

Medical indemnity

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TO THE EDITOR: Recent astronomical awards for medical mishaps, and the follow-on medical indemnity crisis, bring back memories of an earlier editorial I wrote for the Journal dealing with some aspects of this problem. Its message is worth repeating.

In 1990, a letter by Armstrong was published in the Journal, which enclosed a newspaper advertisement for a firm of solicitors, Messrs Stern, Stern & Tanner, inviting custom from anyone who may have been a victim of “obstetric negligence”, “even if your child was born as long ago as 1965 or even earlier. Initial consultation free”. The Journal’s then editor invited me to write an accompanying editorial.

The editorial, published simultaneously with Armstrong’s letter and accompanying advertisement, was headed “No hawkers, canvassers or solicitors”.² It began with a quotation from United States Chief Justice Burger: “Never, never, never under any circumstances hire an advertising lawyer!”.³ It noted that some solicitors claimed to possess special expertise in asbestos-related diseases, others claimed to know all about defoliants. I suggested, in those innocent days, that “obstetric negligence” was a new subspecialty which should henceforth be known as Stern–Tanner disease. (If Drs Guillaín and Barré were to be forever enshrined in medicine’s Hall of Fame, why not Messrs Stern and Tanner?)

My editorial suggested a remedial response, stating that “the law permits parties to any contract to abrogate, limit or qualify their legal rights, duties, liabilities and remedies which might otherwise arise. Thus, while the courts — both here and in the United Kingdom — tend to lean against total exclusion from liability, they are,

surprisingly, more benevolent towards clauses which limit liability, however contemptuous the specified amount.”

I adhere to that view. I can see no reason why doctors — save in an emergency — cannot demand that patients enter into a written “contract of treatment” which limits the treating doctor’s liability to a specified amount. And while such contracts will not be valid against children born impaired as a result of “obstetric negligence”, I can see no reason why the courts should deny the validity of such contracts as a matter of public policy. Why should “contracts of treatment”, entered into between consenting adults, be any different from those entered into with lawyers or dry cleaners? It may seem a trifle offensive, but then the practice of medicine is treated in law as a business, much the same as touting lawyers or dry cleaners. If doctors were once put on a pedestal, this pedestal has been effectively knocked down by astronomical awards of damages freely awarded by the courts — whether by judge or jury — largely as a result of the freely expanded constituent elements of the tort of negligence.

I researched the law relating to “limitation of liability” clauses, which was published in the *Australian Law Journal*⁴ and quoted in the *MJA* editorial:

“Why the courts should be more benevolent to clauses of limitation than to clauses of exemption is not easy to comprehend. . . . The principle, it seems to the present writer, is much the same: Exclusion clauses save a party from having to pay anything, whilst a limitation saves him from having to pay as much as he would otherwise have to pay. [. . .] Alas, the last word on this seems to have been spoken for some time to come.”

As far as I am aware, the law has not changed since the publication of my earlier research.

1. Armstrong M. Claims for obstetrical negligence [letter]. *Med J Aust* 1990; 152: 52.
2. Gerber P. No hawkers, canvassers or solicitors! [editorial]. *Med J Aust* 1990; 152: 3-4.
3. Burger CJ. Address to the American Bar Association Commission on advertising. *Nat Law J* 1985; 22: 18.
4. Gerber P. Limitation of liability. *ALJ* 1984; 58: 418-420. □

Chronic fatigue syndrome clinical practice guidelines

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TO THE EDITOR: The ME/Chronic Fatigue Syndrome Association of Australia Limited. has expressed its concern over the content of the Royal Australasian College of Physicians’ clinical practice guidelines on chronic fatigue syndrome, published as a recent supplement to the Journal.¹ Recognising a shared objective to overcome the challenges of chronic fatigue syndrome (CFS), neither the Association nor the College believes that conflict will provide a useful path to future answers. Accordingly, as the Chairman of the ME/Chronic Fatigue Syndrome Association of Australia and the President (at the time the guidelines were published) of the Royal Australasian College of Physicians, we would like to document the common ground we have identified.

- We acknowledge, as do the guidelines, that CFS is a serious, disabling illness.
- There is no evidence that the illness is primarily psychological in origin.
- There is significant evidence of a range of biological abnormalities occurring in people with CFS. It remains unclear whether these are primary or secondary.
- Treatment should be personalised according to the symptoms and circumstances of the individual patient. Treatment plans should be worked out by the patient together with a healthcare professional and designed to be within the capabilities of the patient.
- Scientific evidence on aetiology, pathophysiology and treatment is, at this stage, grossly deficient. More research is required to understand the biological mechanisms involved and to clarify the role that genetic, environmental and infectious agents might have in the aetiology and pathophysiology of this complex and debilitating illness.
- The medical community, other health professionals and patients and their families should work together to encourage increased funding and research into the epidemiology, aetiology and pathophysiology of CFS so that we may find more effective treatments for this condition (or these conditions).

All clinical guidelines should be viewed as documents that will, in time, require refinement, rewriting and replacement. Doctors must be cognisant of the limita-

Correspondents

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