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### Abstract

The paper describes a study of three groups: patients, orthopaedic surgeons and the surgeons' practice managers, concerning three types of legal risk associated with duty of care: failure to follow up, failure to warn and failure to diagnose. The study found there is cause for concern about doctors' follow-up and documentation of patient care. Doctors may be unaware of the Australian courts' propensity to emphasise practitioner responsibility rather than patient autonomy. A further important result is the considerable disparity between doctors' views and the views of their practice managers. The paper draws implications for improved risk awareness and further research.

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# **Perceptions of responsibility for clinical risk management – evidence from orthopaedics practitioners, practice managers and patients in an Australian capital city**

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## **Abstract**

The paper describes a study of three groups: patients, orthopaedic surgeons and the surgeons' practice managers, concerning three types of legal risk associated with duty of care: failure to follow up, failure to warn and failure to diagnose. The study found there is cause for concern about doctors' follow-up and documentation of patient care. Doctors may be unaware of the Australian courts' propensity to emphasise practitioner responsibility rather than patient autonomy. A further important result is the considerable disparity between doctors' views and the views of their practice managers. The paper draws implications for improved risk awareness and further research.

## **Introduction**

Recent events including the severe financial difficulties of Australia's largest medical insurer, UMP, and increasing publicity about the cost of public liability insurance against clinical and other sources of risk have focussed attention on medical and other forms of risk management. To bring a successful negligence claim against a doctor, a plaintiff must establish that the doctor breached the duty of care owed to the patient and that the breach caused the damage suffered by the plaintiff. The law requires reasonable care and skill – not perfection – in all aspects of the care doctors provide: diagnosis, treatment and the information provided to the patient during consultations. Whilst the tests for each of these areas differ, the law nevertheless sets a benchmark for doctors when treating patients.

While the standard of care as just described might not appear unduly onerous, recent changes to the law have been criticised by the medical profession as, in certain circumstances, demanding a standard of care which goes beyond what is required by acceptable medical practice. An example is the decision of the High Court in 1992 in *Rogers v Whitaker*, in relation to the non-disclosure of material risks. The High Court's confirmation that it is for the courts to adjudicate on what is the appropriate standard of care has led to concerns about the weight that is given to expert evidence from its members and the principles upon which courts may reject common medical practice and come to their own determinations on the issue<sup>1</sup>. The medical profession is increasingly concerned that professional standards are being extended to unreasonable or unobtainable heights, and that it is becoming difficult for the medical profession to understand the complexities of these legal decisions.

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<sup>1</sup> Melnitchouk, O. (1996), 'Extending Liability for medical negligence', *Torts Law Journal*, 4, p 259.

In addition, the incidence and cost of litigation is increasing sharply. Tomkins in 1998<sup>2</sup> reported that worldwide the Medical Protection Union (MDU) has seen a 15% per annum increase in the costs of claims, with an increase of 40% worldwide in the number of indemnity files opened between 1990 and 1997. In Australia in 1997 there were nearly double the notifications compared to 1990. On average the research identified that worldwide costs of malpractice claims have risen but not as steeply as they have in Australia. Nisselle reported in 1999 that, according to Medical Protection Society data, litigious actions, expressed as the number of new claims commenced per 1,000 doctors per annum, doubled between 1983 and 1988<sup>3</sup>. A further increase was seen in Australia between 1992 and 1996 when the incidence of litigation also doubled. Moreover, the average value of a concluded claim more than doubled over that period. Katter<sup>4</sup>, among many others, argues that there is a greater awareness and willingness to litigate for negligence. The potential for large awards of damages for successful litigation is rapidly engaging the focus of the medical community, indemnity providers, lawyers and public authorities in Australia.

It appears that recent decisions of the courts are redefining legal responsibilities and having a significant impact on the practice of medicine, creating increased costs from over-servicing, or 'defensive medicine'. It is often argued that the Australian legal system is approaching the medical malpractice crisis seen in the U.S. The reasons patients litigate are also of interest. Debates centre around whether the legal system helps create a 'blame culture' in which people have a strong financial incentive to blame others for loss, death or injury, or whether, on the other hand, the legal system is simply responding to public demand and the judges and the law are not responsible for the increase in litigation. All these factors suggest the value of researching the development of the common law about the duty of patient care as well as people's perceptions about where their responsibilities lie.

### **The aim of this research**

This aim of this research is to investigate perceptions of clinical risk management responsibility on the part of three groups: orthopaedic practitioners, orthopaedics practice managers (or receptionists), and patients attending those practices. The specific risks relate to three areas of doctors' responsibility recognised by the law in Australia: a) failure to follow up patients who do not attend an appointment, b) failure to warn of material risk and c) failure to diagnose. Views were sought from each of these groups about each of these areas of legal responsibility. The views of each group were then compared to the common law in Australia and the implications of the resulting disparities discussed.

### **Method**

#### **1 Survey instrument**

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<sup>2</sup> Tomkins, C. 1998, 'Recent trends in litigation worldwide – The implications for Australia'. *The Journal of the MDU*, July, p 2.

<sup>3</sup> Nisselle, P. 1999, 'Managing risk in medical practice'. *Journal of Law and Medicine*, Vol 7, no. 2, p 130.

<sup>4</sup> Katter, N.1999, 'Duty of Care in Australia', ed. Mulligan, J, LBC Information Services, Australia

The researchers developed a self-administered questionnaire as the principal data collection tool. The questionnaire contained ten questions that had been developed to address issues that the common law and medical malpractice literature show are commonly found in malpractice claims. The questions were worded as simply as possible in order to capture the views of non-legal and non-medical specialists about the issues. Also, the questionnaire aimed to capture views about *general* legal risks and questions were therefore not directed specifically to orthopaedics or to the types of problems specific patients or practices might be having. The questions sometimes allowed for more than one response. [A copy of the questionnaire is reproduced in the appendix to this article.]

## **2 Respondents**

The survey was completed by three groups of participants:

- Orthopaedic surgeons in private orthopaedic practices or working in hospitals in a major Australian city
- The practice manager or senior receptionist in each of the 10 orthopaedic practices
- Patients attending the 10 private orthopaedic practices during one business day (for each surgery) – a total of 155 patients

Ten surgeons in private orthopaedic practices were approached for permission to gather data from the surgeon, the practice manager and patients in that practice. In addition to the ten private practice surgeons, a further 26 doctors were approached who practised exclusively in orthopaedics. Thus a total of 36 doctors participated in the research.

With the agreement of the practice surgeon, one of the researchers attended the practice during business hours of one day to gather the data. The receptionist for each private practice approached all patients on their arrival for their appointments, explained briefly the purpose and scope of the research, and invited the patients to complete a short, voluntary and anonymous questionnaire. When the patient had agreed, the receptionist referred the patient to one of the researchers who was seated nearby. This approach both legitimated the research and minimised pressure on participants. This was important since patients are often nervous when they arrive at their doctor's rooms, and some patients were unwell, or recovering from surgery. The researcher gave each patient a copy of the questionnaire to fill in and remained available to clarify any questions or answer any concerns.

At the end of the appointments on the day the researcher visited, the receptionist or practice manager and the orthopaedic surgeon of the practice separately completed the same questionnaire. All questionnaires, from doctors, managers and patients, were returned to the researchers either on the same day or soon afterwards by post.

## **3 Analysis**

The results were analysed using the computer package SAS 6.12.

### **1 Failure to follow up patients who do not attend appointments**

Two recent cases in particular, *Tai v Hatzistavrou*<sup>5</sup> and *Kyte v Malycha*,<sup>6</sup> highlight the necessity for doctors to have practice systems to ensure they follow up on investigations, referrals and procedures. It requires more than imparting information to the patient; a doctor needs to actively inform himself or herself about whether recommendations for medical treatment have been followed, appointments have been attended, and test results have been reviewed. In *Tai v Hatzistavrou* there had been delays and errors on the part of the hospital in arranging for tests requested by the doctor to exclude cancer in the patient. These delays were not followed up by either the doctor or the patient. The doctor's defence was that, since the patient had not followed up, he was entitled to believe that the patient was exercising her autonomy to decide not to embark on the procedure. This was not accepted. The court held that the relationship between doctor and patient, once established, could not be ended by the mere will of the doctor, but lasts until treatment is no longer required or the relationship is dissolved by the doctor or the patient.

*Kyte v Malycha* dealt with the failure of a doctor to follow up a patient's test results. The patient, who had been referred for a biopsy, did not telephone the doctor for the results and did not attend her follow-up appointment. The doctor claimed that he never received the results and that they were never faxed to his rooms. The court criticised the location of the fax machine (it was in a communal lunchroom), and also held that the doctor and not the patient was responsible for following up test results. Finally, the court found the doctor negligent for failing to have made an entry in the patient's medical records that would have alerted him to the absence of the pathology report. Such a reminder system would circumvent the situation of patients failing to attend their appointments.

### **'Failure to follow up' items on the questionnaire**

Questions 1, 2, 3, 4, 6, 8, and 10 on the questionnaire relate in various ways to the issue of 'failure to follow up'. Question 1 and 2 respectively deal with perceptions about the number of times and the method by which doctors should follow up on patients who missed their appointment. Question 3 asks whether the method of follow-up should change if the patient has a serious or life-threatening illness. Questions 6 and 10 respectively deal with perceptions about how often and in what way patients' personal or contact details should be checked. Questions 4 and 8 deal with who has the responsibility to follow up on diagnostic procedures that have been performed on patients.

### **Results**

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<sup>5</sup> (1999) NSWCA 306.

<sup>6</sup> (1998) 71 SASR 321

The research identified that the majority of doctors surveyed did follow up on their patients' care. Specifically, 28 doctors out of the 36 (77.7%) surveyed followed up on patients who missed their appointment. Of these 28 doctors, 17 (47.2%) said they followed up on missed appointments once, 9 (25.0%) said they followed up twice and 2 (5.5%) said they would follow up 3 times. There were 8 (22.2%) doctors who said that they do not follow up on patients that miss their appointments.

The overwhelming majority of patients surveyed, 146 (94.1%) of the 155, expected doctors to follow up on their missed appointments. The majority of the patients, 109 (70.3%), expected that the doctor would contact them at least once, and 23 (14.8%) said twice. Fourteen (9.0%) of patients believed that the doctor should contact them at least three times in order to remind them that they had failed to attend. Nine (5.8%) patients did not believe that follow up was necessary.

These results are interesting as they reveal somewhat different expectations of each party. However these results need to be compared to the common law in order to identify whether a clinical risk is apparent. As noted earlier, the law expects doctors to follow up assiduously on their patients' care, especially if a patient has a serious or life threatening illness. The research showed that 33 of the 36 (91.6%) doctors said they would try all the listed methods of contacting patients in the event of a serious or life-threatening illness. However 3 (9.09%) doctors said that the method of contacting patients should not change in that situation or they would not follow up on a patient's missed appointment. This would be considered a legal risk because the Australian courts have been reluctant to recognise the patient's contribution to adverse outcomes if they do not follow up on their test results or attend an appointment. Interestingly, however, 36 of the 155 (23.2%) patients said they did not believe that the doctor had this responsibility.

In addition to doctors' responsibility for follow-up, *Kyte v Malycha* makes it clear that the law also requires their diligence in the *process* of follow-up. Question 2 of the survey asked about the appropriate method(s) used to contact patients. Of the 36 doctors surveyed, 18 (50.0%) said that they would telephone the patient at home and 7 (19.4%) said they would telephone the patient at work. Nine (25.0%) doctors indicated they would send the patient a letter, and only 2 (5.5%) of doctors said that they would send some correspondence to the general practitioner.

A significant result from this question was that only 10 (27.7%) doctors said that in a notation of non-attendance and the attempt to follow up is made in the patient's medical file. This is alarming because it suggests the remaining doctors do not have a record that demonstrates the efforts made to contact a patient. If a doctor makes an effort to contact a patient, regardless of its success, the doctor needs to be able to prove these efforts in the event of litigation. Interestingly, only 13 patients said that they expected the doctor to document the failure to attend and the follow-up methods used.

### **Failure to warn of material risk**

As noted earlier, *Rodgers v Whitaker* is regarded by many medical practitioners as indicating that the courts can demand a standard of care which goes beyond what is required by acceptable medical practice. The High Court's decision in *Rodgers v*

*Whitaker*<sup>7</sup> expressly rejected the ‘*Bolam test*’, which states that a doctor is not generally negligent if ‘*he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice*’. Instead, the court preferred the approach taken in South Australia in 1983 by King CJ in *F v R*<sup>8</sup>, which involved a doctor’s failure to warn a female patient about the failure rates of tubal ligation. She sued the doctor after having the procedure and subsequently becoming pregnant. The Chief Justice of the South Australian Supreme Court said:

*The ultimate question, however, is not whether the defendant’s conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That question for the court and the duty of deciding it cannot be delegated to any profession or group in the community’.*

In *Rodgers v Whitaker*<sup>9</sup> an ophthalmic surgeon, Dr. Wheedon, failed to warn the patient of a small risk that the proposed surgery to the patient’s eye could lead to the loss of vision in the patient’s other eye. The important issue in this case is that the surgery that was recommended to the patient was on an eye that was already visually compromised. Therefore, in the event that the complication arose (loss of vision to the other eye) the patient would be almost blind. The patient post operatively developed sympathetic ophthalmia, (which occurs in 1 in 14 000 operations of this kind). This meant the patient lost sight in the ‘good’ eye due to sympathetic response from the operation on their already ‘bad’ eye. The plaintiff claimed that the doctor’s failure to warn her of the risk that she could be blind constituted negligence.

The High Court held that, despite the evidence from other ophthalmic surgeons that they would have provided the same medical treatment as Dr. Wheedon, the doctor was negligent for not advising all the inherent risks to the patient before she agreed to the surgery. The patient alleged that had she been informed of all these risks, especially the material risk of blindness in her other eye, she would not have had the operation.

The negligent failure to inform a patient of a risk of an operation in *Rodgers v Whitaker*<sup>10</sup> has been discussed by the court as part of a doctor’s wider, general duty to inform. The exact scope of that duty remains unclear, but it appears the doctor is obliged to provide a patient with all the information the patient would want to know or would attach significance to, in addition to the risks the doctor would ordinarily warn the patient of when they ‘consent’ a patient to medical treatment.

In 1998 in *Chappel v Hart*<sup>11</sup> the High Court handed down another decision which has caused concern within the medical profession. The distinguishing feature of this case is that the plaintiff had to establish that the likelihood of the risk eventuating from an operation was not the same as it would have been had the surgery been performed by another more experienced surgeon at a different time. The court applied a legal rather

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<sup>7</sup> (1992) 175 CLR

<sup>8</sup> (1983) 33 SASR 189.

<sup>9</sup> (1992) 175 CLR

<sup>10</sup> (1992) 175 CLR

<sup>11</sup> (1998) HCA 55

than a scientific or philosophical standard to determine that the plaintiff, if warned about the risks of the surgery, would have sought another opinion from another consultant who was more experienced and she would have had the operation at another time. This case affirmed the standard of care that was pronounced in *Rodgers v Whittaker*<sup>12</sup>. It also made clear that a doctor does *not* have a positive obligation to inform a patient that there is a more experienced surgeon who could carry out the procedure when they are informing a patient about all material matters related to the medical intervention proposed.

The growing body of common law decisions in ‘failure to warn’ cases, that in the majority of times favour the plaintiff, are a mounting concern to the medical profession. To shield themselves against these types of claims, doctors need to inform patients of specific particularities of proposed treatment, warn of the inherent risks of the treatment, and then document these discussions in the patient’s medical records. In practice this is difficult to achieve in the clinical environment. Doctors usually do not have the time to document the entire conversation or explain every complication that may arise. In some cases patients do not want to hear what the doctor is saying or are unable to remember what the doctor has told them. It is only when litigation comes to mind that the standards of perfection are retrospectively required.

#### **‘Failure to warn’ items in the questionnaire**

The questions addressing ‘failure to warn’ issues were 5 and 9. Question 5 addresses the specific legal components of the patient’s consent to treatment. Question 9 was structured around the issues of *Rodgers v Whitaker*.

#### **Results**

The results for Question 5 showed that the majority of the doctors informed patients about the majority of necessary issues. However only 1 (2.7%) doctor said that he/she would inform the patient if he/she felt that there was someone else more qualified to do the procedure and again only 1 (2.7%) doctor said that he/she would inform the patient how many times they have done the procedure. This is an important result since in *Chappel v Hart* the patient successfully claimed that if she had been warned how many times the doctor had performed the operation she would have sought a more experienced doctor to do the operation, and that she believed that if she had found this doctor and allowed him or her to perform the procedure that the complication would not have arisen. This discrepancy places doctors in a precarious position. The patients in the research indicated that 34 (21.9%) would like to be told how many times the doctor has performed the operation during the consent process and 16 (10.3%) would want to know if there was someone else more qualified.

In question 9, each response indicated an appropriate element of what patients should be warned about with the exception of ‘only those risks the patients want to know about’. The ideal result would have been that all the doctors responded to each of the responses with the exception of this one. The data does not reveal this; in fact no single option was endorsed by all 36 doctors, although some doctors did respond to all the options. This represents a source of risk for the majority of doctors in the survey.

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<sup>12</sup> (1992) 175 CLR

Interestingly the patients did not provide a 100% response to any of the available options either.

### **3 Failure to diagnose**

*O'Shea v Sullivan* has caused concern in the medical profession owing to the perception that the decision of the court against the doctor, a general practitioner, relied too heavily on the views of academic specialists rather than on more appropriate peers. This case does not deal directly with the doctor's communicative relationship with the patient. However non-compliant patients – those who do not attend for tests or other appointments, or who do not comply with treatment – can pose problems for doctors' diagnosis and subsequent treatment.

#### **'Failure to diagnose' items on the questionnaire**

Question 7, which asked about what should happen if patients are non-compliant with attending for treatment, thus relates indirectly to 'failure to diagnose' issues.

#### **Results**

Results showed 29 (80.5%) of the doctors indicated they explained to patients the consequences of non-compliance with treatment and 27 (75.0%) documented the non-compliance conversation in the patient's medical records. Worryingly, however, 5 (13.8%) of the doctors said that they did nothing with respect to these patients. They were the same doctors who had indicated they do not follow up patients who fail to attend appointments. Their philosophy is presumably that it is the patient's decision whether or not to comply with treatment. This rationale arguably rests well with the decision of *Ibrahim v Arkell*<sup>13</sup>. The patient's autonomy is arguably being respected and the patient is being encouraged to manage his or her own care. On the other hand this case specifically referred to the fact that patients are to be informed so that they can be independent in making decisions about their health. Arguably if doctors elect not to do anything about non-compliant patients then they have failed to treat the patient in accordance with the common law requirement prescribed by *Ibrahim v Arkell*.

#### **Comparison of results of practice managers with those for doctors**

An alarming result came from comparing the data from the ten practice managers' responses to those of the doctors from these practices. On average, the responses of the doctors and their practice managers coincided on 59.8% of the questions. There were two private practices in which the doctor and the practice manager correlated perfectly (100%) with their responses. However, there were four practices where the doctor's and the practice manager's responses coincided no more than in 50.0% of the questions, and in one of these practices, the responses only coincided in 23.3% of the responses.

This suggests that what the doctor thinks is occurring in his or her practice with respect to clinical risk management may not be happening to the extent he or she

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<sup>13</sup> 95 per Fitzgerald J.A.

believes, obviously a source of serious risk. The research did not explore the reasons for the discrepancies.

### **Implications and conclusions**

While the majority of doctors in the sample appear to adhere to risk management practices adequately to protect themselves, there is cause for concern about some respondents for a number of specific items, particularly concerning documentation of the way they follow up patient care. In addition, results for some practitioners across a range of issues suggest they may be unaware of that the courts typically accord less weight to the principle of patient autonomy and more to practitioner responsibility. Improved risk awareness, and a more proactive approach to managing risk, perhaps through the use of software which simplifies the follow-up and documentation processes, is called for.