEEDINGS

THE MEDICO-LEGAL SOCIETY OF VICTORIA

THE MELBOURNE CLUB

MELBOURNE

FRIDAY 2 MARCH 2012

The challenges presented by end of life care.

and

The success or otherwise of our tort-based system, the medical misadventure.

PRESENTED BY: Professor Richard Larkins AO

MERRILL CORPORATION AUSTRALIA
4/190 Queen Street, Melbourne. Telephone: 8628 5555
Facsimile: 9642 5185

DR HOWLETT: The Honourable David Davis Minister for Health, members and guests. Welcome to the first general meeting of the Society for 2012 and what a pleasure it is to see so many members and their guests here tonight.

Tonight's paper will address two controversial issues confronting the professions and the community more generally. Firstly, the challenges presented by end of life care. In centuries past most serious illnesses progressed rapidly to death despite and sometimes because of the application of the best available medical care.

Modern medicine is capable of applying an increasingly well stocked and expensive arsenal of treatments and technologies for the task of retarding the dying process. Do we know when to stop? A limitation of treatment protocols prompting doctors to talk to their patients about death as part of the natural order of things.

The second controversy to be addressed tonight is the success or otherwise of our tort-based system, the medical misadventure. A decade after the IP review how far have we come towards creating a system which is fair to the injured patient and which serves as a driver towards improvements in patient safety.

The views of tonight's very eminent speaker on these complicated matters will be of great interest to all of us. Professor Richard Larkins has had a distinguished career in medicine, scientific research and academic management. Professor Larkins is currently Emeritus Professor at Monash University. His previous positions have included Vice-Chancellor and President Monash University; Dean Faculty of Medicine Dentistry and Health

Sciences at University of Melbourne; James Stewart Professor of Medicine at the Royal Melbourne Hospital; Chair of the National Health and Medical Research Council and President of the Royal Australasian College of Physicians.

Amongst his many current roles Professor Larkins is Chair of the Victorian Comprehensive Cancer Centre Board; President of the National Stroke Foundation; Chair of the Research and Education Foundation of the Royal Australasian College of Physicians and Chair of the Council of the European Molecular Biology Laboratory Australia. His awards include the Sir William Upjohn Medal, for distinguished services to medicine and a Centenary of Federation medal. Professor Larkins was appointed an Officer of the Order of Australia in 2002. Please welcome Professor Larkins.

PROFESSOR LARKINS: Thank you very much Glen, the Honourable David Davis Minister for Health, the President and the Committee of the Medico-Legal Society and the very many distinguished guests. I thank the President and Committee very much for the invitation to speak to you. I was asked what I wanted to speak about and I thought how interested would you be to hear of something that I knew something about like diabetes and I thought probably not very interested, so I have chosen instead the alternative of subjects which you may be interested in but which I know very little about and in fact it's somewhat daunting to come here and see so many people much better qualified to speak to the two issues I have chosen. I am sure they have been discussed previously and in fact I had a note from David Gale to say that the implication was there was

really no need to talk about it because they had been discussed in 1967 so, I will go ahead and talk about these two issues.

The genesis of the talk was a keynote address I was privileged to deliver to the Greek-Australian Medico-Legal Conference on Kos last year and I know a number of you here were there. That talk was much broader. Essentially, it addressed the need for real reform of the Australian healthcare system. I won't rehearse the issues raised at that time but basically I argued that among other problems an essentially publicly-funded fee for service private system, that is Medicare, operating outside of a public hospital system will become increasingly unsustainable when recurrent shortage of medical practitioners is overcome, as it will be in the foreseeable but distant future with the recent doubling of medical school intakes.

Given that Medicare is very popular with the general community it is highly unlikely that any political party will make radical changes to it in the near future, so we need to look at other areas where extra costs are generated in the system without benefit to the patient. The first is end of life care. A higher and higher percentage of healthcare costs are directed to the last two years of life often spent on sustaining a very low quality of life.

In the USA health spending accounted for 17.3 per cent of GDP in 2009 and, as we know, is continuing to rise fast and the Obama reforms may not affect that too much. It is estimated that about a third of all healthcare spending is on individuals in the last year of their

lives. In terms of public spending by the USA Government about 27 per cent of Medicare's annual $327 billion budget is spent on the care of patients in their last year of life. The average cost of end of life care varies markedly from one centre in America to another and at least one factor that has been shown to be relevant in determining higher versus lower costs is the preparedness of a doctor to discuss with the patient or relatives what care they might wish for in their terminal phase.

Indeed, it has been shown that for patients with advanced cancer in the USA discussions between the patient and the doctor led to a reduction of 36 per cent in the cost of care in their last week of life and the difference was between $36,000 in the last week of life, reducing by a third.

Patients with higher healthcare costs - and this is really important - had worse quality of death in their final week. In other words, the lack of that conversation led to a worse quality of death. We do not have comparable data in Australia. Overall we probably manage end of life care better than the most expensive centres in the USA but my own experience suggests we could do much better.

As important as cost is managing this phase of life and the process of dying is often extraordinarily and unnecessarily distressing for the patient and their relatives. Discussion of end of life care too often focuses on the legalisation or otherwise of euthanasia. I believe that this misses the main point but I will discuss my own views with respect to this issue before concentrating on other areas where I think that medical

care is often applied inappropriately.

My view is that the law regarding the wilful and deliberate ending of someone's life for medical reasons could not be changed. Good medical practice dictates that someone who is suffering pain or other debilitating symptoms should have appropriate treatment to relieve those symptoms. Sometimes this treatment will shorten a person's life. If they have a terminal illness this may be an acceptable side effect of the treatment.

For example, someone dying of lung cancer with severe pain and shortness of breath may require large doses of morphine to control the pain. This may hasten death by impairing breathing further but the essential purpose was to relieve symptoms.

Although this may seem like sophistry I think this is different from legalising the process where a doctor at a patient's request can deliberately end a patient's life. Although at first glance the arguments for allowing patients with terminal illness who decide to die with dignity at the time and by the means of their choosing may seem compelling. My experience with people with terminal illness is that their mood can change quite markedly during the course of their illness. During phases of depression they may indeed choose to die but a couple of days later they may once more be cheerful and enjoying positive interactions with family and friends.

Moreover, many dying patients feel that they are a burden on their families and would state a wish to die to ease that burden. Finally, pressure from relatives eager to acquire an inheritance or motivated by more worthy objectives may encourage the patient to request

euthanasia. Complexities such as these would make such a law difficult to administer and with all due respect to my legal friends I do not think legal process is the best way to resolve these difficult issues. As Davis McCaughey concluded in addressing this Society on this issue in 1995 "Let the law protect but not too readily intervene in the freedom of a doctor/patient relationship".

Where we do require real reform is a more general acceptance by the community and the medical profession that there comes a time when aggressive medical care is not only expensive but also futile and meddlesome. Lynn and David Adamson for the Rand Corporation USA have advised on building a care system that works in the elderly and in those with progressively downward trajectories of disease such as an incurable cancer, chronic organ system failure and dementia and frailty.

Doctors, nurses and the community in general should be educated but for default situations when someone with chronic progressive disease approaches death should be death with dignity. The possibility, for example, of cardiopulmonary resuscitation should not need to be raised with relatives or with the patient. This intervention in the situation of chronic progressive disease is futile and to raise it as a possibility only causes confusion and distress. If it is raised, some relatives will insist that resuscitation is offered as they wish everything possible to be done for their loved one. Others will feel guilt and partly responsible when the inevitable death occurs if they had had the possibility of cardiopulmonary resuscitation raised with them and decided against it.

Similarly, it is hugely expensive and not kind to

the patient or relatives to transfer a patient who has a very low quality of life because of physical and mental impairment to intensive care at an acute hospital when they have an acute complication. Advance directives should be encouraged much more actively than they are at present and doctors in a community and aged care facility should be supported in making decisions against transfer and intensive treatment in such circumstances. Fear of litigation sometimes motivates inappropriately aggressive treatment.

The chapter of palliative medicine of the Royal Australasian College of Physicians has been active in encouraging end of life care plans. These should be formulated in partnership with the patient if they are mentally alert and with the relatives. The conversation should not contemplate intervention such as CPR which are medically pointless and futile. As shown in the USA, such conversations and resultant plans lead to less expense and, more importantly, a better quality of dying.

End of life care is a contentious issue. The second topic I have chosen is controversial and inflammatory in the extreme. There is no area where the views of the medical and legal professions are so completely out of alignment. The Honourable Justice Michael Kirby in an address opening a conference at the Royal College of Physicians London in 2000 described a recent exchange between Dr Keiran Phelps then President of the AMA and Dr Peter Cashman then President of the Australian Plaintiffs' Lawyers Association in the following terms:

> "As usual this debate between leaders of the medical and legal professions proceeded in the manner of two ancient vessels passing each other

> in the night. Each profession tends to look on the issue from the viewpoint stamped upon it by its respective mission."

There has little change in attitude by either profession since then, so for me to broad the subject would, I'm sure, be described by Sir Humphrey Appleby as courageous.

Let me put my viewpoint and give two options which I think would each be infinitely better for everyone except for those who currently make a significant part of their income from the current tort system as it relates to medical negligence. Let us look at the current tort law that governs medical negligence.

Put simply, I believe it provides the opportunity for a patient injured in some way by the negligence or incompetence of a medical practitioner to sue that practitioner and to attract damages that would cover cost of ongoing care, loss of earnings and compensation for pain and suffering. There are two objectives of such law: the first is to compensate the patient; the second is to punish the doctor for his/her incompetence or neglect.

How well is the current law as it is practised achieving these ends? First, compensation of a patient. Some patients, through negligence, benefit enormously and justly through the current system but others with similar unfortunate outcomes of surgery or other medical misadventure receive nothing through this system although their disabilities may be identical or worse. This may be either because they do not have the knowledge or inclination to sue or because a court judges that the outcome was not due to negligence. Indeed, Bismarck and Paterson have pointed out that in the United States the majority of patients who sue and receive damages have

received appropriate care and a majority of negligently injured patients do not sue especially if they are poor or elderly. This analysis would suggest that the system is failing to deliver a just outcome for patients who suffer medical misadventure and therefore is not meeting its first objective.

Second, punishing the doctor for his/her incompetence or neglect. Medical indemnity insurance is required for clinical practice. In the event that a successful action is pursued the medical indemnity company pays for damages. This disconnection between the person responsible for the negligent action and the organisation that pays for damages disrupts the pathway of responsibility and punishment. Indeed, the costs are passed on to the body of medical practitioners in general through high insurance premiums. So, all the medical profession, the vast majority of whom are not negligent, pay the punitive costs intended for the negligent individual, hardly the assignment of punishment that would seem to have been intended.

Moreover, some disciplines within medicine attract must higher premiums, notably obstetrics and neurosurgery. As it is inherently unlikely that negligent doctors are selectively attracted to these disciplines the different premiums reflect the likelihood of successful action through the tort system rather than any reflection of successful application of tort law to differentiate negligent outcomes from similar outcomes where negligence was not involved.

So the current implementation of tort law for medical negligence seems not to be achieving its purpose

neither the point of view or just compensation for injured patients or punishment of negligent defendants. But of equal concern is that it is causing adverse outcomes in other ways. Although reforms introduced by the Howard Government in 2002 in which the Government took responsibility for part of the insurance premiums medical insurance premiums remain high of the order of $50,000 for obstetricians and neurosurgeons, for example. These costs are generally passed on to patients in the case of public patients to the Government. In any event, they add significant cost to the healthcare system.

Most doctors, particularly those in private practice or in emergency departments would acknowledge that their practice is affected by tort law relating to medical negligence. Unnecessary investigations such as CT scans in the case of relatively minor head injuries; unnecessary hospital admissions; unnecessary biopsy excisions of benign lesions or unnecessary Caesarean sections are all performed to minimise the risk of accusations of negligence. All generate extra healthcare costs borne by the taxpayer or patient. Aggregate unnecessary investigations and procedures cost Medicare and the Australian taxpayer billions of dollars.

There is a more subtle effect of a current law relating to medical negligence. Relationship between doctor and patients can be adversely affected. This may be in the nature of the information conveyed to the patient before a procedure where legal precedent now makes it necessary to describe even very unlikely potential adverse events. A surgical colleague of mine now routinely tells patients that they may die as a result of

even minor surgical procedures. True but hardly helpful information. Fear of litigation often limits disclosure and explanation after a surgical or other form of medical misadventure and can turn what should be a mutually supportive process into an adversarial one. This despite some advice that open disclosure and apology can limit the risk of litigation although the evidence for this is mixed.

The tort reparation system is poorly attuned to the modern approach for quality improvement, particularly evident in hospital practice but becoming more applicable to community settings where there are now overarching structures such as divisions of general practice and Medicare Locals. In contrast to the tort system the modern approach to adverse events is to examine them in the context of a whole system of checks and balances that should prevent adverse events in an open and non-judgmental way. Methods to prevent similar events in the future are proposed and, if practical, put in place. This approach depends on openness and honesty and is severely impeded by the threat of litigation hanging over the head of those involved.

Another example where the tort system of reparation is particularly poorly aligned with health priorities is in the case of immunisation. Kelly, Looker and Isaacs have recently argued that there is a strong ethical argument based on the concept of redistributive justice for a no fault compensation system for the small proportion of individuals suffering a serious adverse effect of immunisation. Their argument is that any person who is injured while helping to protect the community by

contributing to herd immunity, that is ensuring that there are sufficiently many people immunised to prevent widespread disease transmission within the community could not bear the consequences of injury alone. They conclude that immunity owes a debt of gratitude to that person and it is arbitrary and non-productive to restrict the compensation to situations where negligence can be demonstrated.

It may be claimed, to paraphrase Churchill's description of democracy, that the tort system is the worst form of compensation for medical misadventure except for all the others which have been tried but I would dispute that. Given the failure of the tort system to achieve either of its two objectives and the adverse effects associated with it, alternative systems have very little to beat.

In this country we do have a viable alternative system for motor vehicle accident compensation where for the most part compensation for victims is separated from penalties to those who are to blame. Where there is clear criminality or negligence involved this is pursued separately from compensation for victims except in exceptional circumstances. Although not perfect, the Transport Accident Commission's system of compensation works well and is well accepted.

In the specific case of medical misadventure we need to look overseas for other models. The experience of a no fault system of compensation for adverse outcomes of medical treatment following the introduction of the Accident Compensation Corporation or ACC in New Zealand in 1974 suggests that there is a viable alternative.

Following modifications and broadening of the compensation for medical misadventure in 2005 it covers medical costs, lost earnings and standard compensation for residual disability regardless of a cause of the injury resulting from treatment or failure to treat.

In a comparison with the US tort-based system Bismarck and Paterson found that the New Zealand system had low administrative costs, less than 10 per cent of awards compared with greater than 50 per cent, low versus high average payment, very low physician indemnity insurance costs, weeks to a few months versus years to resolve claims and allow claims analysis to improve patient safety as opposed to the theoretical deterrent effect of a tort system.

It is necessary that a no fault system of compensation is allied with methods of identifying and sanctioning individuals who are performing in a substandard way. In New Zealand the Health Services Commission was introduced with the specific role of following up reported cases and specialist colleges and medical boards have established procedures for advising on appropriate behaviour and sanctioning those for not performing at an appropriate level.

In addition, it remains possible to bring actions for exemplary damages but the courts in New Zealand have found that not even gross negligence warrants such damages unless there is some element of conscious or reckless conduct.

Variants of the New Zealand system are operating apparently satisfactorily in Sweden, Denmark, Finland, France, Florida and Virginia. In their concluding remarks

analyse the outcomes of a New Zealand system in 2006 Bismarck and Paterson wrote "In the 1970s the US Department of Health, Education and Welfare wanted a study of New Zealand's proposed no fault system. Arthur Bernstein, the study's author, reported that - and I'm quoting Bernstein now - "The most effective remedies for the ills of our tort reparation system may be disclosed by demonstration in an attractive, usually tranquil and very civilised little country half a world halfway. The developments Down Under thus merit our most careful and continuing observation" and going back to the quote from Bismarck and Paterson in 2006, "Some 30 years later with the rise of systems thinking about the causes of adverse events the tort system is looking increasingly anachronistic. Although the New Zealand system has not delivered a perfect solution for the problem of medical injury it remains popular and there is no enthusiasm among the public or healthcare providers to return to tort law as an alternative. The Accident Compensation Corporation does not deliver the windfalls of a forensic lottery but it offers injured patients reasonable assistance quickly and without rancour. The unfinished business lies in realising in realising the system's full potential for enhancing patient safety".

In relation to the last reservation about the New Zealand system, articles aimed at quality improvement are now starting to appear in the medical literature as a result of analysis based around ACC data. In accord with this summary I feel that the New Zealand Accident Compensation Corporation system is decidedly preferable to the American or Australian tort-based system and allows

the objectives of a compensation system to be met. I feel that a harder intellectual exercise is to justify financial compensation only if the disability results in an adverse outcome of medical treatment.

As argued by Thomas Douglas of the Uehiro Centre for Practical Ethics at Oxford University, while it is obviously fair to compensate patients for adverse outcomes of treatment regardless of whether negligence was involved, why should individuals who suffer similar outcomes as a natural result of disease not be similarly compensated? Because this already happens in part through the public provision of healthcare and social service payments for disability and unemployment. Douglas argues cogently that funds that might be raised by taxation or insurance against adverse outcomes for medical treatment might more fairly be applied to compensate all who have debilitating disease or injury during normal working life regardless of cause by improved health benefits and social services rather than differentiating on the basis of relationship or adverse impact of medical treatment.

The situation is likely to change in Australia. A review by the Productivity Commission broadly supported by both major political parties has led to a proposed $6.5 billion national disability insurance scheme which would pick up the cost of ongoing care associated with injury regardless of cause and including medical misadventure. Victims would lose their common law right to sue for future care costs, often half the total damages settlement in the current system, although they could still sue for other damages in a negligence claim. e new scheme if accepted by Government would be introduced from

2014 but it is estimated it would not be fully operational until 2020.

In conclusion and thank you for your patience, I'm aware that it is a very severe form of torture to be brought in, sat a dinner table, have a menu in front of you and empty wine glasses and then have to listen to a speaker for 45 minutes before you are either fed or watered. In conclusion I would argue that there remains potential to improve two aspects of our current healthcare system with considerable savings to the system and better outcomes for patients in a wider community.

One is by more sensible end of life care; the second is by replacing our current tort-based system of achieving compensation for a small percentage of patients suffering medical misadventure with a no fault system of compensation similar to the New Zealand system or more extensive disability insurance scheme to include adequate compensation for care, other costs and lost earnings for who have premature illness or injury.

Thank you once again for your attention and I very much welcome comments and questions, thank you.

DR HOWLETT: Professor Larkins, you have given us a feast of ideas and I'm sure that we are more than happy to wait for half an hour or so for the main course to arrive.

Professor Larkins has kindly agreed to take some questions from the floor and I'm sure that the stimulating matter that he has presented tonight with prompt at least a few questions. For the purposes of the sound recording, if you could wait for the microphone which Mr Michael Gronow is wielding and preface your question with your name.

ASSOCIATE PROFESSOR RAIT: Julian Rait, President of one of medical indemnity insurance organisations, MDA National. Richard, I think I completely agree with your supposition about the tort law system. I think it is very imperfect and I think where the Doctor (indistinct) medical indemnity insurers sit we would completely agree.

PROFESSOR LARKINS: A bit louder.

ASSOCIATE PROFESSOR RAIT: Sorry. But we have been engaged for some months with the Productivity Commission with a discussion about the NDIS and NIIS which for those that are unfamiliar with the acronyms they are the National Disability Insurance Scheme and National Injury Insurance Scheme and it seems to me that while there's a lot of goodwill to actually progress this, particularly on part of the medical indemnity insurers, there's a reluctance on the part of Government to contribute their share.

PROFESSOR LARKINS: Yes.

ASSOCIATE PROFESSOR RAIT: And David Davis would probably acknowledge that Mary Wooldridge recently put into print in the Australian the supposition that when she's tried to talk to the Federal Government about this they haven't really sort of come to the party with any proposal about how they would fund it. I think she used the term "the elephant in the room was not being addressed". So while I would concur with your observations about the system and its infections and how it could be improved, really the problem we see as insurers is that we can't really expect doctors to pay for all the no fault claims as well as the fault claims. So how would you see that we can effectively be advocates and argue with Government that this is, indeed, in the public interest.

PROFESSOR LARKINS: For a start the cost of a scheme in New Zealand has not been prohibitive and, indeed, in terms of the Accident Compensation Corporation total payout the medical misadventure side is a small percentage of that total amount and it seems to me that the benefits in our system and, indeed, the savings to our system without the defensive aspects of medicine which I know to be practised from my own experience in seeing just the pressures on doctors, emergency departments, GPs and so on. They would just be ultra careful when they know that it's not really needed to have this CT scan but they had better just to be sure because of cases which have happened in the past.

So I think the argument has to be put forward by those who are convinced by the argument that ultimately in terms of Government costs there will be substantial reductions. It is not prohibitively expensive; it gives a better outcome; it will be electorally popular if it's handled properly and there will be net savings to the system.

QUESTION: Thank you, Richard. I ask you this question from a basis of over 35 years' serious interest in end of life issues and I agree with you entirely that it is high time we put to bed the idea of doctors delivering lethal injections to patients. In my view that is entirely unnecessary. But I do suggest that when we discuss suffering at the end of life the emphasis on it is largely around the issue of pain but it is by far not the least issue that people have to deal with.

One of the more important issues - equally important issues I should say - is the psychological and existential suffering that people suffer as they go towards the end of

their life and in circumstances where they cannot have an open, honest discussion with their treating practitioner. In my view the question should be would we allow doctors to engage in a conversation - an open conversation with their patients who are approaching the end of their life with great suffering and allow them to give them advice, to support them and to prescribe for them medication which that patient could use to end their own life with security, dignity and serenity.

In my view and in fact in my experience dealing with more than 500 patients in these sorts of circumstances, the ability of a patient to have that conversation and to achieve that medication has the most profound palliative value and it is palliative to the extent that if they have control over the end of their life they have a remarkable palliative benefit, psychological and existential distress is relieved and they can go towards the end of their life with confidence that they are in control not their doctor.

I would simply point out that this has been very successfully applied in the State of Oregon and more recently in the State of Washington in the United States. This is a different approach to that of what is commonly known as voluntary euthanasia and in my view it is infinitely superior, it puts control in the hands of the patient and that in itself is its own control.

PROFESSOR LARKINS: Thanks very much. I am obviously full of admiration for the campaign which you have conducted over many years and it is one with total integrity and I do agree that the distinction you make between enabling the patient to end their own life compared with the doctor being the instrument or directly ending the life is a

difference, too, not just sophistry as I mentioned.

My own view is that giving the doctor the power to prescribe medication in that way is potentially a difficult issue but I don't think I'd take a huge amount of issue with your comment. My comments related, as I made clear, to the doctor being the instrument. I guess that's one step removed from that. I was one step further back again and I think I probably just on the slippery slope argument would still argue for the line I took rather than the line you take. But I totally respect your views and haven't got any good reason for putting my views ahead of your views. In fact you've given a lot more thought to it over time than I have.

MR COURT: John Court. As a paediatrician I guess I don't have much influence in the area that you are talking but having said this I have two brief questions. The first is to what extent you think that introduction of a new culture in medical teaching schools may forward the concepts that you have put forward towards us and how much has this been done? The other question is what do you see the barriers that are blocking the suggestion you've made tonight? They seem to me to be so full of absolute incontrovertible argument that it is astonishing that there isn't much more active work in that area.

PROFESSOR LARKINS: I think that things have improved considerably in recent times although what mature physicians and surgeons and general practitioners would say to students and what they then see being practised in their internships are often a long way apart because what we still see practised in our hospitals is very aggressive maintenance of life in inappropriate situations, so not

quite the sorts of things that Peter Greenberg or Michael Hurley or whatever might tell the students but the sorts of, I guess, of aggressive ER type stuff that they see on television but then very much see being enacted in our hospitals.

There's also the fear of litigation in nursing homes where somebody who is on the pretty terminal part of a downward course - demented, frail, has a haematemesis or gets pneumonia or whatever - their first reaction is to push them off to hospital with a lack of proper communication between community settings and our public hospital system through lack of smart cards and things that everyone should have often leads then to the person getting pretty aggressive care before it's realised that neither the patient nor - if they were compos - nor their relatives would wish that to happen.

So I think that there are barriers some of which are fear of litigation, some of which are role modelling around the more aggressive exciting aspects of medicine that you see practised around you in hospital and I think it's just going to take a lot more of sympathetic education before we change that.

We are seeing a demographic transition. I mean we're seeing so many more people in this situation where they're not dying of heart attacks at 65 or whatever but instead they're living into old age and it's not an age issue, it's a state of health issue, so it's not an ageist argument I think you - it is a question of but older people have these problems more often and I just don't think we're handling it properly yet.

The chapter of palliative medicine in the College of

Physicians is doing a great job particularly around cancer but other forms of chronic disease in end of life care plans and I think that's the way we should really go.

DR YATES: Professor Larkins, thank you very much for your talk. As a geriatrician I guess I have an interest in this area and I think the older person is often targeted as a sort of culprit of the burgeoning cost of health. But there's a very interesting work done by Jenny Macklin actually in her days as a social worker which demonstrated if you died after the age of 80 you cost the community a lot less than if you died before the age of 80. So I think that while the older person is often targeted for advance care directives, I think that the advance care directives need to look very carefully at those of a younger age where heroics are often much more likely to be conducted than other times.

AMA Federal has pursued a national advance care directive and wants a legal construct around that. You may know that in the residential aged care sector only about 16 per cent of contacts either health profession with a resident are done by the regular doctor practising for that patient and most of it is done by locums because it's after hours.

PROFESSOR LARKINS: Yes.

DR YATES: Certainly, we would strongly support - and I wonder what your thoughts are - how we would go about deriving a legal construct for advance care directive so the locum who knows nothing about this patient has some protection and some construct around which they can act in a legal fashion to pursue an advance care directive which is planned. I can also say that there is no availability or

not requirement within the Aged Care Act or within the performance indicators for residential aged care or an advance care directive to be performed and certainly in my role on the National Dementia Advisory Committee for the Minister we are pursuing the concept that at least in those patients who do have an underlying dementia that there should be a requirement of a residential aged care provider to ensure there's an advance care directive in place.

PROFESSOR LARKINS: Thanks very much for those comments, Mark, they are obviously really appropriate ones. I think the point about age is very important, too, and I wanted to separate it from the age issue. I mean with people living longer there are more people in the sort of chronic downward trajectory of dementia and frailty for example but it should be something that we talk about in relation to its trajectory of their illness rather than in terms of age. It's not an age issue per se.

There are, as you say, data showing that older people in their last year or two of life do cost less money and that's because I think everyone thinks how tragic it is when somebody dies of some chronic disease at a younger age and tries to do everything, often inappropriately, with that patient. Thank you also for making the point about locums. I quite agree and that's part of the answer to John Court's question I think as well.

The lack of continuity of care, whether it's in the community environment because of the non-usual doctor seeing them or whether it is because of a transition from the community to hospital, both those transitions are

areas where we have severe communication problems and where I think we've been derelict as a nation in not having electronic records in the form of smart cards that people carry that should have these advance care directives and so on very much a part of them.

DR PRAGER: Shirley Prager, Melbourne. I wanted to ask you about Medicare Locals and fund-holding, you mentioned them in your talk. I see a problem ahead that unless we get rid of the Medicare Locals at the next Federal election, which hopefully we will, there will be a problem about rationing by bureaucrats because Medicare Locals are not in any way controlled by doctors but by bureaucrats. They are companies, they are sueable and I am grateful as a doctor that we have our lawyers here to sue if patients are not given the appropriate care because of rationing by Medicare Locals which is a real worry for the future.

PROFESSOR LARKINS: I think I have touched on enough controversial topics without getting into that one. All I was really quoting the Medicare Locals was as the successor I guess of division to general practice which in their first format were really a way of grouping, as you know, GPs together in a way that would be mutually supportive and allow things like quality and so on to be done in a group basis, educational programs and so on and those are the elements that I would like to see preserved, not the ones you referred to. But I'm not sure keeping a tort-based system is the way to address that problem. I would still argue that it's a very heavy hand to bring in to solve that problem.

MS KLEIN: I'm a plaintiff lawyer with a medical negligence practice, Wendy Klein is my name. I see a lot of clients

who come in because they have had an adverse outcome and the shutters have come down and they can't get any explanation or any acknowledgment. I'll start again.

As a plaintiff lawyer I have a different perspective on what is being discussed tonight. I see a lot of clients come in who have had an adverse outcome and they cannot get an explanation or an acknowledgment. As soon as something goes wrong the shutters come down. My question is how would a no fault scheme address the issue of patients being - having some acknowledgment, having some explanation and having some plan devised in an open manner as to how the adverse outcome could be dealt with.

PROFESSOR LARKINS: I accept there are different viewpoints. But my argument would be that it's just because of the adversarial nature of the court system that the shutters do come down. The New Zealand system has the application to the ACC being something that's done together by the medical practitioner and the patient together. It's a collaborative approach, something's gone wrong, a person has been injured, you don't have to say whose fault it is but this is the outcome, the patient needs compensation, so the doctor sort of certifies that, it goes in and it's no judgment about right or wrong. Now if he/she was negligent then the Health Services Commissioner and other ways would follow up that. But it's just those shutters that I think the tort-based system encourages and at least some of the medical insurance companies over time have very much encouraged, just as the motor vehicle insurers encourage you not to admit fault because that will make you more liable, some at least are provided that advice. There's controversy around that. There's been arguments

that there will be less likelihood of suing if you are open with the patient and apologise. But I think a lot of people are not quite game to do that and when it's been studied I think it has been found that there have been more cases of litigation as a result of that policy although the settlements have been smaller. So there are good things and bad things about it but it's regarded as pretty risky, I think, so it does encourage the shutters as opposed to the reverse of that.

DR HOWLETT: Perhaps just a couple more questions.

MS MANDEL: Catherine Mandel. My question relates to appropriate end of life care and I strongly agree with you on compassionate appropriate care but my concern is that it seems from personal experience that many doctors acquaint metastasis with terminal which from my experience at Peter Mac is definitely not the case. How do we get doctors to listen more to patients and get accurate information before they start trying to convince families that care should be withdrawn and patients with non-malignant complications and illnesses were not yet terminal?

PROFESSOR LARKINS: I think the key is a good relationship between the normal caring doctor and the patient and their family. It's an area where obviously it has got to be something that is done in partnership. All of us in medical education now would very much teach that approach which is communication and openness in discussing these issues, not raising things which are medically inappropriate but raising the possibility of more or less aggressive treatment in different situations and I think that's the key - is having doctors who are capable of and

willing to listen and engage in that conversation and I think we're definitely moving in that direction. But to say that everyone is equipped with that skill would be a gross exaggeration at this stage.

MR RIGOS: Michael Rigos, I am a lawyer and I spend my professional life defending doctors in medical malpractice litigation. I have a couple of questions for you, if I may. The first is I found your comment regarding one of the detriments of the tort law reform system is that it has caused doctors and in particular one of your colleagues to inform a patient that they could possibly die as a consequence of a procedure, I found that comment rather curious and I will ask you to expand on why you think that is a deleterious effect.

The other aspect that you raise was you mentioned the Transport Accident Commission and that would be a better system than the current tort law system. That system of course is a no fault system or partly no fault system and it's funded by the very people that cause the injury to others which is the motor vehicle drivers. The people pay their registration and they fund that system. I wonder whether you would respond as to whether if that sort of system were introduced for medical injuries whether it would be acceptable for the medical profession to pay for that system.

PROFESSOR LARKINS: In relation to the second question - I think what your first one was, which will come to me in a moment - I think the costs should be distributed, certainly - I mean doctors pay large amounts for their medical insurance so a component of a no fault system which would I think ideally over time, like the New

Zealand system, extend to include medical misadventure along with other forms of accident. They've really got one system that covers everything and the different employers and so on pay premiums that help to cover it, but doctors would certainly be in amongst that just as they pay premiums now in relation to it.

In relation to the first point which was the bit about "you might die", I mean anything can happen just about but if you provide that type of information in a way that this particular person does it tends to put people off making perfectly sound judgments that the right thing to do is to have this procedure which might be to relieve a problem or symptom which is considerably less severe than dying but nonetheless if they're given the choice that they might die it is somewhat offputting for them.

So I think that just the totally alarmist view of a most extreme form which I think followed the sympathetic ophthalmitis case where somebody wasn't informed about the risk of losing their other eye if they had an operation on one eye, extending it that far just makes it a bit of a mockery because it is not useful information. I mean of course people know with any intervention they could possibly die but if that's put forward as the No.1 thing or very high on the list of information that's transmitted to the patient it's just not particularly useful, I think.

DR HOWLETT: One final question.

MR RIORDAN: Roger Riordan, I'm an outsider. I have a variety of sharp weapons at home. I believe that I have the right to end my life when I wish. If I could rely on my doctor to end my life when I asked him to, I would not contemplate using a sharp weapon. As it is, if I think

there is a possibility that I will find my health in a situation where I can't control it, I will use that sharp weapon; I think that's something which we (indistinct).

PROFESSOR LARKINS: I think the essence is a relationship with the doctor that should enable the doctor to care for your symptoms. Of course people in any situation can commit suicide if they choose to do so. What I'm talking about really in the end of life situation is someone with terminal illness is a discussion about what the choices and options are with the relief of symptoms being the predominant thing driving the doctor in concert with the patient. So, I would hope you would find yourself in a much more supportive environment than one where you chose to use instruments sharp or otherwise to end your life.

MR RIORDAN: (Off mic).

PROFESSOR LARKINS: Yes, well I think if we start to get legal prescription we will have such restrictions placed around those prescriptions or whatever that it will become a very difficult and cumbersome process and I think if Davis McCaughey was right, the less the doctor/patient relationship is interfered with probably the better for everyone in this setting. A very difficult setting. There's no absolute right answer. I don't think your sharp instruments are the right answer but I think a good relationship that's worked through is the best way of care plan. Palliative care now will relieve most of your symptoms in a way which will be very satisfactory allowing death with dignity. There are a few exceptions, as Rod would say, but the vast majority of cases, the much more positive environment than the one that you envisage, I am pleased to say.

Sorry, it's a bit of a morbid topic to be talking about before you have a nice dinner at the Melbourne Club. Can I just thank everyone for their attention. It has been great talking to you and thank you for your questions.

DR HOWLETT: I call upon Dr Robert Nave, treasurer of the Society, to give the vote of thanks.

DR NAVE: Thank you Mr President, the Honourable David Davis, members and guests. I have had the great privilege and pleasure of being a friend of Richard for many years or many years I think longer than we can remember or either of us care to remember, put it that way, and having shared numerous classes, lectures and exams with Richard I very quickly realised that there's no way that I could ever become top of the class and there's a number of my colleagues here tonight who would have experienced the same problem.

Richard has always protected all of us from the arduous duties of being top of the class. Richard has a very brilliant mind and if I just summarise his life as I know it in one word that would be "excellence". I think we've heard from the President tonight some of his wonderful achievements. One I don't think he mentioned was past captaincy of the Royal Melbourne Golf Club which indicates he is more than just an academic.

We have been privileged tonight to have Richard share with us examples of his excellence on thought in two topics enduring and medico-legal interests. The first one on the end of life care which is a topic of interest to everyone here tonight, as seen from the questions that have been asked, and eventually we just don't know, one

day we may be called upon to make a decision to end the life of a loved one; this is a very topical subject.

Those of you who may have seen the film with George Clooney "The Descendants" will know what I'm talking about. In real life at present Queen Beatrix of the Netherlands and her daughter-in-law, Princess Mabel, they are both currently facing this very problem with respect to Prince Friso who suffered from prolonged cerebral hypoxia when he was buried in an avalanche in Austria.

On the topic of end of life care, even the decision of end of life, many of you may have read in the Odd Spot of The Age yesterday about a 96 year old Chinese woman that got out of an open coffin six days after she was pronounced dead and put into that coffin and she was found cooking a meal claiming that she was very hungry. Well you may say, that can only happen in China, it wouldn't happen here, but I wonder.

The second topic which Richard covered adequately was medical misadventure. This is a perennial topic. As he mentioned, it has been brought up many times in the Medico-Legal Society in various forms in the past and in fact the first case, if I could recall, is in 1936, only five years after the Society was formed, when Dr Murray Morton referred to "the medical profession was receiving a raw deal at the hands of the sister legal profession" and he also said that "some of the claims are so disproportionate to the grievances that they are obviously blackmail". Now that was 75 years ago. Since then the topic has been covered by several presentations with frequent reference to the inequality of first injury from medical event only being compensable when medical

negligence can be established.

What really concerns me is that no action has ever occurred as a result of these past papers as far as I'm aware. I would hope and I believe that Richard's talk tonight would provide the basis for investigation and possible reform of current legislation, consider no fault legislation. Perhaps it would be possible to review the Wrongs Act 1958 as applies to medical misadventure and remove references to negligence that retain threshold levels for trivial claims and also change the name to the No Wrongs Act 2012.

I realise that changes in law are not made by lawyers but by Parliament and tonight we are privileged to have the presence of the Victorian Minister for Health the Honourable David Davis and whilst the issues are not necessarily at a State level also the Federal level, I would hope that David and perhaps a colleague in their spare time, or David when he's sorted out the problems with the nurses' dispute, might find time to organise a committee to thoroughly investigate the possibility of eliminating some or all of Richard's suggestions.

I would hope that Richard's talk on 2 March 2012 will be the catalyst for a new chapter in medical misadventure and not just another chapter in the proceedings of the MLSV. Please join me in thanking Richard for a most erudite and thought provoking lecture.

- - -