

**AHMAC**

**Legal Process**

**Reform Group**

**Responding to the Medical Indemnity Crisis:**

**AN INTEGRATED REFORM PACKAGE**

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## CHAPTER 1

# Background and brief history of medical litigation reform

### The Australian Health Ministers Advisory Council (AHMAC) process

1.1 In December 2000, the major Medical Defence Organisation (MDO), United Medical Protection (UMP), imposed a one-year additional subscription “call” on its members. Concern was expressed about the increasing amounts which doctors were being required to pay to purchase indemnity cover. The ACT initiated some background work on the reasons for these increases.

1.2 This work was submitted to the Australian Health Ministers’ Advisory Council in February 2001 and a reform strategy was proposed. The strategy included a focus on patient safety, the prevention of the occurrence of adverse events and risk management both before and after an adverse event. This issue was referred by AHMAC to the Australian Council for Safety and Quality in Health Care.

1.3 On 23 March 2001, the Australian Health Ministers’ Conference (AHMC) endorsed the establishment of the AHMAC Jurisdictional Working Party on Medical Indemnity to:

- (a) develop options to provide sustainable solutions to address long term care costs for those involved in health care litigation;
- (b) develop draft medical indemnity industry standards;
- (c) look at ways of reducing the administrative and legal costs associated with health care litigation; and
- (d) develop a model for the collection of national data on health care negligence cases.

An additional term of reference was added at the next AHMC meeting to include the

- (e) assessment of the need for a national regulatory regime for medical indemnity insurance.

1.4 AHMC asked that the Working Party focus on:

“practical solutions, which will minimise the human and financial costs associated with health care litigation and provide greater security for consumers and providers”.

1.5 A Consultative Forum was also established at that time to include stakeholders such as consumers, the Australian Medical Association, the Committee of Presidents of Medical Colleges, Medical Defence Organisations (MDOs) and the Institute of Actuaries. The two groups have frequently met together to work on solutions in these areas.

1.6 Initially the Jurisdictional Working Group developed a set of discussion papers in the four areas of the terms of reference. The paper on Reduction in Legal and Administrative Costs Associated with Health Care Litigation set out a range of options for reform – a form of “shopping list” but this work was put on hold while other work was being undertaken. At that same time, the NSW government introduced various tort reforms and market regulations in the medical indemnity area, to address growing concerns about the long term viability of current medical indemnity arrangements.

1.7 The initial focus of the work of the AHMAC Working Group was the development of standards for the MDO industry to ensure the future viability of the industry. An AHMAC Workshop on National Standards and Regulation of the Medical Defence Industry was held on 12 September. This workshop involved stakeholders with a broad range of interests in the industry, including the Australian Prudential Regulatory Authority (APRA), consumers, doctors and the MDO and insurance sectors.

1.8 Work also continued on the national data collection and on gathering information on the factors which had led to increases in “premiums”.<sup>1</sup> While the data was incomplete, it became clear that for any reforms to have the effect of reducing costs, there needed to be a focus on

- addressing long term care costs
- reforms to legal processes

1.9 Estimates from Trowbridge Consulting showed around 25% of premiums related to long term care costs and 25% related to the legal costs of plaintiffs and defendants<sup>2</sup>. This data and other sources are discussed in more detail below.

1.10 At the same time as this work was progressing, the insurance industry was rocked first by the HIH collapse and then on 11 September, by the destruction of the World Trade Centre and related events. September 11 led to an immediate downturn in the international reinsurance market with consequent effects on some MDO premiums. It also led to the withdrawal of St Paul, a major player in the medical malpractice insurance market, from that market.

1.11 There were repeated calls for governments to assist doctors with their premiums, and this accelerated when it became clear that UMP premiums were rising by an average of 50%, on top of the call the previous year (even with the benefits of the NSW legislative changes).

1.12 In a further attempt to reduce the premium pressure, the week before Christmas 2001, NSW and ACT governments announced that they would in future cover liabilities arising from the treatment of public patients in the public hospital system. This arrangement was already in place in other States<sup>3</sup>.

### **National Summit and Litigation Reform Workshop**

1.13 At the same time, the Prime Minister announced that a national forum into medical indemnity would be held in early 2002 to address the issues of rising medical indemnity premiums. This event occurred on 23 April 2002, and was preceded by the AHMAC Medical Indemnity Litigation Reform Workshop on 22 April 2002. This Workshop, which was convened by Professor Marcia Neave, was attended by 80 people, and included lawyers, MDOs, doctors, State and Territory Health Departments, health service commissioners and public interest advocates. The aim of the Workshop was to identify areas of agreement and disagreement and to achieve consensus on reform directions if that was possible, in preparation for proposals for the National Forum the next day.

1.14 Proposals from that workshop included a broadly agreed set of principles for reform. These were intended to

- provide equity for people who have been harmed in health care by:
  - ensuring there is flexibility to respond appropriately to people’s needs;
  - ensuring that seriously harmed people were adequately compensated;
- ensuring continued access to health services by members of the public;

- making premiums affordable for doctors; and
- providing a rational interaction with other accident compensation systems.

1.15 So far as individual reform issues were concerned, the Workshop reached agreement on some areas, but failed to do so in others. Broad agreement was reached that:

- courts should determine the standard of care on the basis of expert evidence. There was no support for a return to the use of the *Bolam* test discussed later in Chapter 6 under which evidence that the doctor's behaviour was not negligent according to a responsible body of medical opinion means that the court cannot find that the defendant was negligent. The Workshop agreed that it was for the court to decide whether or not the defendant was negligent. Expert medical evidence is already used by courts to determine the appropriate standard of care in the vast majority of cases and this is appropriate; and
- if cost containment is necessary, the focus should be on meeting the needs of those who are catastrophically harmed.

1.16 There was disagreement about whether thresholds should be introduced for claims and about whether limiting damages was the most appropriate means of addressing the problem of high-paying specialty groups. There was some recognition that the affordability of premiums could be addressed through market regulation of premiums, because the move away from mutuality which had occurred over the past 15 years had been the major cause of the differential increases across specialties. The issue of expert witnesses and the best way for them to be used was also vigorously discussed at the Workshop without agreement being reached.

1.17 Strategies to achieve the agreed principles were presented by Professor Neave at the National Forum the following day, under the broad headings of:

- improving quality assurance and risk management;
- reducing the need to litigate;
- improving the legal process; and
- getting the law right.

1.18 Because the first area is being considered by the Australian Council for Safety and Quality in Health Care, Professor Neave focussed her presentation to the Forum on the other strategies. Various ways of reducing the need to litigate were identified, including:

- open disclosure and the need to protect apologies from being admissible as evidence of liability;
- an emphasis on conciliation and mediation through improved use of health complaints processes to reduce the adversarial nature of existing processes;
- creating a system that learns from its mistakes, through enhanced incident reporting and follow-up, and the encouragement of a culture which recognised that mistakes often have systemic causes and required systemic responses;
- the need for accountability and quality in health care, including career-long education for health professionals on these issues; and
- the desirability of meeting long term care costs without the need for litigation, through taking care costs out of the tort system and providing them through statutory entitlements – the question about whether doctors or the community should pay where the need for care arose from negligence was not agreed, nor

was whether the access should be limited to those who could prove fault or be available on a no-fault basis.

1.19 Options for improving the legal process included:

- support for reforming the court system, rather than creating a specialist tribunal, principally because of the very small numbers of cases which are litigated and are actually heard by a court;
- moving towards a national model for procedural reform;
- cost penalties for failing to make adequate disclosure or reasonable offers, as in the South Australian 90-day rule or the Queensland pre-litigation process in compulsory third-party matters;
- support for active case management and court-related conciliation; and
- exploration of the use of specialist accreditation or licensing of medical indemnity lawyers, given the complexities of medical litigation and the costs associated with poor claims handling.

1.20 The Joint Ministerial Communique from the National Medical Indemnity Forum supported the principles put forward from the Workshop and noted the concurrent work on public liability discussed below. Ministers agreed to pursue urgent work on reforms which:

- minimise the need to resort to litigation;
- enable improved handling of adverse events;
- encourage the early resolution of claims before litigation commences; and
- continue to streamline the litigation process to reduce unnecessary delays and costs.

### Public Liability concerns

1.21 Concurrently with these processes, there had been significant developments in the public liability area, following a National Ministerial meeting in late March. These focussed attention on changes to tort law and legal processes. The Joint Communique of 27 March 2002 between Commonwealth, State and Territory Ministers and the President of the Australian Local Governments Association supported a range of changes to the present litigation system, including:

- legislative changes to support structured settlements;
- targeted claims cost reduction eg protecting volunteers, community and appropriate sporting bodies from legal action;
- tort reforms; and
- examination of legal system costs and practices, such as legal advertising.

1.22 Action followed swiftly in a number of States and Territories – including the introduction of the *Civil Liability Act 2002* in NSW, which essentially extended the Health Care Liability Act reforms to all common law personal injury cases, with some additional changes to voluntary care costs and legal costs; and the *Personal Injuries Proceedings Act 2002* in Queensland. Actions and proposed actions in other States that were described in the Ministers' Communique of 30 May 2002 are set out in Appendix 1 to this paper.

1.23 On 2 July 2002, the Commonwealth Assistant Treasurer Senator Coonan announced that a Negligence Review Panel was to be established, chaired by Justice

David Ipp, and including: Professor Peter Cane, Professor of Law at the Australian National University; Dr Don Sheldon, Chairman of the Council of Procedural Specialists; and Cr Ian Macintosh, Mayor of Bathurst. The terms of reference of this group are at Appendix 2 to this Options Paper.

### ***UMP/AMIL crisis***

1.24 The perceived urgency for action accelerated even further with the announcement of the appointment of a voluntary liquidator to UMP on 29 April 2002. This followed several weeks of uncertainty after APRA had advised UMP of the need to improve the adequacy of their capital reserves, because of an unexpected and significant draw down on the reserves of their wholly owned insurer AMIL. This draw down had occurred for a number of reasons. One was the 2001 verdict in the case of *Simpson v Diamond*<sup>4</sup>. This set a new record verdict in medical negligence of over \$14M, which almost doubled the previous record verdict, and resulted in a significant increase in the size of reserves set aside for large claims.<sup>5</sup> Other factors included the need for UMP to increase their capital because of losses associated with the collapse of HIH (one of their reinsurers) and the higher capital requirements imposed by APRA in the wake of HIH. As a result of all these factors, UMP's financial position looked increasingly vulnerable.

1.25 In addition, UMP's practice of not disclosing its incurred but not reported (IBNR) liabilities on its balance sheet came under increasing criticism from the Urgent Issues Group of the Australian Accounting Standards Board. Greater public knowledge of the level of UMP's unfunded liabilities led to increasing concerns among its members of their financial risk exposure and had led to considerable speculation about the need for another call. While generally seen as a means of reducing UMP's long term liabilities, the introduction of the *Health Care Liability Act 2001* in NSW in mid 2001 also led to a "claims spike" as people sought to get their claims in under the previous arrangements. While most of this simply brought forward claims which would probably have been lodged over the next few years, it had an immediate negative impact on UMP's bottom line.

1.26 This "collapse" of UMP/AMIL brought further attention to the need for changes to improve the long term sustainability of the industry. While many of these changes related to the need to address long term unfunded liabilities in the industry, which had first been identified by the Professional Indemnity Review in its 1995 Final Report, there was also concern about the growth in the size of claims and in some jurisdictions, the number of claims.

1.27 The Commonwealth Government provided a guarantee to the liquidator to enable UMP to continue trading and to allow time for the placement of members in new organisations. This guarantee has been extended to the end of 2002, and the voluntary liquidator still has to report on the longer term future of UMP/AMI (if any). In the meantime, a Committee of the Commonwealth Secretaries of Prime Minister and Cabinet, Treasury and Health has been formed to look at sustainable solutions to the industry crisis precipitated by UMP/AMIL situation.

### **Formation of the AHMAC Legal Process Reform Group**

1.28 Soon after the Litigation Reform Workshop discussed above, AHMAC asked Professor Neave to chair an expert group to pursue this work. Unfortunately, the relationship between the AHMAC process, work by the federal Treasury on public liability including the formation of the Negligence Review Panel, and the work of the

Commonwealth Secretaries Committee was complex. In the end, it was not until mid July that the Legal Process Reform Group was able to begin its work.

1.29 The terms of reference of the AHMAC Legal Process Reform Group are:

1. The Legal Process Reform Group will develop proposals for the consideration of State, Territory and Commonwealth Governments that will
  - maximise opportunities to reduce the need for litigation
  - enable improved handling of adverse events;
  - encourage early resolution of claims prior to litigation commencing; and
  - streamline the litigation process to reduce unnecessary delays.
2. The Legal Process Reform Group will consider the issues of standard of care and the concept of negligence as it currently applies to medical litigation and report on any reforms which may be needed to ensure the law reflects an appropriate balance between the interests of health care consumers, doctors and the community.



## Chapter 2

### Our approach

2.1 In commencing its work, the Legal Process Reform agreed on the overall objectives which should underpin the changes that it was asked to consider. These objectives reflect the complex issues that need to be weighed up to produce an appropriate package of reforms. To be sustainable, practical and in the public interest, any reform package must strike an appropriate balance between

- the public interest in ensuring that people receive fair compensation; and
- the public interest in ensuring that premiums are affordable and sustainable so that an appropriate level of medical services to the community can be maintained.

2.2 The changes required to achieve this balance are complex. They must

- be **integrated**, in the sense that proposed changes in one area must be considered in conjunction with proposed changes in another area. It is important that the recommendations in this Options Paper should be treated as “a package”. This is necessary to ensure that a change in one area does not produce an undesirable effect in another. In addition, reform proposals will often need to operate together in order to achieve their optimal benefit. The Paper clearly indicates where this is the case and sets out recommendations as a template for reform.
- be **balanced**, in the sense that they address the needs, both of service providers and consumers. We see this approach as a central feature of any acceptable reforms in the area. For example, a “solution” which saw all the benefits going to doctors or insurers and all the costs to injured consumers or taxpayers (or vice versa) is unlikely to be acceptable.
- contribute to a more **consistent** approach between jurisdictions.

2.3 There are a number of difficulties in achieving greater consistency between jurisdictions. These include:

- differences in claims experience of the MDOs operating in different jurisdictions, which may give rise to different priorities for action
- lack of relevant data in some jurisdictions
- variations between jurisdictions, relating to existing compensation laws. These variations have increased as a result of the recent legislative changes made in response to concerns about the financial viability of MDOs.
- the need to take account of reforms or proposed reforms to meet concerns about public liability.

2.4 Recent New South Wales reforms have sought to bring about greater consistency between areas of compensation law dealing with different types of injury. These, and other reforms have presented the Legal Process Reform Group with a position in which the laws in a particular jurisdiction may well be changing as we write this Paper.

2.5 For these reasons we have not attempted to design jurisdiction-specific proposals for reforms to the particular legislation in force in the various States and Territories.

Instead, the integrated reform package makes general proposals and provides some examples of how changes could be achieved.

### **The purpose of the Reform Package**

2.6 The overall purpose of the package is to

- improve patient safety and minimise the likelihood of patient injury;
- reduce the need to litigate and encourage early finalisation of disputes;
- provide fair compensation to those injured as a result of medical negligence; and
- ensure affordable and sustainable premiums.

Each of these goals is discussed in more detail below.

#### ***To improve patient safety in the health care system***

2.7 The Australian Council for Safety and Quality in Health Care has primary responsibility for achieving this goal. Significant work is proceeding independently in this area at State and Territory levels through the various State and Territory based patient safety and quality initiatives and forums. However, there are some legislative changes which could be put in place to support these activities and which could assist in:

- creating incentives and encouraging practices that minimise the incidence of harm to patients arising from health care;
- creating an environment where the health system learns from its mistakes; and
- ensuring that there are adequate systems for dealing with deliberately or recklessly unsafe care or systematically poor performance in the health system.

This Options Paper deals briefly with these proposals in Chapter 4.

#### ***To reduce the need to litigate and encouraging early finalisation***

2.8 This goal recognises that the adversarial context of litigation is one which both doctors and consumers wish to avoid if at all possible. This is not just because of the potential costs, but more fundamentally because it strikes at the underlying trust relationship which is central to the doctor/patient relationship and to the developing concept of partnership. Reducing the need to litigate requires, among other things:

- ensuring complaints are resolved without resorting to litigation wherever possible; and
- encouraging early settlement and a less adversarial process for providing compensation.

These matters are discussed in Chapter 5.

#### ***To provide fair compensation***

2.9 Many changes which are suggested as so-called tort reforms are simply benefit reductions, which if not well-considered will have the affect of increasing the harm and disadvantage suffered by those people who are most in need of assistance. Cost containment is an appropriate aim for reform. However the means of doing so needs to be considered and the basis for changes justified by the evidence.

2.10 Often the implications of such changes are not well-understood because of their technical nature eg changes to the “discount rate”.<sup>6</sup> To allow broad community

engagement in reform and consideration of the issues, this Options Paper seeks to explain these options and their potential effects in as simple a manner as possible. In achieving “fair compensation”, we believe reforms should focus on:

- reducing the consequence of harm that does arise from adverse events through early access to rehabilitation and related assistance, including long term care; and
- minimising costs to the community, while directing compensation resources to those people who suffer the highest levels of disability and the greatest levels of long terms need.

These proposals are discussed in Chapters 6 and 7.

***To ensure affordable and sustainable premiums so that medical services are maintained***

2.11 Much of the current concern with medical indemnity arises from fear of increases in premium levels. This concern is being reflected in choices young doctors are making about their specialties and older doctors are making about their retirement. In some cases, it is influencing doctors to limit their work to public sector employment.

2.12 All doctors are struggling to cope with the unpredictable nature of indemnity premiums, with concerns about their MDOs future financial viability and with a belief that there is a “litigation crisis” which requires them to practice so-called “defensive medicine” to reduce their chances of being sued. For consumers, there is uncertainty about whether a practitioner has cover at all in most jurisdictions and, if they are harmed by negligence, whether any compensation will be available in any case.

2.13 Tackling this issue gives rise to a range of options which extend beyond legal process reform, and we consider that it is important to look at these areas as well, with the aim of ensuring that reforms:

- ensure that conscious decisions are made about where the costs of different reform options are borne in the community; and
- reduce the impact of premium costs on health care workforce composition

These proposals are discussed in Chapter 8.

***Objectives of the AHMAC Legal Process Reform Group's Proposals***

1. TO IMPROVE PATIENT SAFETY IN THE HEALTH CARE SYSTEM THROUGH, FOR EXAMPLE:
  - creating incentives and encouraging practices that minimise the incidence of harm to patients arising from health care;
  - creating an environment where the health system learns from its mistakes; and
  - ensuring that there are adequate systems for dealing with deliberately or recklessly unsafe care or systematically poor performance in the health system.
2. TO REDUCE THE NEED TO LITIGATE AND ENCOURAGE EARLY FINALISATION BY, FOR EXAMPLE:
  - ensuring complaints are resolved without resorting to litigation wherever possible; and
  - encouraging early settlement and a less confrontational process for providing compensation.
3. TO PROVIDE FAIR COMPENSATION BY, FOR EXAMPLE:
  - reducing the consequence of harm that does arise from adverse events through early access to rehabilitation and related assistance, including long term care; and
  - minimising costs to the community, while directing compensation resources to those people who suffer the highest levels of disability and the greatest levels of long terms need.
4. TO ENSURE AFFORDABLE AND SUSTAINABLE PREMIUMS SO THAT MEDICAL SERVICES ARE MAINTAINED BY, FOR EXAMPLE:
  - ensuring that conscious decisions are made about where the costs of different reform options are borne in the community; and
  - reducing the impact of premium costs on health care workforce composition.

## CHAPTER 3

### Data on medical litigation

#### Introduction

3.1 The absence of good quality national and state data on the incidence, costs and causes of medical litigation has been a substantial barrier to national policy-making. In its 1995 Final Report, the Professional Indemnity Review (PIR) noted

an absence of publicly available data on both health care negligence actions and adverse patient events arising from health care, has led to the creation and perpetuation of many myths and much misinformation<sup>7</sup>

3.2 The PIR compared the estimated number of adverse events (more than 400,000 with around 230,000 being clearly preventable) and the estimated incidence of litigation (fewer than 2,000 per year, where negligence is alleged, a handful of which go to court and many of which never result in payment). The Final Report went onto say, however that:

... the paucity of data on the tort system makes it impossible to make definitive statements about these matters. A top priority is the establishment of a national de-identified claim database for health care negligence cases, containing sufficient information on new claims and claims paid to allow proper policy decisions to be made promptly in future and to provide data for health professionals, MDOs and tort funders, health care consumers and governments.<sup>8</sup>

3.3 Unfortunately the PIR's recommendations in this area were not acted upon. As a result, in 2001 when the AHMAC process began, significant problems arose in analysing the reasons for the significant premium increases that were occurring. While steps are underway to remedy this now, through a joint exercise involving the public sector through the Australian Institute of Health and Welfare and the MDO industry through Insurance Statistics Australia, the continuing paucity of data has made it difficult to define the problem and develop appropriate solutions. Work on the incidence of adverse events is also proceeding separately through the Australian Council for Safety and Quality in Healthcare. While the frequency of adverse events far outweighs the frequency of litigation, it is hoped that the different processes for statistical collection will use common definitions where possible and that data duplication will be avoided.

3.4 Given that the problems associated with medical litigation appeared urgent, the need for action could not wait until the national data collection had begun. The AHMAC Working Group asked one of their consultants to prepare a paper that looked at all available information and data to provide as much information as possible about the reasons for premium cost rises in the medical indemnity industry. The background paper, entitled *Why Premium Costs have increased for Professional Indemnity in Health Care*<sup>9</sup> was used as a resource for the National Medical Indemnity Forum in April 2002. The following section of this options paper is mainly extracted from that source, supplemented by additional subsequent data from the ACT public sector.

#### What we know and what we don't know - the implications

3.5 The absence of good publicly available aggregated and identified data has several consequences.

- It makes it difficult to be certain of the exact contribution of different factors to overall costs and to rises in costs.
- It has led to some simplistic conclusions about the connection between premium rises and rises in claims frequency which are not necessarily strongly supported by the existing evidence.
- The contribution of different cost drivers appears to vary between different MDOs and between different jurisdictions, making an overall “formula” for change more difficult to determine and implement.
- The causes of medical indemnity premium increases are quite broad and extend far beyond the very public debate, which focuses on a handful of large dollar size cases often involving so called “brain-damaged babies”. As a matter of fact about 80% of cases in the obstetrics and gynaecology specialty relate to alleged negligence in gynaecological procedures.
- Lack of accurate information may limit the effectiveness of safety and prevention strategies.

3.6 Inadequacies in data make it difficult to design an effective reform agenda. However we do know enough to give us some general guidance to start addressing the problems of health care professional indemnity while we are waiting for better information. It is important to recognise that there are a number of forces at play that are reflected in MDO premium increase.

- Some relate to the reallocation of costs within the medical profession and health sector – some of these have resulted in increases and some have resulted in decreases in costs.
- Some relate to increases in overall claims costs.
- Some relate to the financial framework in which the MDO and insurance arrangements operate. These have generally been upward pressures as well.

### **Cost reallocation within the health care sector**

#### ***Changed risk pooling***

3.7 One of the key reasons for the “crisis” in premiums for some specialties has been the move away from a single risk pool, where costs were shared across all doctors. While such “mutual support” was a feature of medical indemnity arrangements for a long period of time, doctors have apparently indicated to MDOs that they are no longer happy to participate in this manner, because the larger number of GPs are inevitably asked to cross-subsidise their higher income earning specialist colleagues. This is discussed further in Chapter 8.

#### ***Public sector liability for public patients***

3.8 Cost re-allocation could reduce MDO subscriptions in two jurisdictions – NSW and the ACT. In these two jurisdictions doctor’s MDO subscriptions were set to cover public as well as private patient liability. This approach changed at the end of 2001. Public sector arrangements now cover the liability of doctors so far as it relates to public patient care. The impact that this is likely to have on MDO subscription rates is not yet clear. It may vary from specialty to specialty, depending upon how much public work is

performed by the specialty and what proportion of litigation arises from each group. Preliminary indications are that private patients sue much more frequently than public patients. If this is the case, the anticipated lowering of premiums may not be as high as expected.

### **Increases in claims and costs of claims**

3.9 There is some evidence that both the number of claims and the size of claims is increasing, though not at the rate that might be expected if premium rises were solely caused by these factors. There is also evidence that the increases are not universal across all jurisdictions and are not consistent between public and private sectors. Because of this, national data for the public and private sector as well as aggregated public/private sector data on a jurisdiction by jurisdiction basis would be particularly useful. At the moment there are conflicts between different data sources which mean that the size, and even the existence of increases in claims and/or costs of claims in some cases, is not clear.

3.10 Often assertions of increased litigation have been used by stakeholders to lobby governments to amend laws relating to damages or to criticise lawyers or plaintiffs. These assertions have also allowed doctors and MDOs to avoid taking a more reflective view about the extent to which their actions or inactions are also contributing to the problems. Current premium escalation arises from a range of “contributing factors” and so it is likely that any solutions also involve a range of actions as well. Even in the area of claim costs, there are two main factors which need to be looked at – claim numbers and average claims costs. It is important once again to recognise the limits on the data discussed here and to see it as indicative rather than definitive.

### ***Claim numbers - cautions about data***

3.11 An increasing number of claims overall may be one explanation for rising indemnity premiums. If a long term historical perspective is taken, the frequency of litigation against health professionals and in many other circumstances has increased. However, over the shorter periods (say the past 5-10 years) the absence of high quality comparable longitudinal data makes it very difficult to judge whether or not, and to what extent, claim numbers have increased, and the States or Territories in which such increases have occurred. The information that does exist often provides conflicting views.

3.12 Caution when looking at any of the piecemeal data is also required because the definitions used and the proportion of doctors that are covered by the data at any one historical point is not clear. For example, sometimes it has been claimed that numbers of claims have dramatically increased over a time when the numbers of their doctor members have also increased significantly. Others will claim dramatic increases over a period when the definition of a claim has changed e.g. from only counting claims once the legal process has commenced to counting all claims which have been reserved against by the MDO (which may or may not give rise to legal processes). Sometimes, actuarial or other reviews of incidents in an MDO can lead to a “reallocation” of a matter as a claim, even though no legal process has commenced, because the MDO is becoming more cautious with its reserving policies. Other significant increases have occurred when the MDOs have encouraged doctors to report all incidents early. While this is good practice, it may or may not be reflected in an actual upward trend in litigation.

3.13 Increases in numbers of claims may also reflect underlying rises in risk exposure. For example, if there are more health care services provided, then even if the **rate** of

litigation remains constant, the number of cases may rise. Such rises may have little impact on premium affordability on their own.

3.14 Another increase can come through the development of a claim portfolio. Two MDOs, the Medical Defence Association of Victoria (MDAV) and the Medical Defence Association of Western Australia (MDAWA), separated from the UK based Medical Protection Society in the late 1980s. The MPS members had “claims incurred” cover, so their claims prior to starting the new organisations were claims on MPS but this was disputed by MPS.<sup>10</sup> When an MDO first starts, it has only the claims from one year, and so there is a period of rapid increase as their claim profile “matures”.

### *An example of the problem of “mixed evidence”*

3.15 To provide one example, in Victoria, the 2001 Annual Report of the Medical Defence Association of Victoria (MDAV) stated that the number of claims reported to it had increased by almost 180% over the last 10 years. Part of this has to do with its history – as described above, it separated from the Medical Protection Society in the late 1980s and had only a small number of claims in its first few years of operation. The data available in its 2001 Annual Report shows a relatively stable index of claims reported between 1994/95 and 1999/2000 of 120, with the index rising to 180 in 2001. Part of the recent increase is also likely to arise from increasing membership. For example, data in the Annual Report shows numbers of doctors covered increasing by around 1,500 over the past 3 years between 1997/98 when member numbers were 8,014, to 2000/2001 when member numbers were 9,760. Over the 10 year period, MDAV has (like most MDOs) been urging its members to report incidents which could give rise to claims. Some proportion of the increase is therefore likely to relate to improved early notification of incidents (which may then be reserved against as claims). Whether or not this will flow onto the lodgement of a legal claim is not clear.

3.16 In the Victorian public sector claims are said to have risen at around 4% per year. Discussions with the Victorian Managed Insurance Authority indicate that this appears to be roughly equivalent to the rate of increased throughput in the public hospital system, so it may not indicate a greater propensity to litigate. Equally, while about 1,500 of these are estimated to have the potential to become claims, a much smaller proportion actually become claims.

3.17 Comparing this information with the actual number of cases before the Victorian County Court special list for this type of litigation, the number of cases has remained steady over the past 3 years at around 250 cases. In 2000-2001 there were 246 new cases commenced. Of those cases on the list in 2000-01 about 4% of cases went to trial, 39% were settled and 28% were discontinued or dismissed for lack of action. There are probably also a limited number of cases before other courts and some potential claims will be resolved in the Victorian Health Services Complaints Commission.

### *Data from different jurisdictions – another mixed message*

3.18 Data from some MDOs shows a pattern where the number of incidents being reported has increased significantly, due to greater emphasis on early reporting, but where the number of claims has remained fairly constant. For example:

- the Medical Defence Association of South Australia’s (MDASA) Annual Report 2000-01 indicated that “the claims frequency per hundred members has been fairly static since 1998 (2.4-3.0 claims per hundred members), notwithstanding



the media and anecdotal reports about increased litigation in Australia. In 1995 the frequency figure was 2.6 per 100 members.” (page 7)

- the Medical Defence Association of Western Australia (MDAWA) and MDA National Annual Report 2001 contains a chart which “tracks the trends of the past 11 years, indicating a significant increase in total case load, but what appears to be a levelling off in claims.” The Report goes onto say “This is, we believe, largely due to the excellent early incident reporting by members which allows us to analyse trends and develop strategies to avoid litigation and to adequately prepare ourselves for potential claims from reported incidents.

3.19 Data from the South Australian public system is broadly consistent with the MDASA experience, though it shows an apparently encouraging decline in the number of claims in recent years, following a period of very active risk and claim management. There is no trend data over a longer period, because until 1998/1999 the data on claims and incidents could not be split.

3.20 Other MDOs show increased incidents and increased claims, but decreased membership. For example:

- United Medical Protection’s (UMP) Annual Reports for 1999-2000 and 2000-01 show an increased number of incidents reported from 4,368 to 6,447, a decreased number of members from 42,000 to 39,000, with a modest increase in the number of claims from 4,432 to 4,961. The latter figure includes a significant number of claims lodged immediately before the commencement of the *NSW Health Care Liability Act 2001*, as discussed later in this Chapter.<sup>11</sup> From the graphs in the UMP Annual Report, it seems likely that the claims spike explains most of the increase in the number of claims. It is highly likely that many of these will not proceed, but were lodged as a measure of caution by lawyers “just in case”. It is understood that many of these cases are being struck out through the Professional Negligence List case management processes.

### *NSW review*

3.21 Prior to the introduction of the *NSW Health Care Liability Act 2001*, certain UMP data and data from the NSW Treasury Managed Fund current to 1999 was reviewed. The conclusions of this review were as follows:

- In the public sector, the claims rate appeared to have remained generally stable from the mid 1980s to the mid 1990s. From 1996/97 to 1999, although there had been some claims growth, it was difficult to precisely estimate the growth due to the changes in the excess arrangements (a \$1,000 excess was removed in 1996/97).
- Based on the UMP data, there was no substantial growth in claims rate per 1000 members from the mid-1980s through to the mid 1990s, but there was evidence suggesting that the claims rate per 1000 members had increased between 1995 and 1999. It was difficult to estimate the changes in the claims rate over the period because of further maturing of the portfolio. Based on a three year moving average, the actual rate of claims has already increased between 1994-1998 by 12%. Based on projections by UMP, this could result in increase of as much as 45%.
- Although changes in the rate of claims were clearly evident, this appears to be a relatively recent phenomena (that is since the mid 1990s). Prior to this time

claim numbers appear to have remained fairly stable, suggesting they had little to do with changes in premiums in the early 1990s. Overall, there had been growth, but it was not as dramatic as suggested by some. That said there was an area of significant concern: the growth in large claims. This was particularly so because small changes in the growth rate of large claims have a significant impact on the portfolio overall.

### ***NSW Supreme Court Professional Negligence List***

3.22 Data from the NSW Supreme Court Professional Negligence List also provides a useful part of the picture of more recent trends. The List commenced in April 1999 to “reduce delay and costs and increase the number of settlements and improve communication between the parties”. It deals with medical and legal professional negligence matters in the Common Law List of the NSW Supreme Court. The management of these cases is outside the normal court case management regime and the List has its own rules and practice notes. While the period immediately before the commencement of the NSW Health Care Liability Act at the beginning of July saw a dramatic increase in numbers of cases filed for the four months before that, the average monthly numbers of new cases filed has been less than 10 in the 23 months prior to that period, around 44 per month for each of the 4 months between March and June 2001, and an average of less than 3 per month since then. This more recent lowering probably reflects the earlier lodgement of cases prior to the new Act commencing, rather than a genuine decline in the average. However, this is limited data since only a proportion of NSW medical indemnity claims are lodged with the Supreme Court.

### ***Trowbridge analysis***

3.23 A 2001 analysis by Trowbridge Consulting using selected data provided by MDAV, MDASA, MDAWA and UMP drew different conclusions again. Using an index measure, they concluded that claim frequency:

- had increased dramatically over the early 1990s;
- had continued to increase over the late 1990’s but at a lower level; and
- overall, had increased 2.5 times over the ten year period.

3.24 They went onto say the “Each of the MDOs contributing to the study has shown a similar increase”. They made it clear that this data was of claims not incidents, so it is interesting that their conclusions differ from some of the MDOs and of the NSW Review. Discussions with Trowbridge indicate that some of these differences are because of the operation of the index measure and that the patterns of change may have varied from jurisdiction to jurisdiction, with some jurisdictions showing increases in the early part of the period and others more recently. Trowbridge’s analysis has not taken any account of the increases in numbers of health services provided over that period – this will have affected the numbers of claims over the whole period as well.

### ***Conclusion on claim numbers***

3.25 It seems likely that there has been an increase in claims numbers over the past 10-15 years – possibly doubling over that period in some jurisdictions. However, this is not simply explained by a theory of more litigious patients. Over that same period, the number of Medicare services provided has increased by 66% and the number of hospital

admissions has increased by 76% so a significant proportion of that increase will have arisen from greater exposure to risk.

3.26 Moreover, there is no clear and consistent recent pattern of claims increases that can, of itself, explain the recent significant increases in MDO premiums. In particular, there is little evidence that there is a recent change in behaviour where many more patients are suddenly suing their doctors and hospitals. What is more certain is that the long term pattern of litigation in this area, like many others, has been upward over several decades, from a very low rate of litigation in the mid part of the 20th Century to where it is now. Some of the likely reasons for this are discussed below.

### *Average claim costs*

3.27 There is evidence indicating that the average costs of claims are increasing. This is partly explained by significant increases in large claims costs, but there is also an apparently growing contribution from the smaller claims. In both cases, they can have significant effects on average costs – the larger claims because of their sheer size in a small risk pool, and the small claims because of their combined value.

#### RISES IN LARGE CLAIMS

3.28 The number of large medical indemnity claims incurred in any one year is small, but the financial impact of these cases is significant. For example, data from the NSW Treasury Managed Fund (TMF) shows that the claims for over \$1 million contribute 30% of total costs, while constituting considerably less than 1% of total claims. This is broadly consistent with Commonwealth Health Insurance Commission data which shows that 29% of the total amount of medical negligence compensation, linked to identified medical defence organisations, was for judgements or settlements over \$1 million. United Medical Protection (UMP) disclosed in its 2000-2001 Annual Report that 105 (2 per cent) of claims were valued at \$1 million or more and these accounted for over 45 percent of overall claims costs.<sup>12</sup>

3.29 The lack of data prevents a definitive picture being provided on the breakdown of settlements and judgments. We are obliged to draw on some limited studies and individual cases. A review which preceded the *NSW Health Care Liability Act 2001* analysed the components of all damages paid in settlements over \$50,000. For those settlements over \$1 million, the breakdown of damages was:

General damages	7.8%
Past economic loss	9.1%
Future economic loss	5.1%
Out of pockets (medical etc)	11.6%
Future care	22.4%
Gratuitous services	11.5%
Plaintiffs legal	1.6%
Defence legal	1.8%

It should be noted that the division of damages in this way, in cases which have been settled, is artificial, as a sum may be attributed to particular levels of damages after an overall figure is agreed.

3.30 However, the review stated that the small number of very large claims made it impossible to conduct a detailed analysis on changes in heads of damages in these cases. It concluded that anecdotal evidence suggested that future care costs are increasing in

large claims because of increases in the anticipated hourly costs and the number of hours needed.

3.31 This seems to be backed up in the analysis of more recent judgments. Court awards had risen from around \$2 million in 1993 to around \$7.5 million in 1996 for catastrophically injured children, with the 2001 *Simpson* judgment in NSW stretching that to \$14.2 million, \$6.5 million of which was for future attendant care costs. If all past and future care and rehabilitation-related expenses were included, the proportion of damages payable for these costs exceeds 80%. NSW TMF data showed settlements for severe brain damage of neonates or infants increased from around \$2 million in 1992 to \$7 million in 1999, which is broadly consistent with the pattern of award increases.

#### RISES IN SMALL CLAIMS

3.32 While there is no comprehensive data, both the limited data available and observations from MDOs indicate that the financial costs of small claims are also increasing. While each of these claims is a relatively small amount, there are a proportionally large number of them and this means that as the average rises, the overall cost impact can be significant. NSW data shows that there has been a two to three fold increase in the average cost of claims less than \$100,000 over 10 years. NSW data shows that the biggest single components of damages in cases between \$50,000-\$100,000 are legal costs (around 25-30%) and general damages (around 60%). It is highly likely that these proportions are even higher in claims less than \$50,000.

3.33 A complete analysis of small claims is not available at the moment in Australia, but NSW data supports a picture which may not be dissimilar to that in the UK, where in 65% of settlements less than £50,000, legal costs and other costs of settling a claim exceeded the damages awarded.<sup>13</sup> This compared to overall UK average data of 32% of the total costs of a claim going to plaintiff or defendant's legal and related costs (include the costs of expert evidence).<sup>14</sup>

3.34 Most of these cases involve temporary disability and pain and suffering, with minimal loss of earnings. Even in the NSW group between \$50,000-\$100,000, there was only 0.2% provided for future care costs. NSW data showed that the general damages component (which covers pain and suffering and loss of enjoyment of life) for claims under \$50,000 had grown quite rapidly over the past decade and considerably faster than legal costs.

3.35 NSW comparisons of data on legal costs in these smaller cases of less than \$50,000 shows different patterns between MDOs and the Treasury Managed Fund, with MDO's defence costs being considerably higher than the TMF costs (at least double) and with MDO costs rising steeply, but not those of the TMF. These differences make it difficult to draw certain conclusions about legal costs in small claims and why they have been increasing. The pattern of plaintiffs legal costs is not clear either.

3.36 This pattern of increasing small claims was one of the reasons that the NSW Government introduced its provisions imposing thresholds on general damages claims. These are discussed in detail in Chapter 7.

#### MEDICAL DEVELOPMENTS AS A SOURCE OF CLAIMS

3.37 Changes in medical care have also potentially contributed to different types of litigation and increased numbers of claims. For example, the capacity to detect some cancers or congenital abnormalities earlier means that failure to do so may now be regarded as negligent. People whose lives are shortened because the cancer is not detected early, or who suffer a more serious outcome because of the delay in diagnoses,

can sue for the failure. In the past, such claims would not have been made because early detection was not possible.

3.38 Better medical care has reduced the likelihood that some people who are harmed will die. When they survive with a disability, the costs of care may be significant because more can now be done to enhance their health and well-being. Courts are becoming more reluctant to assume an early death in assessing damages for future care, because of the catastrophic impact an error may have on the person's quality of life and access to assistance.

### **MDO industry change cost drivers**

3.39 There have also been a number of significant longer term changes in the medical defence industry that have led to increases in medical defence organisation (MDO) premiums and which continue to exert upward pressure on premiums. These include the following.

- Residual problems from long term MDO underfunding and moves to address these.
- Risk pool size decreases with the move away from mutuality.
- Increased costs associated with prudential supervision and the need to increase capital reserve adequacy.
- National and international short term inflationary effects, for example the effects of 11 September.

### ***Residual problems from long term MDO underfunding***

3.40 Up until the 1960s the frequency of litigation against doctors was very small - perhaps only one or two cases a year throughout all of Australia. With other changes in community attitudes, the frequency of litigation has risen. The size of damages claims has also increased.

3.41 For a long time, MDO premiums did not rise significantly in response to these pressures. Because they were not insurance companies, they were not covered by the prudential requirements of the then insurance regulator, the Insurance Commissioner, during most of the 70s and 80s. Nor were they required to meet accounting standards for general insurance companies. These were put in place to ensure that insurance company premiums were sufficient to meet the liabilities they had incurred, so that if they stopped trading, the claims of their customers up to that date would be able to be paid. Inadequate reserving, particularly for IBNRs but also for known claims, can result in the failure of an insurance company.

3.42 The MDO industry was not (and is still not) subject to this financial discipline, except so far as an MDO may have constituted some of its operations as an insurance business. For many years, while they offered cover on a "claims incurred" basis, MDOs collected their contributions almost on a "pay-as-you-go" basis. This meant that they only collected enough each year to pay out claims they had to pay that year with an amount for their administration and costs. Crunch point came at the end of the 1980s, when two organisations had to make calls on their members to meet claims costs.

3.43 At that time, MDOs also faced their first competition from insurance companies, which tried to come into the "low risk" end of the market, by offering attractive premiums to non-procedural General Practitioners. Up to that time all doctors had paid a similar contribution, whatever their specialty or their risk of a claim. This sharing of

financial risk across all doctors had also allowed the MDO contributions of higher risk groups to remain low. However, when insurers targeted the low risk groups, the MDO industry recognised that the high level of support for medical defence organisations across all doctors could easily unravel and leave them further financially exposed.

3.44 The combined effects of these events were that MDO premiums began to rise, and the cross-subsidisation across all doctors started to reduce, with individual specialty rating coming in the early 1990s. However, competition for members between the MDOs without any prudential supervision to oversee their activities meant that the underfunding question was not fully addressed. The Commonwealth's Professional Indemnity Review took a close look at the MDO industry and in 1994, its actuaries estimated that the industry had unfunded liabilities of about \$250M.

3.45 A recent Urgent Issues Group Report of the Australian Accounting Standards Board showed that many MDOs had improved their financial position over the past 7 years, but that there was still significant underfunding of past incurred but not reported liabilities in two MDOs.<sup>15</sup>

### *Addressing industry underfunding*

3.46 From the mid 1990s, the industry went through a period of considerable change, with the two large United Kingdom based MDOs moving out of Australia, the aggregation of a number of the smaller MDOs and the movement into the market of a number of commercial insurers. Most MDOs also moved to have at least part of their business operating through an insurance company - a so-called "captive insurer", which is a wholly owned subsidiary of an MDO and subject to prudential regulation under corporation and insurance law. While the industry was now aware of many of its problems, action on unfunded IBNRs was slow due to the competitive nature of the industry and concerns about loss of market share.

3.47 MDOs have acted to address this problem:

- by increasing their premiums;
- by changing the nature of the cover they provide from "claims incurred" to "claims made" and keeping premiums at the "claims incurred" level; and
- by making calls on their members.

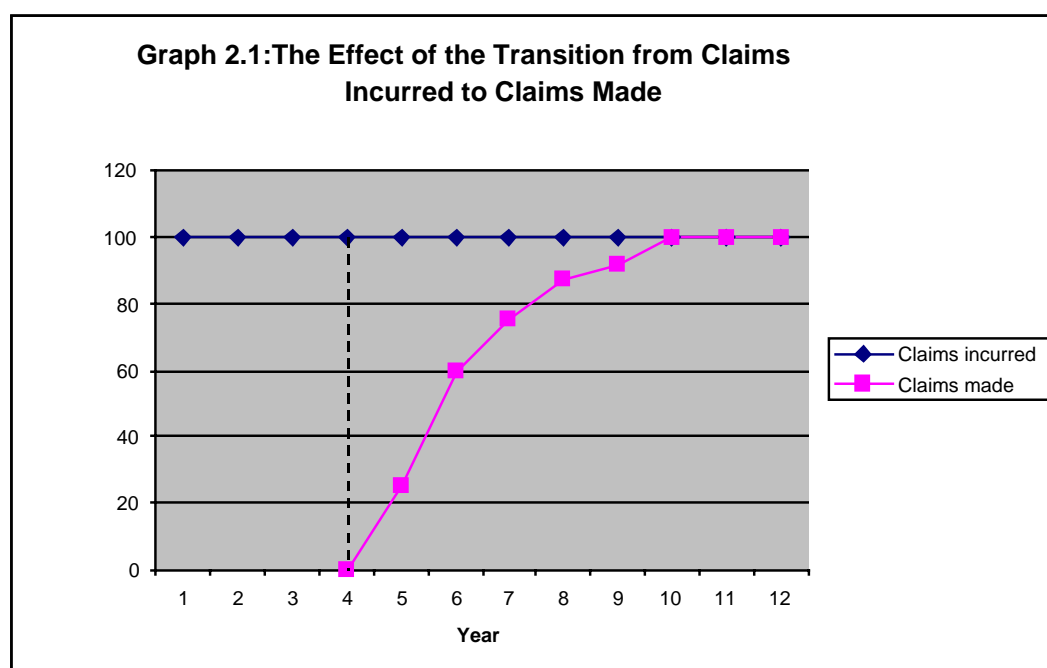
3.48 Premium increases were undertaken earlier by some MDOs than others. In fact, UMP competed on price with other MDOs in an attempt to move into most of the other MDO markets in other States and Territories. It gained a greater market share at the cost of a worsened financial position for the organisation.

3.49 Insurers and some MDOs have opted to provide "claims made" cover, which means premiums are collected to cover claims which become known in that year, either because the incident was reported by the doctor or because a claim was lodged. [This contrasts with "claims incurred" cover which means that a claim is covered if the doctor had cover when the event giving rise to the claim arose, even if the doctor does not have cover when the claim is made.] Many MDOs have taken a planned approach to addressing their shortfalls and have or are in the process of trading out of their situation. To inform their members better, most MDOs chose to disclose their estimated IBNR (incurred but not reported) liabilities on their accounts, as well as the provisions made for them. It seems likely that the Urgent Issues Group of the Australian Accounting Standards Board may make this disclosure obligatory in the near future.

3.50 MDOs except MIPS, MDAV and MPS TAS, have moved away from “claims incurred” cover to “claims made” cover. Where the MDOs also kept premiums at the same level or have increased them at the same time, those organisations have in reality gained a “one-off” financial boost. This occurs because medical indemnity claims are often not made or reported until some years after the year of occurrence. The following table gives an example of the type of pattern of receipt of claims that might be seen by an MDO for the claims incurred for a particular year.

**Table 2.1: Representative MDO claim lodgement profile**

Year of claim after occurrence	% of claims made each year	Cumulative total %
Year 1	25	25
Year 2	35	60
Year 3	15	75
Year 4	12	87
Year 5	5	92
Year 6 +	8	100



3.51 When a transition is made from claims incurred to claims made cover as set out in the graph, claims which are made from an incident that occurred prior to the move to claims made cover are “tied” to the cover which was in place at the time of the occurrence – they were part of the IBNR reserving for those past years. For a couple of years, then, from the transition junction between claims incurred and claims made cover, the number of new claims being made (and thus reserved against) are lower than the numbers that would have to have been reserved against in a claims incurred environment.

3.52 If an MDO (or insurer) keeps premiums at the level they were when the cover was claims incurred, they gain a one off “windfall”, (the area between the vertical dotted line and the graph lines). This can be used to either meet old unfunded liabilities or potentially act as a buffer against future increases in premium rates, if the reserves for old claims are already adequate.

3.53 Calls were first made by MIPS, MDAV and MDASA in planned strategies to address the unfunded IBNRs within their organisations. UMP made a call in December 2000.

3.54 Through a combination of these processes and prudent premium setting practices, the overall financial position of the 5 smaller MDOs has improved, but due to some of the factors discussed in Chapter 1 and here, UMP and its wholly owned subsidiary insurer AMIL has entered voluntary liquidation.

3.55 As the industry overall heads towards regulation, the need for greater capital and transparently adequate reserving is likely to mean that premiums will remain high and possibly increase, all other things being equal.

### *Risk Pool Size*

3.56 The main driver for specialty specific premium increases has been the move away from mutuality and risk pooling across all doctors in the late 1980s. At that time, premiums ranged between \$1,000 and \$2,000 per doctor, depending upon the jurisdiction.<sup>16</sup> Over time, MDOs have moved to create further and smaller risk groupings. This has been on the basis that it was a “good idea” to remove so-called “cross-subsidisation” among doctors, which is in fact the core way insurance operates.

3.57 Of most concern was the cross-subsidisation between low-earning doctors and high-earning doctors, often exemplified by the GP versus other specialist divide. However, given the relatively small size of the whole MDO market in insurance terms, this has led to “risk pools” which are so small as to be essentially unsustainable.

3.58 Risk pool reductions have brought about unsustainable specialty specific increases. These have been on top of increases in the overall liability pool. Options to address these issues are discussed in Chapter 8.

### *General insurance factors*

3.59 There are a number of general insurance industry influences that have also led to increased premiums in the MDOs.

- Prudential requirements of the MDO’s solely owned insurance organisations that are currently regulated by APRA have increased with the changed APRA requirements as a consequence of the failure of HIH.
- The cost of other forms of professional indemnity cover has increased nationally as well.

### *Shorter term premium inflationary effects*

3.60 There are a number of shorter term events which have added to these upward pressures.

- The collapse of HIH, which had been a reinsurer of some MDOs – for example, UMP disclosed an exposure of \$67.4M<sup>17</sup>, Medical Defence Association of Victoria disclosed exposure of \$20.2M<sup>18</sup> and the Medical Defence Association of



Western Australia disclosed exposure of \$5M.<sup>19</sup> Most MDOs do not expect to recover anything reinsured losses and so have had to commence a program of recapitalisation to meet these losses.

- The impact of September 11 on investment earnings and international reinsurers – UMP’s reinsurance negotiations took place before the other MDOs, and there are unique problems for UMP compared to other MDOs. However, its reinsurance costs increases led to an average increase in premium of 30%. Other factors raised the average increase to 50%. It is not yet known whether other MDOs will face the same level of increase, but most MDO annual reports warn members that the World Trade Centre tragedy and its financial consequences are going to have a significant effect on the costs of reinsurance. The increased conservatism in the international reinsurance market is expected to continue to affect premiums for the next year or more.
- The claims spike immediately preceding the recent NSW *Health Care Liability Act 2001* Solicitors lodged a large number of claims prior to the commencement of the NSW health care liability legislation in July last year. For the three months prior to the legislation commencing, claims numbers lodged with the Supreme Court increased from an average of less than 10 per month to 44. However, indications since are that this was probably a “bring forward” of claims which would have been lodged in the future, as numbers of new claims dropped to an average of less than 3 per month since. This the spike is likely to reduce in effect over time, as many of these cases will not proceed.

## CHAPTER 4

# Improving patient safety in the health care system

### Links between Patient Safety and Litigation

4.1 The prevention of adverse events and consequent harm to consumers using health care services can reduce the human and financial costs associated with adverse events, as well as having some effect on the rate and costs of litigation. This makes the improvement of safety and quality an integral part of any long term solution to medical indemnity issues. It is unlikely that all adverse consequences to patients from negligence will be able to be designed out of the system. However, the culture change in health care that accompanies a focus on patient safety can also have an impact on medical litigation in a number of direct and indirect ways.

4.2 Because the Australian Council for Safety and Quality in Health Care is undertaking work on these issues, this Chapter does not deal in detail with the wide range of processes and strategies which can be used to improve patient safety, though these all play a role in risk management around litigation. However it contains a brief discussion of some relevant strategies and the legislative reforms necessary to support them.

### *Adverse events*

4.3 Over the past few years, there has been a growing focus on the safety and quality of health care in Australia and many other countries. Modern health care is complex and some treatments carry inherent risks. As a consequence, things may go wrong and sometimes a patient is harmed. Research has shown that this occurs relatively frequently – about 1 in 6 patients admitted to an acute hospital experience harm which is sufficient to extend their hospital stay, to cause disability or even to result in death.<sup>20</sup>

4.4 Where incidents give rise to harm, they are known as an “adverse event”. Research shows that probably at least a half of all adverse events are preventable<sup>21</sup>. Some, but not all of these, will be due to negligence. New tools are being developed to document and analyse the causes of adverse events, so that the health system can put in place barriers to prevent harm occurring. Sometimes it is even possible to “design out” the risk.

4.5 What is clear is that very many more people are harmed in health care than ever sue, and that is so even in highly litigious places such as New York, where the Harvard Medical Practice Study (HMPS) showed that about a quarter of the adverse events in that study or around 1% of admissions involved negligence<sup>22</sup>. The Professional Indemnity Review’s Interim Report summarised the studies conclusions about the relationship between litigation and adverse events (AE) in the following manner:

The HMPS estimated that eight times as many patients suffered a negligent AE as filed a tort claim and only half of those that filed recovered any compensation. When the HMPS matched cases where it had found negligence with those where legal claims had been commenced, even fewer than 1:16 had commenced legal action.<sup>23</sup>

4.6 The consequences of this is that there is a large group of potential litigants who, were they to decide to sue, may well have an action. However, in the vast majority of cases, they choose not to use.

### *Why people sue*

4.7 Why is it that many patients who have suffered harm do not take legal action? A number of studies have looked at the reasons some people sue and some do not. Generally litigation involves anger and frustration as well as an adverse event. Where a patient experiences these emotions in relation to an adverse event, they are much more likely to sue. For example, where there is a perceived mismatch between what is promised and what is delivered or the doctor has not told the patient about the risks of a procedure and they are harmed by one of these risks, patients are more likely to sue. Once an adverse event has occurred, patients may sue if they do not feel that they have been able to communicate frankly and effectively with the doctor about what has occurred.

4.8 Health care consumers give a range of reasons for suing when an adverse event occurs. These include:

- an inability to find out what happened to them during treatment;
- the belief that information is being hidden from them; and
- concern that nothing is being done to prevent a recurrence of the adverse event for other patients.

4.9 These motivations are backed up by research into what consumers say they want at the commencement of a claim.<sup>24</sup> In a survey of claimants in the United Kingdom, plaintiffs had an extensive range of aims other than a quest for money – these included steps to stop the same thing happening to someone else (52%); the provision of an apology (44%); an opportunity to make the other side understand their concerns (40%); and to be told what had happened to them (38%). This survey was taken of people who had started to sue, so when they were asked to prioritise all their aims, 36% put compensation as their first priority, followed by a desire to prevent the same thing happening to another person (27%). If people are better informed before receiving health care and are treated more appropriately at an early stage immediately following the occurrence of an adverse event through an effective “open disclosure” process which meets many of their needs, then the whole process of litigation can often be avoided.

### *Litigiousness*

4.10 It is often stated that our society is generally becoming more litigious. This may reflect broader social and political trends. These include more awareness of consumer and human rights, and greater questioning of the privilege and trust traditionally accorded to professionals of many kinds. Medical practitioners in particular have been affected by a cultural shift, which encourages a more questioning approach, but it has also affected litigation against other professionals as well.

4.11 People no longer see a doctor as automatically occupying a special status – the respect and trust that may once have “gone with the job” is something that now often has to be earned. If there is little trust between the doctor and the patient and something goes wrong, the injured person is more likely to seek legal redress. If they feel the adverse event or its handling also involves a breach of trust, they are even more likely to take this step. The importance and value of developing and maintaining trust in the doctor/patient relationship cannot be underestimated. Developing a good trust-based partnership with patients can be a strong defence to legal action, as well as making the work of medicine more satisfying. A key element in the creation of trust is the disclosure of adverse events to consumers when they occur, both through telling a patient or, in appropriate circumstances, their family, that an adverse event has occurred, and through

systematic gathering of this data. Neither of these have traditionally occurred in health care.

### *The culture of secrecy*

4.12 Historically, disclosure has been very difficult for doctors, because the culture of medicine made it hard for them to admit that an error had occurred. One doctor has concluded that the training of medical practitioners and medical culture lead doctors “to expect to function without errors” and to “view error as a failure of character”.<sup>25</sup> The fiction of perfection resulted in

a need to deny the existence of error at a very fundamental level, because the admission of an error [was] no longer simply a recognition of every doctor’s essential humanity and the reality of modern health care ... Rather, admission of an error [became] “a confession of having a flawed character. Having erred [was] seen as the antithesis of the very self-perception that a doctor [had] developed over years of training and enculturation.”<sup>26</sup>

4.13 This cultural reluctance to admit error and acknowledge that the health care service resulted in harm was reinforced by the fear of litigation and by advice from medical defence organisations that the doctor should say nothing to the patient, for fear that it be taken as an admission of liability. The complex consequences of this culture were generally negative for all concerned.

4.14 Doctors were strongly advised against expressing regret for the adverse outcome, and yet the lack of information and an apology were often the things consumers mentioned as the very thing that distressed them most. Ironically, most of the evidence shows that the behavioural consequences of this fear and the subsequent secrecy have been major factors for many consumers in initiating litigation<sup>27</sup>.

4.15 Thus, while an ethical duty existed to inform a patient about what had happened to them, there were many practical barriers to this being done effectively and in an open manner. When an adverse event occurred, often a patient or their family were not told about it. If they were informed, the information provided was often fairly superficial and people were not encouraged to ask more questions. This often left patients and their families feeling frustrated and distrustful of the health care system.

4.16 The Taskforce into Quality in Australian Health Care identified management, when things go wrong, as a significant concern.

Many consumers complained to the Taskforce about the way they were treated when an adverse event occurred. The perception that the system closes over and information is withheld is common. Health practitioners were perceived as unwilling to be critical of their peers – for some consumers this led to a loss of confidence in the health care system. A sense of grievance can be carried for a very long time, with the original error or injury compounded by a sense of betrayal by the whole system. It is acknowledged that practitioners and institutions may themselves be constrained by insurers who are concerned about what is admitted regarding liability. This issue may have to be addressed if adequate communication is to take place when adverse events occur.<sup>28</sup>

4.17 In the words of one US clinician, Dr Albert Wu of Johns Hopkins University School of Medicine:

In over 25 years of representing both physicians and patients, it became apparent that a large percentage of patient dissatisfaction was generated by physician attitude and denial, rather than the negligence itself. In fact, my experience has

been that close to half of malpractice cases could have been avoided through disclosure or apology, but instead were relegated to litigation. What the majority of patients really wanted was simply an honest explanation of what happened, and if appropriate, an apology.<sup>29</sup>

4.18 Evidence that greater openness is likely to reduce the risk of litigation is provided by the experience of the US Department of Veteran's Administration, where there has not only been a policy of open disclosure of an adverse event but a proactive acceptance of liability when the hospital becomes aware of an adverse event which gives rise to negligence.

### **Moving towards a culture of openness**

4.19 The gradual move towards greater openness in health care can be seen as having its roots in the move away from professional paternalism to a legal recognition of a patient's right to self-determination, which was first recognised in Australian law in 1983.<sup>30</sup> This was endorsed in the well-known 1992 decision of the Australian High Court in *Rogers v Whitaker*,<sup>31</sup> where the obligation on a doctor to disclose risks was first clearly spelt out. While this dealt with disclosure of risk before treatment, rather than disclosure of an adverse event after it occurred, the two information-giving processes are closely related. The Professional Indemnity Review's Final Report described this connection, when looking at ways of preventing litigation, where one prevention strategy was:

recognition and acknowledgement that adverse patient outcomes can and do occur.<sup>32</sup>

4.20 The PIR went on to describe the next two main strategies for the prevention of litigation as

- greater openness when an adverse event occurred; and
- putting in place processes to detect and report adverse events and to prevent their recurrence.

4.21 The barriers to greater openness after an adverse event occurred were acknowledged in the Professional Indemnity Review's Interim Report, which drew attention to the conflicting advice doctors were receiving. On the one hand, they were being told that greater openness and prompt sensitive handling after an adverse event was good practice, as was saying that they were sorry that the patient had suffered harm. On the other hand they were being told to contact their MDO, rather than the patient, immediately after an adverse event occurred.<sup>33</sup>

4.22 The Interim Report therefore made two recommendations suggesting that clear and consistent advice should be developed to give to consumers and providers about what to do when an adverse event occurred.<sup>34</sup> Within the limited time available, the Professional Indemnity Review commissioned preparation of these by the Victorian Health Services Commissioner and the Health Issues Centre, with the co-operation of the Medical Protection Society and they were included as Appendix D to the Final Report. Recommendation 43 proposed that the draft guidelines "be made available to State Government, consumer groups and professional bodies to modify appropriately and to ensure their wide dissemination in user-friendly formats."<sup>35</sup>

4.23 In 1996, the Taskforce on Quality in Australian Health Care recommended that "State and Territory governments distribute the Professional Indemnity Review's draft information guidelines for patients and providers through health care services after appropriate further development by professional bodies and consumer groups".<sup>36</sup> The National Expert Advisory Group on Safety and Quality in Australian Health Care, which

was established in 1998 to identify those safety and quality matters that would benefit from national effort and coordination, recommended as one of its national actions the development of “strategies and partnerships to improve information flows between all parties about areas for quality improvement, and to ensure that patients, their families and carers and health care agencies receive timely advice about incidents.”<sup>37</sup>

### **Australian Council of Safety and Quality in Health Care and Open Disclosure**

4.24 Following the recommendations of the National Expert Advisory Group, the Australian Council for Safety and Quality in Health Care was established in December 1999. Up to that time nothing had been done to implement the recommendations about improved information availability for consumers once an adverse event had occurred. However, the Council’s National Action Plan 2001 identified four priority areas. Under most of these there were strategies to encourage increased openness and acknowledgement of how frequently error occurred in health care, through:

- better use of data and information throughout the system to support safer patient care, which included national steps to improve the openness of error and incident reporting systems including the role of mandatory reporting of deaths and serious injuries;
- supporting those who work in the health system to practice safely, which included using accreditation to reinforce open communication with patients and their families when things go wrong;
- actively promoting opportunities for consumer feedback and participation, which included the development of standards and guidelines for health care providers and facilities about what to do when an adverse event occurred (eg to avoid communication shut down); and
- redesigning systems and facilitating a culture of safety, which was defined as a system which recognises the inevitability of error and system failure and actively works to minimise the impact and prevention of errors.

4.25 It was in this changing context that the Council determined to fund the development of National Standards for Open Disclosure, which are currently being developed through a Standards Australia consensus building process. These standards are intended to promote best practice in open disclosure when an adverse event occurs.

- The standards are intended to provide a code of ethical behaviour for health care providers when an adverse event occurs.
- The standards are also intended to provide guidance for consumers about what they can expect so far as openness is concerned throughout the entire process of health care.
- It is intended that the adoption of these standards be encouraged by managers and insurers or medical defence organisations as an important element of risk management and good practice.
- Compliance with the standards should be built into accreditation processes for hospitals, other health services and other providers.

4.26 The standards also acknowledge that open disclosure is only a part of good communication. The process does not start after harm arises – it begins before a health service is provided, with full discussion of risks, potential and likely benefits and treatment options (including no treatment) for the consumer.

## Facilitating a culture of openness

### *“Open disclosure”*

4.27 Open disclosure is used here to mean the discussion with a consumer or their family of incidents that have resulted in harm to them when they are receiving health care (so called “adverse events”).<sup>38</sup> The aim of open disclosure is to create a different culture and approach to adverse events – one which is less adversarial, which is more reflective – a so-called “learning culture” – and one where consumer trust and confidence can be maintained or improved. When finalised, the standards that are currently being developed are intended to set out a range of best practice processes for discussing many aspects about an adverse event with a consumer.

4.28 Open disclosure is also a process rather than a single act – that is, it involves not only the initial disclosure of an adverse event, but also telling someone what will be done to determine why the adverse event happened and what will be done to prevent it happening again. It also includes the follow-up action from that investigation process. The elements which might be included in an effective initial disclosure of an adverse event to a patient (or where relevant and appropriate, their family) include:

- factual information about what happened;
- factual information about the immediate effect on the patient;
- an apology or expression of regret to the patient;
- discussion of the possible consequences for the patient;
- factual information about options to ameliorate harm done to the patient;
- a brief outline of what will be done to ensure that lessons are learned from the adverse event to prevent recurrence; and
- the identification of someone who will be able to answer any questions which the patient or family may have once they have had some time to think about it.

### *Litigation, negligence and openness*

4.29 There are varying views about telling consumers after an adverse event about their possible options to take further action (either complaint or litigation based), but the implications of the underlying principles of open disclosure seem fairly clear. If the hospital or doctor obtain unequivocal legal advice that the care which led to the adverse event was negligent in the legal sense, then it is strongly arguable that the hospital or doctor is under an ethical duty to contact the person. This is the antithesis of what has traditionally been the case in health care litigation, but it has been the practice adopted by the Lexington Veterans Affairs Medical Centre in the USA since 1987. In a 1999 article the genesis of this approach was described:

In 1987, after losing two malpractice judgments totalling more than \$1.5million (partly because of inadequately prepared defenses), the management of the Lexington center decided to use a more pro-active policy in cases that could result in litigation. This new policy was intended to better prepare the risk management committee to defend malpractice claims by identifying and investigating apparent accidents and incidents of medical negligence. However, when investigation identified an incident of negligence of which the patient or next of kin was apparently unaware, ethical issues arose. The committee members decided that in such cases, the facility had a duty to remain in the role of caregiver and notify the patient of the committee’s findings. This practice continues to be followed because administration and staff believe that this is the

right thing to do and because it has resulted in unanticipated financial benefits to the medical center.<sup>39</sup>

4.30 Once the advantages of open disclosure based on trust are recognised, it is hard to argue against it. This approach also reduces the adversarial nature of the process at the grass-roots level and can allow much earlier access to compensation when it is probably most needed.

### *Continuing barriers to openness*

4.31 Most doctors and consumers express strong support for a more open system for dealing with adverse events. However, there are a range of practical and attitudinal barriers to the widespread implementation of best practice in the area. These include fear among doctors that an apology or expression of regret will be used as an admission of liability if litigation does occur. This belief exists among doctors and many insurers even though the legal position is fairly clear that an apology is not an admission. The Open Disclosure Project's Legal Review also indicates that lawyers often aggravate this fear through their own cultural practices –

The apparent disinclination of lawyers and some insurers to recommend or approve apologies reflects, and to an extent betrays, an assumption that “medical mishaps” are just another form of potential dispute which, like any other dispute, needs to be “managed” so that the financial consequences can be minimised.<sup>40</sup>

4.32 Concerns about the effect of an apology could be overcome by legislation which makes it clear that an apology made as part of an open disclosure process is inadmissible as proof of negligence in an action for medical negligence.

4.33 Another barrier to openness is widespread concern about the possible use in litigation of speculative information gathered in a thorough investigation of the causes of an adverse event and ways of preventing a recurrence.

4.34 A significant proportion of adverse events arise from system based problems. Consumers want to have better access to factual information about the adverse event – that it happened, how it happened and what will be done to prevent it happening again. Under the present system they may need to litigate when they do not in fact want to seek compensation. At the same time, doctors fear that disclosing this information to a consumer may increase the likelihood of litigation. This issue has arisen in the Open Disclosure project and the Australian Council on Safety and Quality in Health Care has agreed to fund additional legal research to identify how to address the balance of interests and maximise open disclosure.

4.35 Doctors are also concerned that if more information is known about adverse events, then they will face punitive sanctions from their peers and hospital management – they doubt the reality of a “no-blame” culture which will enable them to learn from their mistakes.

4.36 On the other hand consumers are concerned that a “no-blame” culture could be used to protect poor practitioners who put at risk patients' lives, or that it may mean that no-one is responsible for implementing changes. There are a number of famous examples, such as the Chelmsford hospital in NSW, where many consumers have been harmed before the health system acted to stop the harm which occurred. The health care system must have a means of detecting the small number of dangerous and incompetent practitioners before they cause serious harm. In addition, the health care system should have the capacity to fix systemic errors – clinical governance needs to be proactive and strong in these situations. While consumers understand issues about funding priorities,



too often changes to processes which are not costly do not occur because no-one takes responsibility for ensuring the changes actually happen.

### ***Incentives for openness***

4.37 Just as there are barriers, there are also some incentives for openness in the present system. While insurers and other risk holders have often resisted greater openness, they have at the same time argued strongly for improved reporting of incidents, both to allow early investigation while evidence is still fresh and to give greater certainty to their liabilities. The early determination of liability also allows appropriate cases to be managed outside the court system and compensation to be made available much earlier and at a lower cost. In cases where there is no evidence of negligence, it also allows the refusal of a claim with greater certainty. Unfortunately, insurers have also sometimes punished people who report incidents regularly, whether or not these incidents give rise to claims or are indicative of poor practice or are rather indicative of a real focus on learning from mistakes.

4.38 Greater openness about the occurrence of an adverse event might allow a doctor who requires either additional training or assistance with some other problem (such as addiction) to be identified earlier and be prevented from causing additional harm. It would result in doctors being provided with assistance to reach an acceptable standard.

### **Open disclosure - directions for reform**

4.39 To create a balanced set of proposals for reform in this area, three themes are evident. Proposals should

- foster open disclosure;
- create a health care culture that learns from its mistakes; and
- put in place appropriate mechanisms to foster systemic responsibility for patient safety and to provide incentives for all parts of the health system to act proactively to protect consumers and ensure adequate service standards.

4.40 As we have already pointed out, reforms which meet these objectives will also help to achieve other goals. Open disclosure can reduce the need to litigate and can ensure more claims predictability, thus leading to more sustainable insurance or MDO arrangements and probably more stable premiums.

### ***Fostering open disclosure and creating a health care culture that learns from its mistakes***

4.41 There is a need to foster greater openness in reporting of adverse events, the active investigation of adverse events and the implementation of changes to prevent such events occurring again. Reforms in this area need to be developed with the Australian Council on Safety and Quality in Health Care and other stakeholders. They should include

- provision for consumer involvement on quality and safety committees;
- the introduction of standard legislative arrangements dealing with the admissibility of incident monitoring and similar adverse event reporting processes in litigation; and

- making the work of these committees more transparent through de-identified public reporting of the activities and the actions which have occurred over the previous year.

*Reform template for legislation to support open disclosure*

The AHMAC Legal Process Reform Group supports the work of the Open Disclosure project and recommends the implementation of a balanced package of “open disclosure” legislation to support the broader work of that project. The package should include:

- provision that an apology made as part of an open disclosure process is inadmissible in an action for medical negligence.

4.42 Because of work being undertaken by the Australian Council on Safety and Quality in Health Care, the Legal Process Reform Group has not made detailed recommendations about

- what matters should be disclosed to patients; and
- what legislation should be put in place to support open disclosure.

4.43 We have been advised by Ms Pam Burton that the AMA does not support incorporation of open disclosure standards in legislation. It is the view of members of the Legal Process Reform Group (excluding Ms Burton) that any open disclosure process should include a requirement to disclose the occurrence of an adverse event to the patient (or their family) as soon as the practitioner becomes aware that it has occurred.

4.44 The majority of the Group also believes that legislation should protect the process of investigation designed to investigate systemic errors from admission as evidence during court proceedings, but that the actual findings of the investigation should be admissible in court proceedings and should be made available to the consumer (or where appropriate their family).

4.45 In order to provide an additional incentive for health professionals to disclose the occurrence and causes of adverse events to patients we have made recommendations about changes to limitation of actions legislation, which imposes a time limit on the commencement of legal proceedings. We propose that the fact that a consumer (or their family) has been notified of the cause of an adverse event, following an investigation process, should be taken into account in deciding whether they are entitled to an extension of time within which to bring proceedings. This is discussed in Chapter 7.

### **Legislation to encourage systemic responsibility for patient safety**

4.46 The Legal Process Reform Group also considers that change is necessary to make the health care system more responsive to and responsible for addressing systemic safety issues. The vast majority of practitioners are competent performers. In a small minority of cases however, it will be necessary to address poor performance of particular practitioners. The legislative framework needs to address both systemic safety issues and problems of poor performance, without compromising the goal of having a system which is open enough to admit and learn from its mistakes.

### ***Professional accountability for exceptionally poor performance***

4.47 The National Patient Safety Centre in the US Department of Veteran's Administration (VA) has a preliminary screening process for adverse events. This determines at the beginning which investigation process should be followed. If it is either:

- a criminal act;
- patient abuse;
- an act involving substance abuse by a care provider; or
- a purposefully unsafe act

then the VA requires the case to go down a disciplinary stream, where the whole process is open, transparent and accountable. If it is any other adverse event, then its investigation can be protected as discussed above. We support a similar approach in the Australian health care system. The protection applicable to investigation of adverse events, which is discussed above should apply, unless the adverse event was an excluded act which requires disciplinary or similar processes in order to maintain public confidence in the system.

### ***Systemic accountability through complaints bodies***

4.48 A second means of encouraging systemic responsibility for patient safety would be through enhancing the powers of State and Territory Health Complaints Commissioners to identify, initiate an investigation and report to Ministers on systemic problems identified through the complaints received by them. This already occurs in some jurisdictions, and the Australian Health Care Agreements, require a process of this kind so far as public hospital complaints are concerned. However, a combination of resource shortages and lack of legislative capacity means that the potential of complaints for systemic improvement is under-utilised at present.

### ***Reporting of litigation and systemic use of the data***

4.49 A third way to develop a more systematic response to adverse events is to link different systems which provide information on performance. This could be done through the use of litigation information to better inform other accountability processes, such as registration boards or the health complaints commissioners. Models like the US National Practitioner Data Bank provide a different model, which allows potential employers to access the claims history of a doctor before employing him or her. Section 72 of the South Australian Medical Practitioner Act 1983 requires a medical practitioner to notify the South Australian Medical Board of specified details of any settlement or judgment relating to their performance as a medical practitioner. Section 80(1)(j) in the NSW Health Complaints Act 1993 allows the Commission "to investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners." Both powers are required to be fully effective.

4.50 The Group believes that there should be an obligation on either the doctor or any provider of medical indemnity cover to report claims information to the relevant body, which could be either the health complaints commissioner or the relevant registration board. Secondly the relevant body should have an obligation to monitor the frequency and nature of claims and where necessary investigate them and recommend actions.

### *Statutory protection of risk management activities*

4.51 A fourth issue which may need to be considered is the statutory protection of risk management activities, which are initiated when an adverse event occurs. To date Governments have traditionally limited protection to quality assurance activities. This creates some ambiguity when information on incidents is gathered for both patient safety and quality as well as risk management purposes. There is concern that this ambiguity could lead to a failure of the protection of quality assurance activities, because risk management purposes may be considered outside the realms of quality assurance. This is most likely to be the case where the risk management activity includes notification of the insurer.

4.52 In some cases, hospitals attempt to overcome this ambiguity by referring matters to their lawyers at an early stage to attempt to invoke legal professional privilege. The success or otherwise of such a strategy depends upon the content of the information and its purposes. At best this is a fairly ineffective strategy. The resolution of the issue is complicated by the blaming attitude of some health care managers and insurers. Clinicians argue that if information they provide for quality assurance purposes can also be used to increase their premium or for risk management that occurs in a blaming environment, they may be reluctant to report. Equally there are others who are concerned that if two different reporting systems are required, that reporting will be generally inadequate as people will simply choose not to do either, or will deliberately not report adverse events that they can avoid reporting to reduce the likelihood that their premiums will increase.

4.53 It is difficult to determine in the end, how to balance these in a commercial risk-taking environment, and indeed, when frequency of reporting indicates good risk management or unusually high frequency of adverse events that indicate a problem. The whole philosophy of anonymised incident monitoring as it occurs in Australia, principally through the Australian Incident Monitoring System, is that anonymous reporting gradually improves the system, because there are few “bad apples”. This system suggests relying on other reporting arrangements to identify these cases, but exactly what these are and how effective they are at present must be open to question.

*Reform template to encourage a systemic responsibility for patient safety*

The AHMAC Legal Process Reform Group recommends the following:

- (a) that any legislative protection for open disclosure activities should not apply where the adverse event was an excluded act;
- (b) excluded acts are those which
  - (i) could constitute a criminal act,
  - (ii) could constitute carrying out a procedure or failing to carry out a procedure with reckless indifference to its effect on the patient and where foreseeable harm occurs to the patient; or
  - (iii) involve substance abuse by a care provider; or
  - (iv) prima facie appear to require discipline of the practitioner by the relevant registration body;
- (c) that States and Territories require that registered practitioners notify their registration boards at any time there is money paid in respect of a matter involving personal injury to a patient and/or their performance as a registered health professional;
- (d) that registration boards can share this information with Health Complaints bodies in their jurisdiction for the purposes of the Health Complaints bodies monitoring complaints and litigation against individual practitioners and initiating investigation or disciplinary processes where appropriate; and
- (e) that States and Territories should review the powers of professional disciplinary bodies and/or professional registration bodies to ensure they are adequate to deal with issues of consistently poor performance;
- (f) that States, Territories and the Commonwealth work together to ensure a consistent framework for the statutory protection of risk management and quality assurance activities. Statutory protection should be provided within a framework of public disclosure of anonymised information on risks and on what is being done to address these by bodies which have the benefit of this legislation.

## CHAPTER 5

# Reducing the need to litigate and encouraging early finalisation

### Introduction

5.1 Both consumers and doctors dislike the adversarial nature of litigation. The experiences of consumers were examined in one of the Professional Indemnity Review's Research Papers, where consumers talked about the costs, delays, and distress caused by the adversarial nature of the whole process:

The participants' injuries brought them into contact with both medical and legal system, ... Neither system adequately provided the participants with the support and counselling that they so frequently desired. Lawyers frequently did not act supportively and chose not (or were not able) to address the emotional needs of their clients. Health/medical care providers were estranged from patients by legal proceedings and participants often did not know where else to turn for counselling and support. ... The present legal system of compensation places a barrier between health/medical care provider and claimant which can only be resolved in legal and economic terms. Bitterness is engendered by the long struggle. Although the struggle at the financial level is really against the insurers, the use of one or more named defendants and the adversarial process makes it difficult for claimants not to personalise their bitterness ...<sup>41</sup>

5.2 Provider dissatisfaction is also well-documented. The Professional Indemnity Review summarised health professional concerns in this manner:

7.14 ... The process of litigation is also an adversarial one, and a conscientious doctor may well feel very upset at the breakdown of their relationship with their patient, particularly if it has been a long term one. They may feel further alienated by the legal processes of claim and counter claims, and the different processes for gathering and hearing evidence. These are normal human responses. Because of the professional culture of medicine, doctors in these circumstances may feel their self-esteem is diminished and so act even more defensively to protect their own self-perception.

7.15 Where the spectre of litigation becomes a reality, the doctor can also become fearful of public humiliation. The culture of the system can also lead the doctor to feel very isolated, with little personal or professional support around him or her. In those few cases that go to court, a judge can accept another person's view of events, which can leave the doctor feeling public humiliation even more acutely. While similar feelings of unhappiness with the evidentiary processes of the courts are felt by plaintiffs, it can also increase the vulnerability of the professional to depression and even increase the risk of suicide. These are the direct and unsatisfactory consequences of existing arrangements coupled with the unrealistic culture of professional perfection. They can sometimes result in permanent harm to the doctor or other health professional.<sup>42</sup>

5.3 As well as having concerns about the adversarial process, doctors criticise the common law negligence action because they believe it leads to a simplistic analysis of complex health care situations. The search for someone to blame is a fundamental characteristic of our current fault based system. Since the industrial revolution, fault has been considered an appropriate "sieve" to determine which people should be able to

recover compensation and which should either have to rely on their own resources or those of the community. Although there are arguments against reliance on fault to determine entitlement to compensation, the terms of reference of this Group do not allow us to propose the introduction of a no-fault statutory compensation scheme as an alternative to the common law negligence action. However some aspects of negligence are discussed in more detail in Chapter 6.

5.4 This Chapter assumes the continuation of a fault-based system and focuses on:

- alternatives to litigation;
- avoiding litigation through early settlement;
- how to reduce unnecessarily adversarial elements of litigation once it begins;
- how to speed up resolution of claims when they are commenced.

### **Alternatives to litigation**

5.5 Alternatives to litigation can help to reduce the adversary nature of the current process. They include

- greater emphasis on health complaints processes
- early no-liability payment legislation.

### ***Existing health complaints processes***

5.6 All States and Territories have health complaint mechanisms in place. These were first required under the 1993-98 Medicare Agreement, and also formed part of the 1998-2003 Australian Health Care Agreements. The Agreements require the bodies to be independent of public hospitals and the Health departments, and to cover public hospital complaints. However, most jurisdictions have given their complaints bodies much wider scope. The Agreements also require the complaints body:

- to have powers to investigate, conciliate and/or adjudicate on complaints received by it;
- to recommend systemic and specific improvements to the delivery of public hospital services;
- not to interfere with or override the operation of registration boards or disciplinary bodies; and
- in the exercise of its powers, not to affect rights that a person may have under common law or statute law.<sup>43</sup>

5.7 The models which apply in all States and Territories differ in their scope and operation. Some models have well-developed conciliation functions, which may or may not be currently able to be used as an alternative way of resolving a claim for compensation. There are generally three broad functions of complaints bodies:

- resolution of individual complaints either through conciliation or investigation and finalisation;
- involvement in systemic quality improvement relating usually to problems identified in complaints; and
- referral to, and sometimes even prosecution of practitioners before, disciplinary processes.

5.8 They may be linked into other complaints mechanisms at the service level, or to “patient advocate” positions.

### *Avoiding litigation through better use of health complaints processes*

5.9 Health complaints bodies can be important alternatives to litigation, if they are adequately resourced and have appropriate statutory powers. They can serve as vehicles for resolving as many complaints as possible outside the current litigation system. The use of complaints systems in other areas of consumer rights have been used in this way very successfully, for example in the insurance, banking, telecommunications and utilities sectors. The 1995 *Justice Statement*<sup>44</sup> identified the important role that such consumer dispute schemes can have in providing a speedy independent, affordable way of resolving consumer concerns. The statement noted that both providers and consumers benefit from these schemes, because they are less complex than courts and vastly improve the public perception of the service providers involved.

5.10 A key feature of the operation of these schemes is that upon receipt of a complaint, the body responsible examines whether the complaint is justified and attempts to seek redress through a process of reconciliation and mediation. There are different models, which range from having an Ombudsman, to a Panel which includes an independent chair, a consumer and an industry representative. Most of these bodies are funded by their industries, with greater contributions required by organisations that have greater numbers of complaints. This funding model is intended to encourage effective in-house complaints resolution.

5.11 The PIR listed a range of functions that were needed by a health complaints body to meet the needs of consumers:

- to help the consumer clarify the nature of the complaint and the consumer's preferred outcome from the complaint;
- to seek an explanation/response, including an apology where appropriate, for the consumer from the health care professional involved;
- to assist with conciliating an agreement between the health care professional and the consumer, if that is what both parties want;
- to ensure that any steps necessary to improve health care services and maintain professional standards are taken; and
- to recognise when significant issues of public health and safety are implicated and ensure prompt appropriate action or referral is undertaken to protect the public.<sup>45</sup>

5.12 Health complaints bodies in Australia fall somewhere between an industry ombudsman model and a regulatory body, with broader public interest obligations.

### *Directions for reform in health complaints*

5.13 Chapter 4 of the Options Paper discussed the need for greater openness of communication about the management of adverse events. Cultural change of this kind is likely to change the nature of complaints, which frequently relate to poor communication among other things. Directing initial consumer concerns to point-of-service complaints processes and then to independent complaints bodies for conciliation and resolution would seem an appropriate way of avoiding the more adversarial environment of litigation in many cases. However to achieve widespread use and to be a practical alternative for consumers, these processes need to be undertaken within appropriate time frames and without undue delay. In some jurisdictions, there are long delays in health complaint assessment, investigation and conciliation.



5.14 Additional resources may be needed to allow these mechanisms to expand in the conciliation area, particularly if they are to be seen as a viable alternative to using the litigation system. One option for providing additional funding may be to impose a modest fee on the conciliation process where a settlement is arrived at – this could be a sliding scale depending upon the size of the settlement. Another alternative would be to recognise the dual “industry ombudsman” and regulatory functions and seek partial contribution from the health industry through registration fees, and through other mechanisms dependent on the usage made of the services.

5.15 Some have argued that attendance at health complaints conciliation should be a prerequisite for litigation to commence. Given the range of cases in the medical litigation area, it is likely that such a mandatory requirement will simply add an additional step in the more complex cases, where liability is in dispute. However, it may be that plaintiff lawyers and MDOs or insurers should be compelled to inform someone of their rights to use the complaints bodies option at the first visit to a lawyer or on the first notice of a potential claim.

5.16 Individual States and Territories also need to consider whether their complaints body has all the necessary legislative powers to deliver the kinds of services that may be necessary for the body to fulfil its greatest potential to divert claims from litigation. Rather than specifying a single model for a health complaints scheme, a checklist of what might be useful could be developed between AHMAC and the National Health Complaints Commissioners Forum. There is already a starting point for this in the Professional Indemnity Review’s outcome standards for health complaints mechanisms. The outcome standards picked out various elements of each of the models in use at the time. Subsequent experiences of complaints bodies will no doubt be able to build on these.

*Reform template for complaints process reform*

The AHMAC Legal Process Reform Group recommends:

- (a) increased emphasis on point of service or patient advocate level complaint and dispute resolution to reduce the pressure on Health Complaints bodies and increase the resolution at the lowest level of cost;
- (b) enabling the Health Complaints bodies to expand their conciliation services and make them more timely. This could be achieved by State and Territory Governments providing cost recovery mechanisms, including
  - contribution by the MDO or/and health sector industry as occurs in other industry ombudsmen settings,
  - modest consumer contributions in appropriate cases;
- (c) where necessary, modification of the legislative powers of the Health Complaints body to ensure they have the full range of powers necessary to reduce the need for complainants to resort to litigation, including the capacity to mediate a settlement involving payment of compensation, with or without the admission of liability.

*Directions for reform through “early no-liability payment” legislation*

5.17 With the encouragement of early notification of consumers and health care managers that an adverse event has occurred, comes the opportunity to alleviate the needs of a consumer and avoid the need for litigation. This is recognised as a proactive risk management strategy after an adverse event has occurred.

After early notification, the continuing process of risk management is designed to ensure the injured person and their family receive prompt, sensitive assistance and information and that the risk realised in the incident is addressed, if possible. These actions may well mean no legal action commences, particularly if a person's needs are provided for as they arise in the immediate post-accident period, and any costs to the patient of the original treatment and any remedial treatment are waived.<sup>46</sup>

5.18 Doctors often fear that the provision of assistance or financial relief could be interpreted as an admission of liability. Under the current law a payment made on the basis that liability is not admitted meets this concern. Nevertheless, a letter to the recipient of the payment indicating that liability is not admitted may itself be seen as adversarial. To meet the concerns of doctors and support early payment the AHMAC Legal Process Reform Group believes there should be statutory provision to prevent the early payments of costs incurred or the waiver of fees being used as evidence of an admission of liability by the health provider. This allows the provider to continue to fill a caring role, and may enable the maintenance of a positive therapeutic relationship with the consumer.

*Reform template for early “no-liability payments”*

The AHMAC Legal Process Reform Group recommends the introduction of a statutory provision to prevent the early payments of costs incurred or waiver of fees for professional services being used as evidence of an admission of liability by the health provider.

### **Early settlement options**

5.19 There is significant evidence that the costs associated with litigation are strongly related to the time it takes to resolve a matter. While some of this relates to the fact that more complex cases take more time, some of it is simply a consequence of more legal costs being able to accrue over a longer period of time. Where cases can be settled prior to litigation commencing, it is therefore likely that costs and stress will be lower for all concerned.

5.20 This principle underlines various pre-commencement processes which are in place in different jurisdictions, and often in different courts in different jurisdictions. Some examples are:

- the “90 day rule” in the South Australia Supreme Court Rules;
- the NSW early evaluation scheme; and
- procedural requirements under the Queensland Personal Injuries Proceedings Act 2002.

5.21 Other processes are being developed in these and other States as part of the concurrent reforms in public liability litigation. The following summarises these 3 options as examples of what may be done.

### ***South Australian 90-day Rule***

5.22 Rule 6A of the South Australian Supreme Court Rules provides that at least 90 days before commencing an action, a plaintiff must notify the defendant of the proposed

claim with sufficient detail so that the defendants have a reasonable opportunity to make an offer to settle the claims before it is commenced. This notice should generally include the amount that the plaintiff would accept in settlement of the matter, or the reasons why it cannot be stated, and be accompanied by the expert evidence that is to be relied on by the plaintiff. Non-compliance can lead to the Court depriving a plaintiff of all or part of any costs.

5.23 Within 60 days of receipt of such a notice, a defendant must respond. If the claim is to be denied, the defendant must give reasons and provide expert evidence that will be relied upon in defending the claim. If the defendant fails to do this, the court may order them to pay solicitor/client costs for the plaintiff for whole or part of the action. There is power for a plaintiff to seek exemption from this rule.

5.24 There are a range of views about the success of these provisions – with some defendants seeing them as facilitating early settlement and others believing that the quality of the information provided by plaintiffs is inadequate for the provisions to achieve their aims. This latter concern could be addressed through greater scrutiny by the court, when the claim is lodged and through legal professional education.

### *NSW Early Evaluation Scheme*

5.25 This was introduced as a compulsory component of claims handling under Part 4 (2) of the *Health Care Liability Act 2001 Insurance Regulation Order*. This followed a successful trial of such a scheme by United Medical Protection in 2000.

5.26 From 1 April 2002, all insurers and MDOs providing medical indemnity cover in NSW are required to have in place a process for the early evaluation of claims. It is the duty of the plaintiff to notify the defendant when ready for early evaluation and provide a brief statement about their claim. The requirements set out in Part 4 (2)(2) (b) include information on:

- (i) the factual circumstances upon which the claim is based;
- (ii) details of the negligence the plaintiff claims has occurred;
- (iii) a statement about causation, that is, a statement as to how the loss or damage suffered resulted from the medical negligence;
- (iv) details of damages, that is, the economic loss that the plaintiff has suffered as a result of the negligence claimed, including loss of wages and earning capacity, hospital and medical expenses, and non-economic loss, that is, the monetary compensation they are seeking as a result of pain and suffering, loss of amenities and loss of expectation of life; and
- (v) a statement setting out the amounts of damages sought;

5.27 This statement must be accompanied by medical reports on disability and letters supporting the claimed economic losses. A defendant then has 60 days in which to respond, and the possible responses are set out in Part 4(2)(2)(e):

- (i) the insurer is willing to try to resolve the claim and will begin negotiations with the claimant for this purpose; or
- (ii) the insurer is not willing to try to resolve the claim and the reasons why;
- (iii) that the insurer is willing to consider the matter further, if the claimant provides additional information which is set out in the insurer's letter to the claimant.

5.28 An insurer is prohibited from seeking to claim a matter is outside the statute of limitation, if it is only out of time because of the time it has taken for the insurer to determine a claim under early evaluation.

### *Procedural requirements under the Queensland Personal Injuries Act 2002*

5.29 This legislation arose out of the Heads of Treasury public liability initiative, and is based on the success of the Motor Accident Insurance Act 1994 in reducing claims costs and legal costs associated with injuries from car accidents. Chapter 2, Part 1 sets out pre-court procedures required for all personal injury matters other than motor vehicle and workers compensation matters, each of which have their own legislation.

- A claimant is required to give notice of prescribed details to a potential defendant within 9 months of the incident or of the first appearance of symptoms or within one month of consulting a lawyer, whichever is the earlier, unless they have a reasonable excuse for the delay (section 9(3) –(5));
- Lodgement of a complaint with the Health Rights Commissioner within the time required under the Health Rights Commission Act 1991 is considered to be a reasonable excuse for delay (section 9(6));
- A potential defendant must respond in writing within the prescribed period (or one month if no other period is prescribed), indicating whether they are the proper respondent to the matter or if they require further information to decide this, what is required (section 10) – such a response does not constitute an admission of liability (section 11);
- The respondent may add a contributor, who must also respond within 1 month – there are also provisions allowing one respondent to be a claim manager on behalf of all respondents (sections 14 – 17);
- Respondents must attempt to resolve a claim within 6 months including taking reasonable steps to inform themselves about the incident, giving notice of whether liability is admitted or denied or whether contributory negligence is claimed, providing a response to any written offer of settlement or an estimate of the damages to which the claimant would be entitled in any litigation and making a written offer or counter offer of settlement. Any such offers must be accompanied by supporting documents eg medical reports; assessments of cognitive, functional or vocational capacity; documents relevant to assessing economic losses. A respondent or claimant has three months to respond in writing to the offer or counter-offer (section 20).
- Division 2 specifies the obligations on the parties to provide enough information to assess liability and the amount of compensation relating to a claim. A wide range of reports are required to be made available between the parties (section 22) – including a special provision for an expert medical report in a health care claim that sets out the nature and extent of the personal injury alleged and the causal relationship between the incident and the personal injury (section 22(2)). There are a wide ranging number of provisions relating to expert opinions and examinations that are discussed further below. Division 3 allows a court to order a party to comply with any of the provisions of Divisions 1 and 2.
- Before court proceedings can be commenced, section 36 in Division 4 requires that a compulsory conference must occur, except with agreement of the parties or on application to the court. A mediator can be used (section 38). Section 37 requires certain documents to be exchanged, including a statement of incurred legal costs and estimated legal costs if the matter proceeds and the cost implications relative to the amounts included in offers and counter-offers.

- If the conference cannot settle the matter, the parties must exchange mandatory final offers. If a claim proceeds to court, these offers will be filed in the court in sealed envelopes that are not opened until the court has decided the claim. These are then opened and considered in the context of costs orders (section 40).
- Proceedings must be instituted within 60 days of the compulsory conference, or if the parties agree that no conference should occur, within 6 months of the date of notification of the last respondent. If these time limits are not complied with, the claim is statute barred, despite the *Limitation of Actions Act 1974* (section 42).
- Section 43 allows the initiation of urgent proceedings despite non-compliance with this Part of the Act.

### *Directions for reform through early pre-claim resolution processes*

5.30 There are a range of processes which can be used to try and resolve matters before litigation commences. Experience from the States which have had the longest experience with these processes, such as South Australia, is that courts need to ensure these provisions are implemented effectively, for example through cost penalties or sufficient proof of compliance being required before a claim can be commenced.

5.31 There seems to be broad agreement with the concept of avoiding litigation in as many cases as possible. Reform in this area should build on the successes in similar initiatives in these areas and from the lessons available from less successful provisions. Key features of the arrangements are legislation to establish a pre-claim resolution framework, which is either compulsory or required to be made available to a potential claimant.

#### *Reform template for pre-claim resolution processes*

The AHMAC Legal Process Reform Group recommends the introduction of processes designed to resolve as many claims as possible prior to lodgement of a claim. These processes must:

- ensure early notification and clarification of the details of the claim;
- ensure early production and sharing of evidence both on liability and quantum;
- focus defendants' attention on what has been claimed and require them to specify what their view is of the circumstances
- ensure notification of other potential defendants at an early stage;
- provide an opportunity to clarify uncertainties in an informal manner to facilitate settlement;
- provide a formal opportunity to make and consider settlement offers;
- include tight timeframes for response; and
- use cost penalties or other enforcement mechanisms to maximise compliance.

### **Reducing the adversarial nature of litigation**

#### *Alternative Dispute Resolution*

5.32 Alternative dispute resolution (ADR) is an important means of reducing the costs and adversarial context of litigation. ADR covers a range of activities designed to promote resolution of a matter without going to court.<sup>47</sup>

5.33 The Australian Law Reform Commission mapped some common forms of ADR, on a continuum from the least to the most adjudicative, in the following manner:

- negotiation;
- mediation;
- neutral evaluation;
- conciliation;
- expert advice and assessment; and
- arbitration.<sup>48</sup>

5.34 While these categories sound quite distinct, the lines between them can be somewhat blurred depending upon the level of participation of parties, the role of any lawyers and the role of any independent third party. Each of these processes will be briefly described here, and some of the possible variations within them outlined.<sup>49</sup>

### *Forms of ADR*

5.35 **Negotiation** has traditionally been the mode used to finalise a litigated or potentially litigated matter by settlement. While it is seldom thought of as a method of ADR, it is probably one of the most used in the medical negligence arena. Around 95% of cases are settled prior to going to court. Traditionally negotiation has often involved adversarial bargaining.

5.36 **Mediation** involves a trained neutral third party, who assists the parties to reach their own solutions. The different modes of mediation can be broadly categorised as process-oriented and substance-oriented. The role of the mediator or evaluator is seen quite differently in these two modes – in the process mode, the evaluator is a facilitator who helps parties to derive their own solutions, while in the substance mode, the mediator is an expert, authority figure who evaluates the case and offers recommendations on how the matter could be resolved. There are in fact many more variations on these themes, which can be used in the resolution of medical negligence claims – depending upon the complexity and nature of the issues to be resolved, the personality of the mediator and the parties, whether or not lawyers are present, and other variables.

5.37 **Neutral evaluation** processes are sometimes called “early evaluations” or “case appraisals” which provide an independent evaluator’s opinion about the likely outcome of a matter if it were to proceed to trial. The process can seek to reduce the matters of fact and law in dispute. These processes can be used in different ways. For example, there can be a “mini trial” with the giving of evidence in strict time limits before a case appraiser, where parties can agree to be bound by the evaluators decision or agree that the decision will not be binding. There can also be provisions that if the matter is litigated following an evaluation and the case comes out consistent with the evaluation, then the party who has chosen to litigate may have to pay the costs of the process after the evaluation.

5.38 **Conciliation** often involves a more directive role for the evaluator. The conciliator raises possible outcomes of a case, and expressing a view on the likely outcome. Conciliation may also involve the conciliator considering of the merits of a case.

5.39 **Arbitration** is the form of ADR which most closely resembles court adjudication of a matter. Arbitration models vary considerably from ones where the parties and the arbitrator can mould the process to suit the dispute, to ones where the arbitrator can adopt an inquisitorial process. Arbitration may or may not include pleadings by the parties and can be done “on the papers” without a hearing. Often the findings of

arbitration are binding with some limited appeal rights. Registration of the agreement reached in a court may be required as well.

### *Current use of ADR in medical indemnity cases*

5.40 The availability in most States and Territories of health care complaint mechanisms may be considered part of the ADR spectrum. As discussed above, the health care complaints models in Australia vary considerably between jurisdictions, particularly so far as they are involved in ADR. Some States' health complaints bodies have an active conciliation role, which includes the settlement of matters for significant amounts of compensation. Others have little or no role in this area, though they do carry out investigations of the complaints, the findings of which may be useful in subsequent litigation.<sup>50</sup> This has been discussed more fully earlier in this Chapter. It is worth noting that complaints bodies which adopt a more conciliatory style are often considered more satisfactory by respondents and the majority of consumers, though there is no comparative evaluation to date to see how effective the different models and styles are in achieving changes either at the individual practitioner level or at the system level.

5.41 ADR processes have also been introduced in a number of jurisdictions as part of the court process, once litigation has commenced. The use of more informal processes needs to be appropriate for the case, or it may lead to greater unfairness. For example, in his Final Report into Access to Justice in the UK, Lord Woolf reflected on these issues:

There is in existence an expanding range of alternative dispute resolution mechanisms for medical negligence claims which may be better suited than litigation to the needs of both patients and doctors. This applies especially to smaller claims, and to those where financial compensation is not the patient's main or only requirement. It is, however, important to ensure that informal procedures do not put claimants at a disadvantage because of the inevitable imbalance of knowledge and power between patients and hospitals.<sup>51</sup>

5.42 Little is known about the effectiveness of mediation in medical negligence as an alternative to litigation, because most of the documented alternatives overseas have used arbitration<sup>52</sup>. The United Kingdom launched a medical negligence mediation pilot scheme in April 1995 which sought to address some of the criticisms made of the litigation process. The pilot scheme found it difficult to recruit cases in the pilot areas, only mediating twelve cases in a three year period. Half of these cases involved obstetric and gynaecology matters, and four cases had issued proceedings. The mediations took between four and eleven hours to complete, the average being just over 7 hours. Financial settlements between £5,000 GBP and £80,000 were made in all but one case, with a range of other remedies also being provided. These included:

- apologies;
- extensive explanation of medical decisions and the rationale for treatment decisions;
- new treatment plans; and
- information about a foetus' place of burial.

5.43 Claimants were represented by solicitors in 10 cases and were usually accompanied by a friend or partner. Cases identified as suitable for mediation were generally considered simple and involved small to medium claims. Other suitable cases were those with emotional overlay issues and where people were seeking non-legal remedies such as apologies and explanations; claims where parties wanted greater

involvement in case management; claims where speedier resolution was required; and those where the parties had a long term relationship with the health care provider.

5.44 Unsuitable cases were cases where settlement was not possible eg where parties wished to use them for precedent purposes; those with a high claim value; and those without sufficient evidence to base a settlement.

5.45 A number of problems were identified with the pilot, some to do with the lack of support from the National Health Service and the Litigation Authority and the failure of many solicitors to refer cases to mediation. Some of these difficulties arose from legal aid funding difficulties and other changes that were occurring on the ground in the National Health Service. There were also a number of criticisms made about practices such as last minute production of evidence or information, unnecessarily defensive stances adopted by solicitors, perceptions of mediator bias and other concerns about the mediators role.

5.46 The successes which were identified were a heightened awareness among medical negligence specialist lawyers; increased participation of claimants in the process, flexibility in the process and the potential for involving non-legal remedies; privacy and the efficient disposal of cases through the concentrated negotiations required. For consumers, their increased participation was rated very favourably.

5.47 Heightened participation was particularly important for claimants. Participation took several forms including visibility of process; the opportunity to put one's case across; catharsis and the opportunity mediation presented for personalised explanations and apologies.

5.48 In the small number of cases mediated, it seemed likely that the costs were somewhat higher in the mediated ones, but the small numbers make it impossible to be conclusive about this overall – in many ways it depends if the mediation “brings forward” a settlement in the matter. The pilot evaluators concluded that:

Mediation may not be suitable for all medical negligence cases and it is certainly not a panacea for the problems of medical negligence litigation, but it clearly has the potential to encourage more appropriate and effective resolution of disputes.<sup>53</sup>

5.49 On the issue of whether mediation should be compulsory, particularly given the apparent reluctance of solicitors to participate in the pilot, the evaluators felt that there were insufficient numbers to form a view on the question. They did indicate however that:

... there are different levels of compulsion. There are schemes in which every case in which proceedings have been issued has to attempt mediation before it can even be considered for trial. There are also situations where litigators routinely take the responsibility to identify the benefits of mediation to their client alongside the benefits of litigation.<sup>54</sup>

5.50 The report goes on to suggest that the pilot results may give judges some basis for quizzing solicitors about why they have chosen not to participate in mediation. Other options which involve the court may be to limit costs if mediation is not attempted unless there are reasons why mediation would not be suitable.

5.51 A number of Australian jurisdictions have introduced the option of mediation into the management of their medical negligence case management systems eg Victoria's County Court Damages (Medical) Division List and the NSW Supreme Court Professional Negligence List. In both of these cases, the court may order mediation or allow mediation where parties agree. In NSW, this referral may be to an agreed mediator or to the registrar, and parties have to report back to the Court after the mediation about the results.<sup>55</sup>



### *Directions for Reform in ADR*

5.52 ADR can avoid the highly adversarial style which often characterizes medical negligent litigation. ADR processes can vary significantly in nature and operation. It seems unlikely that any single method would be ideal in all cases. Rather it is important that the “right” method should be available for the “right” case.

5.53 Because of the personal nature of health care adverse events, the limited available evidence indicates that claimants are more likely to be satisfied by a process where they actually have face-to-face contact with the defendant or potential defendant and where they can see and possibly directly influence what is happening. The findings of the UK mediation pilot showed this quite strongly:

In comparison [to the process of settlement of litigation], an appreciation of process and a greater ability to participate in settlement was evident amongst the mediation sample and became one of the outcomes. Even where claimants adopted a fairly passive role, the process of settlement was visible and much more comprehensible than would probably be the case in settlements negotiated between plaintiff and defendant solicitors. Claimants appreciate the remedies mediation was able to provide which the litigation system is less able to consider or award. There was an emphasis on resolution, not just settlement.<sup>56</sup>

5.54 These findings are also consistent with what consumers ask for in relation to open disclosure and in relation to better communication in all aspects of health care. It is also the broader direction that courts are going in the future. For example, in his landmark Access to Justice Report, Lord Woolf stated that litigation in the future would be “less adversarial and more cooperative”. And this cooperation was to be supported and directly encouraged by courts:

There will be an expectation of openness and cooperation between parties from the outset, supported by pre-litigation protocols on disclosure and experts. The courts will be able to give effect to their disapproval of a lack of cooperation prior to litigation.<sup>57</sup>

5.55 The Access to Justice Report has influenced the direction of civil litigation reforms in Australia. States and Territories need to consider whether there should be more emphasis on early access to ADR processes either before litigation commences (like the NSW early evaluation scheme and the Queensland compulsory conference) or during the early stages of litigation (like the NSW Supreme Court and Victorian County Court list processes). They should also ensure that the ADR processes in place to emphasize the value of participation by the parties and that a non-adversarial approach is reflected in the methods and processes used. Specific training may be required to ensure that those who conduct ADR in the medical negligence area understand the importance of maintaining trust and mutual respect which is at the core of an effective doctor/patient relationship, and, where possible, a satisfactory relationship between the consumer and the health care provider.

5.56 Perhaps the first step in jurisdictions should be to conduct an audit of formal and informal ADR processes already used in their health complaints and court systems when dealing with medical negligence cases, identify options which are missing and may be useful, and extend provisions which are working well either in their own jurisdiction or elsewhere to other courts involved in medical litigation. Options for expanding the ADR services in health complaints processes also need to be explored, as well as potential additional funding resources, as discussed above. The NSW model of requiring an insurer or MDO to provide early evaluation is another way of extending the ADR options available at less direct cost to the Government budget.

5.57 A question remains about whether one or more ADR processes should be compulsory in medical negligence matters. On the one hand, ADR seems to work best when both parties are willing participants. However, use of ADR methods on a widespread basis requires a change of culture in the legal profession. It seems likely that as a minimum, options which encourage the use of these services in appropriate cases should be implemented and evaluated. This could include a statutory obligation to inform a consumer of the various options available for resolving matters and their relative costs up front on a first visit to a lawyer or on receipt of a complaint or claim by an insurer or MDO.

5.58 Alternatively, an obligation to pursue an appropriate form of ADR to attempt to resolve a matter could be a requirement for lodgement of a claim in any court. Such an obligation may not have to be directive about the form of ADR, given the range of circumstances in medical negligence cases. For example, it may provide a range of options which could satisfy the statutory obligation to explore ADR at an early stage, including early evaluation, use of the health complaints conciliation processes, mediation direct with a service provider etc.

*Reform template for alternative dispute resolution*

The AHMAC Legal Process Reform Group recommends that

- (a) all courts have a range of alternative dispute resolution methods available for the active management of medical litigation matters after a claim has been lodged;
- (b) so far as possible, these should actively engage the parties at as early a stage as possible, in the definition, refinement and where possible, resolution of the issues between them within a court-managed timetable and before the commencement of a hearing; and
- (c) such mechanisms should include at least
  - court managed or court ordered mediation; and
  - early exchange of reports and early neutral evaluations.
- (d) State and Territory governments should consider legislation to
  - (i) impose an obligation on lawyers to inform a consumer of the availability of ADR mechanisms to resolve medical negligence claims, and of the costs involved with various forms of dispute resolution
  - (ii) and/or require participation in an ADR process (which could include a health complaints process) prior to initiation of proceedings; procedures for initiating proceedings should require proof of participation in an ADR process and that the process was unsuccessful.

*Expert witnesses*

5.59 Both plaintiffs and MDOs usually rely on expert witnesses in medical negligence litigation and in health complaints processes. In most medical negligence cases the plaintiff lawyer needs to determine if there is a potential case. Except in a small number of very obvious cases, such as if an instrument is left in someone's body cavity, this usually requires some form of expert advice on the adverse event. The nature of this initial inquiry will be somewhat different if there is better information available about the facts of an adverse event through improved disclosure, but it will still be necessary in

most cases to get an expert opinion about whether the harm was caused by the negligent act. Experts are then required at all other steps – through to the final closure of a case at court.

#### PROBLEMS FOR THE COURTS WITH EXPERT WITNESSES

5.60 While costs obviously require the evidence of expert witnesses in order to make decisions about medical negligence, current systems have various shortcomings. Some of the problems which arise in the use of expert witnesses were listed in a recent Family Court of Australia Discussion Paper<sup>58</sup>:

- **partisanship and lack of objectivity** - the most pertinent criticism of expert evidence arises from a perception that some experts are “hired guns” acting as advocates for those who instruct them. Accordingly, “ ... all evidence is selective, and is selected on the basis of what will help the party to win, not on the basis of whether it will help the court to find the facts correctly”;
- **experts exceeding their area of expertise** – there is concern that some experts intentionally or unintentionally express opinions that fall outside their field of expertise. It may not always be obvious to the court when an expert exceeds their expertise and if the issue is not identified, it can impede the fact-finding process;
- **clarity of evidence** - ... most judges encounter evidence that is not in a comprehensible form ... ;
- **costs and delays** – the uncontrolled use of expert witnesses is costly and can add greatly to the length of the trial without significantly advancing the case for either party . A dispute between experts unwilling to concede points often leads to a trial within a trial and concerns have been expressed that litigants with financial means enjoy a strategic advantage over less financial and unrepresented litigants.

5.61 AIJA surveys of judges discussed below showed that the experience of bias was also widespread. Commenting on this study, Justice H D Sperling of the NSW Supreme Court Professional Negligence Division said:

65% said they encountered bias “occasionally”. 26% said that they encountered bias “often”. 70% said the same expert witnesses appeared regularly before them for the same side. 85% said that they had encountered partisanship in expert witnesses, and of those, 47% said that was a significant problem for the quality of fact finding in their court.<sup>59</sup>

#### PROBLEMS FOR CONSUMERS AND PROVIDERS

5.62 For consumers in medical negligence litigation, problems with expert witnesses have generally been of a different kind. They may find it difficult to obtain expert evidence to see whether their adverse event arose from negligence. The Professional Indemnity Review (PIR) described this problem:

There are practical and attitudinal barriers which make it very difficult for patients. Many doctors are uncomfortable alleging a professional colleague was negligent - partly because of the wide variety of actions which can be taken in various situations and the unspoken thought that it could have been them in the situation. More insidiously, there is a view among some professional groups, that a professional owes a greater duty to his or her professional colleagues, than to a

member of the public who suffers an adverse outcome through negligent health care.

5.63 The PIR was strongly critical of this approach, which often also worked actively against doctors who provided expert evidence.

Notions of "protecting their own", which are implicit in the difficulties patients have in obtaining expert advice even in cases of clear negligence, [are] strongly against the notion of public responsibility inherent in the status of a professional. Further, the punishment of those who speak out - either through professional discrimination, social ostracism or other victimisation - should itself be seen as unprofessional conduct and grounds for significant sanction, if not deregistration.<sup>60</sup>

5.64 In addition to the barriers they face as expert witnesses, health care providers express concerns about the quality of evidence which is sometimes given, particularly when they believe that experts speak beyond their fields of expertise. There is also considerable concern about providers being judged by an inappropriate standard because of the experts that are chosen. Some see the whole unsatisfactory processes associated with expert medical witnesses as a stain against the profession – both because of the unethical conduct that the current system engenders, either through doctors “selling out” their professional integrity and opinions to the highest bidders, or through the refusal to testify in a meritorious case for fear of professional retribution.

#### REFORMING THE USE OF EXPERT WITNESSES

5.65 In the recent NSW Court of Appeal case of *Makita(Australia) Pty Ltd v Sprowles* [2001] NSWCA 305 paragraph 79, Justice Haydon reaffirmed the law relating to the duties and responsibilities of expert witnesses that are known as the “Ikarian Reefer” Principles :

In *National Justice Compania Naviera SA v Prudential Assurance Co Ltd ("The Ikarian Reefer")* [1993] 2 Lloyd's Rep 68 at 81-82 Cresswell J set out a list of duties and responsibilities of expert witnesses in civil cases as follows:

"1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation ... .

2. An expert witness should provide independent assistance to the Court by way of objective unbiased opinion in relation to matters within his expertise ... . An expert witness in the High Court should never assume the role of an advocate.

3. An expert witness should state the facts or assumption upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.

4. An expert witness should make it clear when a particular question or issue falls outside his expertise.

5. If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one. In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the

whole truth and nothing but the truth without some qualification, that qualification should be stated in the report.

6. If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the Court.

7. Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports ... ."

Cresswell J's list has been influential both in causing rules of court to be devised in this and other jurisdictions to control expert evidence and in later judicial pronouncements.

5.66 These issues and the need for reform of the use of expert witnesses have been widely discussed in a number of reports and reforms over the past decade, including:

- the UK Report of Lord Woolf entitled *Access to Justice* and its subsequent implementation in the new Civil Procedure Rules which commenced in April 1999;
- several reports of the Australian Institute of Judicial Administration (AIJA) concerning judge and magistrate experiences of expert witnesses;<sup>61</sup>
- several publications of the Australian Law Reform Commission;<sup>62</sup>
- work of the Law Reform Commission of Western Australia,<sup>63</sup> and
- NSW Supreme Court procedure changes under the Professional Negligence List.<sup>64</sup>

### ***Directions for Reform in the use of Expert Witnesses***

5.67 Reforms proposed or implemented in this area have been fairly far-reaching, including:

- requirements to disclose expert witness reports before trial or even before commencement as discussed earlier;
- joint conferences of expert witnesses to narrow the issues in dispute and thus reduce unnecessary costs and delays in finalising the claim
- various restrictions on calling expert evidence eg only in specific circumstances, with the leave of the court etc;
- greater use of court appointed experts;
- the use of single experts agreed between the parties;
- use of assessors and referees – the suggested model below for the development of a list of experts who are accepted by both plaintiff and defendant lawyers might provide a pool for this;
- the use of “panel presentations” where all the expert witnesses provide evidence on the same occasion in a free-form manner in a discussion involving counsel, the experts and the judge;

- allowing experts to summarise their views both before and after cross-examination;
- allowing expert witnesses to be able to ask for directions in carrying out their functions.

5.68 It seems likely that many of these will be desirable in appropriate situations. In some States legislative reforms or changes to court rules will be necessary to ensure the options are available for courts and parties to use in appropriate cases.

5.69 A key concern which is not really addressed by the above proposals is the quality of expert medical witnesses. The development in some areas of “codes of conduct” for expert witnesses with specific training and accreditation would seem to be a useful model to pursue in this area. A national system could be established, as well as a national code of conduct. This could be developed between the Committee of Presidents of Medical Colleges, the AHMAC Medical Indemnity Working Group and appropriate legal representation (whether from the Standing Committee of Attorney-Generals or a more specific group such as the Australian Institute of Judicial Administration).

5.70 None of these really deal with the other issue of how a patient accesses experts. One model that is used overseas involves the nomination of the appropriately qualified and experienced people to serve a term on a panel of experts for provision of information to decision-making bodies, such as courts and tribunals. Nomination is considered a sign of professional excellence. Such a model applies in Finland, for example, where they have a National Board of Medicolegal Affairs (the TEO in Finnish), which was founded in 1992. This is a highly prestigious board, to which people are invited to appointment as permanent scientific experts for a maximum term of 4 years. The tasks of the Board include regulation of the medical and other health professions, providing advice to inquests, and the provision of opinions to courts and similar bodies in their fields of expertise, as well as a range of other functions.<sup>65</sup>

5.71 As noted, one of the reasons that consumers may have trouble accessing experts is the approach taken by some practitioners to the giving of evidence in favour of a plaintiff. It is unethical for practitioners to discriminate against a clinician because he or she gives evidence for a plaintiff. This should be considered unprofessional conduct for which a practitioner can be disciplined.

*Reform template for reform in the use of expert witnesses*

The AHMAC Legal Process Reform Group recommends the introduction to all courts of a suite of options relating to the better use of expert witnesses. These should include:

- requirements to disclose all expert witness reports;
- joint conferences of expert witnesses for the purpose of producing a joint report identifying areas of agreement and issues to be resolved;
- power to use court appointed experts to provide an independent opinion to the court or otherwise assist the court;
- power to use of single experts agreed between the parties;
- the use of “panel presentations” where all the expert witnesses provide evidence on the same occasion in a free-form manner in a discussion involving counsel, the experts and the judge;
- allowing experts to summarise their views both before and after cross-examination; and
- allowing expert witnesses to be able to ask for directions in carrying out their functions.

The AHMAC Legal Process Reform Group recommends that a national system and code of conduct be established to ensure the quality of expert medical witness evidence in medical litigation. This could be developed between the Committee of Presidents of Medical Colleges, the AHMAC Medical Indemnity Working Group and appropriate legal representation.

### Speeding up court processes

5.72 Historically, courts did not manage litigation - this was the realm of the parties. At the recent 20th Annual Conference of the Australian Institute of Judicial Administration, Judge Davies of the Queensland Court of Appeal set out the basis for this:

Control of the litigation process, especially before trial, by the parties or their lawyers, and the subsequent limited role of the decision maker, also followed from the fact that the decision maker was a jury. It is no doubt because of that that it did not occur to judges that they should become involved in the pre-trial resolution of the issues in dispute or the evidence to be adduced on those issues.<sup>66</sup>

5.73 The initial change from the court's passive position commenced in Australia in the mid-1980s, when courts began using case flow management to control the progression of cases brought before them, to enhance court control of interlocutory steps and to encourage the pre-trial disclosure of information. Important features of a successful case flow management system include the following.

- The court should supervise and maintain continuous control of all cases from the time proceedings are initiated through to final disposition.
- Rules, conferences and other techniques should be used to establish times for the completion of core pre-trial steps.
- Events should occur when they are scheduled to occur and there should be a firm consistent policy for minimising adjournments.
- The court should be prepared to reach reasonable accommodations with lawyers.
- Procedures should be put in place to ensure that cases which may be particularly long or complex are identified and are given close attention.
- Standards should be developed for case processing time and for monitoring the performance of the case flow system.
- Appropriate systems should be established to monitor court performance.<sup>67</sup>

5.74 UK *Access to Justice Report* by Lord Woolf pushed the direction of common law courts further towards a more interventionist management approach, by stating that there would be clear lines of judicial and administrative responsibility for the civil justice system, which would involve a partnership between the judiciary and the Court service. Lord Woolf argued that the lack of control by the courts led to an increased adversarial atmosphere, as cases were run by parties not the court. Australian law reform bodies have also contributed to this level of activity, for example the Australian Law Reform Commission's 2000 Report *Managing Justice* and the Law Reform Commission of Western Australia's 1999 Final Report on a *Review of the Civil and Criminal Justice System*. The acceptance of case management on Australian courts has almost become "an article of faith".<sup>68</sup>

5.75 The creation of special lists for medical litigation matters in the Victorian County Court's Damages (Medical) Division of the Damages List under Judge Tom Wodak,<sup>69</sup> and in the NSW Supreme Court's Professional Negligence List under Justice Abadee<sup>70</sup> have accelerated the introduction of case management in medical litigation cases. In an overview of the operation of the Victorian List in March 2002, Judge Wodak said that only 4% of cases went to verdict or judgement. The guiding principles of management in the Division are:

- provision of speedy access to the Court for determination;
- reducing the costs of litigation;
- clear, early, full identification of the issues in dispute; and
- comprehensive provision to each party to each other of all relevant information and documentation .

5.76 Judge Wodak also meets every 6 months with solicitors for plaintiffs and defendants, and they are encouraged to make recommendations, criticisms and comments about the functioning of the list

5.77 The new Professional Negligence List in NSW was established in April 1999. Medical negligence cases are now controlled and managed from the time of institution of proceedings to the time of trial. The management of cases is coordinated through holding conferences, with parties being present or represented to enable orders and directions to be made. The management processes allow different use of expert evidence, the option of ADR and control of timing in a case to ensure "just, quick and cheap" resolution of matters.<sup>71</sup>

#### *Reform template for Court-based case management*

Courts in Australia are actively engaging with court-based case management. The AHMAC Legal Process Reform Group supports this process and recommends that it should continue and be extended to include all courts, where medical litigation occurs. In smaller jurisdictions, the relatively small number of cases may not justify a separate list. However, similar goals could be achieved if these strategies were introduced to all civil proceedings with or without a separate list.

#### **Protecting doctors from adverse publicity**

5.78 Some members of the Legal Process Reform Group believe that legislation should be enacted suppressing the name of a doctor who is a defendant in a medical negligence claim, prior to judgment. An application would need to be made to the court before the doctor's name could be published in the media. Provision for suppression of doctors' names would meet concerns about the effect which publicity about a medical negligence claim may have on a doctor's reputation, even if the claim is ultimately unsuccessful. If such legislation were enacted it would be necessary to decide whether it should apply to health care practitioners other than doctors, and to hospitals.

#### **Conclusion**

5.79 This Chapter has considered a variety of procedural changes designed to avoid litigation, improve the management of medical negligence cases, and make the system less adversarial than is currently the case.



5.80 The Chapter does not propose the establishment of a specialist Tribunal to resolve complaints, as some commentators have proposed. There are insufficient numbers of cases to justify the creation of such a Tribunal in the smaller jurisdictions and in New South Wales and Victoria the specialist list in the Supreme Court serves a similar purpose. A similar specialist list could be established at the lower level of jurisdiction if there are sufficient numbers of cases to make this desirable.

5.81 The AMA has argued for the adoption of a “more inquisitorial approach” but has provided few details about the precise procedures that should be adopted within such a system. Similarly, Ms Pam Burton has argued that “This is Australia’s opportunity to move to a more efficient and fairer inquisitional model”<sup>72</sup>

5.82 As this Chapter has discussed, this is already occurring, as courts place greater emphasis on alternative dispute resolution and active case management. Our recommendations support this trend.

5.83 Greater emphasis on resolving claims before litigation commences, and on early settlement will also require cultural change in the profession and among the judiciary.

*Reform proposal for cultural change*

The AHMAC Legal Process Reform Group recommends that law societies and the National Judicial College should include programs providing information on the effective resolution of medical negligence claims and the management of such claims after proceedings have been instituted.

## Chapter 6

### What is fair compensation?

#### Introduction

#### *Needs arising from adverse events*

6.1 People who experience an adverse event may have a variety of needs, depending on the extent of the disability arising from their health care. Table 6.1 sets out the numbers of people suffering different levels of disability as estimated in the Quality in Australian Health Care Study. The Quality in Australian Health Care Study estimated that adverse events accounted for around 3.3 million bed-days per year, with 8% of all admissions involving adverse events with a high degree of preventability.<sup>73</sup> The disability may be temporary or permanent.

Table 6.1: Quality in Australian Health Care Study

#### **Disabilities flowing from Adverse Events 1992 Admissions**

Degree of disability	Proportion of Admissions	Estimated number of people
Death	0.79%	18,000
Permanent disability		
- Greater than 50%	0.77%	17,000
- Less than 50%	1.45%	33,000
Temporary disability		280,000
- 1-12 months	4.95%	
- Less than 1 month	7.57%	

Source: Wilson R, Runciman W, Gibberd R, Harrison B, Newby L and Hamilton J. "The Quality in Australian Health Care Study. *Medical Journal of Australia*, vol 163 (9), 6 November 1995, pages 458-471: Box 3, page 465.

6.2 A minor temporary disability may only need an extra day in hospital, which for most people will involve no or minimal costs. If the disability is significant, then costs may be much higher. Someone of working age may suffer loss of wages or the ability to earn while they are recovering, or they may have an inability to carry out their normal unpaid activities such as raising children, and providing household services for themselves and/or their family. They may have significant hospital and care costs.

6.3 People in older age groups may go from independent living in their own home, to needing significant support or to having to live in a nursing home, as the result of an adverse event. Where an adverse event results in catastrophic harm to someone, their needs may be extensive – income replacement, household support, long term care costs, disability related needs such as continence products, home and vehicle modifications,

cushions to avoid pressure sores, physical therapies and aids and appliances like wheelchairs.

### *How needs are met under the current system*

- 6.4 People who have needs arising from an adverse event may obtain assistance from
- services available to the whole community, for example Medicare, social security;
  - benefits tied to the person's own contributions eg disability insurance, private health insurance;
  - assistance arising from their conditions of work eg. sick leave, superannuation disability pension;
  - the hospital system, which may provide remedial services and ongoing care needs;
  - the fault-based compensation system (sometimes called the "tort system").

### *How the cause of the injury affects compensation*

6.5 It is the cause of the injury which determines the source from which needs are met and the extent of compensation payable. A person can only recover damages under the tort system if they can prove they have been injured as the result of another person's fault. In the case of compensation for health-care related injury it is often difficult to differentiate between people who are injured as the result of negligence and people who are injured as the result of an accidental event not caused by negligence. A similar problem also arises where people are injured by other causes, but the problem is particularly acute in the area of medically –related injury.

6.6 For example, if a child is born with cerebral palsy, it may be claimed that the injury was caused by the obstetrician's negligence. There is some association between a difficult birth and the occurrence of cerebral palsy. For many years doctors believed there was a strong causal connection between inappropriate obstetric activity and cerebral palsy. However, the work of Eve Blair and Fiona Stanley in Western Australia shows that only around 7% of children with cerebral palsy have a difficult birth, with only a much smaller proportion considered to be caused by medical mismanagement.<sup>74</sup>

6.7 Those who receive compensation under the tort system also receive different levels of compensation from those whose needs are met from other systems. The tort system theoretically seeks to place a person in the same position as they would have been in, had the harm not occurred. The generosity of this model compared to some "needs based" schemes is illustrated by payments for loss of earning capacity. Social security payments are flat-rate, relatively low level payments, that take account of numbers of dependants, housing status and a number of other matters. The tort system on the other hand assesses lost earning capacity on the basis of the likely income someone would have earned had they not had been injured, (though this of course involves considerable speculation). In practice people may not receive adequate compensation under the tort system because of the difficulty of estimating future income loss or future care costs.

6.8 The different levels of compensation payable to those injured as a result of medical treatment reflects the history of compensation and community-based systems in Australia and what people have considered "fair" in terms of who should pay. The existence of a range of forms of compensation means that people with similar needs may receive different levels of support depending upon the possible cause of their disability.

This is one of the reasons that some commentators argue that people suffering medical accidents should have their needs covered by a no-fault system of compensation.

6.9 Our terms of reference focus on negligence, so that this Paper does not examine the possibility of a no-fault compensation scheme. However it should not be forgotten that the “medical indemnity crisis” deals only with the costs of the tort system. The torts system provides compensation to those who can prove that their injury was caused by negligence. However, the total costs associated with adverse events are considerably greater than the costs of the torts system. While there are no figures on absolute numbers of cases, the relative numbers of people who sue are very small compared to the number of adverse events. For example in the year of the Quality in Australian Health Care Study adverse events, there were estimated to be 470,00 adverse events and about 2,000 tort claims incurred. In a recent report on iatrogenic injury in Australia, the total health care costs of adverse events were estimated to be \$2,539M per annum and estimated life time costs per annum were \$5,078M.<sup>75</sup>

6.10 These total costs compare to the likely costs of litigation involving both public and private sectors, which are likely to be somewhere around \$400-600M per annum.<sup>76</sup> It is important to recognise that changes which restrict access to compensation for negligence may result in the transfer of costs from the tort system to other areas, for example the social security system.

6.11 Given the relatively small number of people who recover compensation through the tort system its overall costs are quite expensive. Legal costs associated with these payments appear to be relatively high.

### **Fault and compensation**

6.12 The distinguishing basis for this higher level of compensation and for the provision of an award for “non-economic losses” such as pain and suffering, is whether or not some one can be shown to have been at fault. The concept of fault is not based in a concept of moral perfidy as might be generally understood – that is the role of punitive or exemplary damages or the criminal justice system. Instead it requires that the doctor has breached the duty of care owed to the patient and the patient has suffered harm. The concept of negligence is discussed further below.

6.13 The development of the modern negligence action arose at the time of the industrial revolution. Prior to that period, the law regarded certain types of relationships as giving rise to liability for harm, whether or not the person causing the harm was negligent. However, with the burgeoning of new industries and risks, the view developed that there should be “no liability without fault”.

It was felt to be in the better interest of an advancing economy to subordinate the security of individuals, who happened to become casualties of the new machine age, rather than fetter enterprise with the cost of inevitable accidents.<sup>77</sup>

### ***Corrective justice theory***

6.14 This was the birth of the concept of fault as it applied to the provision of compensation. Negligence law was justified by theories of corrective justice and deterrence. Applying these to health care, the theory suggests that the doctor should pay for the losses caused by negligence because this will deter poor practice and punish the doctor.

6.15 The wide availability of insurance and medical defence cover negated this direct financial effect. The corrective theory of tort enjoyed a resurgence in the later quarter of

the 20th Century and remains strongly favoured by the individualistic, neo-classical economics based schools of law.<sup>78</sup> Much of this support comes from the theory that doctors will improve their practices if they are directly responsible for the costs – the “moral hazard” argument. This is highly debatable in a system supported by insurance. If this was truly believed to be an effective way of improving health care, it is arguable that there should be no cover. The Professional Indemnity Review’s Interim Report examined this idea and drew the following conclusions:

... the punitive effects of this could be greater than the punishment required under the criminal law. For example, a criminal assault which causes serious injury may result in a fine of several thousand dollars whereas an uninsured negligent act resulting in the same injury could result in a very much greater damages award, which could mean the financial ruin of the defendant and/or her or his family. Similarly, the probability of compensation being non-existent or inadequate for an injured plaintiff in these circumstances indicates the inappropriateness of this as the main purpose of tort remedies – to provide compensation to injured plaintiffs.<sup>79</sup>

6.16 The torts system would not be a reliable means of compensating those who could prove negligence if it were not supported by liability insurance. This is recognised by systems providing compulsory third party motor accidents insurance and workers compensation insurance. Insurance provides a collective risk sharing mechanism. For risk pooling to work, the pool needs to be large enough to allow sharing of losses. This issue is discussed further in Chapter 8.

### *Fault, damages and publicity*

6.17 Under the negligence system there is no connection between the degree of “fault” or wrong-doing and the amount of payment required. A health professional can make a small mistake, but if the patient is catastrophically harmed, the losses suffered by the patient will define the compensation, rather than the size of the error. This aspect of the present system is of great concern to doctors who will also suffer adverse publicity if the case goes to court. Ironically cases where the doctor is most transparently negligent are usually settled early on, so that the doctor’s negligence is not subjected to public scrutiny. Where however, the negligence is most questionable, the case is more likely to go to court and be subject to the full glare of publicity, whether or not the doctor is found to have been negligent.<sup>80</sup>

6.18 There is some limited evidence that the fear of litigation improves the quality of care of practitioners.<sup>81</sup> However, negligence also brings with it the risk of defensive medical practices where doctors perform tests and procedures not because they are clinically necessary but “in case” they get sued. There is also some evidence at the moment that fear of litigation and cost of premiums are having a deleterious affect on workforce choices, with younger doctors said to be avoiding specialities with higher contribution rates, and doctors in these same specialties retiring earlier due to the financial impact of the premiums.<sup>82</sup>

### *Distributive justice theory*

6.19 During the past 50 years, a competing theory of tort law arose, which took more account of the widespread existence of insurance. This theory of “distributive justice” argues that in reality the element of moral fault in most tort litigation is relatively small, and that the main purpose of tort law is in fact to work out how the costs of losses

should be borne. The same theory underpins the “mutuality” concepts of insurance and medical defence.

The reality of industrialisation and the widespread use of motor vehicles, in particular, led to a recognition that the vast majority of people did not have sufficient funds to pay “proper” damages if an action of negligence was taken against them. There also came a realisation that, in an increasingly complex society, most of the occurrences were accidents, in the true sense. While “negligent” at law, they did not involve any moral culpability, or at least not at a level sufficient to justify the financial ruin of the negligent person.<sup>83</sup>

6.20 Under this theory, decisions in a society about what degree of fault should remain to determine entitlement in any particular case and how much “no-fault” assistance should be provided is a fairly arbitrary division, often reflecting deeply but often almost unconsciously held notions in a society about what is “fair” and “just”. At its most “distributive end” it merges into various “no-fault” options. However, the very acceptance and encouragement of insurance is a reflection of the importance of this theory of tort law:

The principal concern of the law of torts nowadays is with casualties of accidental, that is, unintended harm ... the law is concerned chiefly with distributing losses, which are an inevitable by-product of modern living, and, in allocating the risk, makes less and less allowance to ideas of punishment, admonition and deterrence.<sup>84</sup>

6.21 This theory seems to have been more influential in the areas of car and work accidents than in the medical area. This may be because courts more reluctant to find negligence because it can be seen as implying a negative conclusion about an individual professional’s standard of care.<sup>85</sup>

## **Medical negligence and fault**

### ***Fault: the social barometer***

6.22 To some extent, how fault is applied in the negligence action may be seen as a “social barometer” or pivot point, which moves between either corrective and distributive justice as the values and views of a society move between the extremes of individualism and communitarianism. In other words there is no “right” or “wrong” place for that pivot to sit – it may vary as the mood, values and power balances in a society change. These same balances are also reflected in so-called “no-fault” schemes, where there are often exemptions from benefits for people who harm themselves while they were behaving in a socially unacceptable manner.

6.23 Doctors often argue that in recent years the trend of court decisions has been to favour injured people in medical negligence cases and to find against doctors. Evidence on increased costs of claims has been discussed in Chapter 3, but this does not answer the question whether a higher proportion of plaintiffs are successful than was the case in the past. If it is the case, it probably reflects the different weight over time given to various factors, such as individual versus community responsibility, as well as what is considered acceptable so far as “cost spreading” and “cost containment” is concerned. Sometimes it has been claimed that judges have used the tort system as a social security supplement, though there is little evidence of this. Where judgements are said to have departed from appropriate practice with the intention of ensuring compensation is available to someone with a severe disability, these cases have often been overturned on

appeal.<sup>86</sup> MDOs generally argue that when they do litigate, they are highly successful in defending their members.<sup>87</sup>

6.24 The recent public liability debate has brought these questions into the public domain again. The reasons for this have been partly to do with the premium “adjustment” behaviour of the insurance industry in the wake of the HIH collapse, and the reaction of the industry to any risk taking in the wake of the World Trade Centre tragedy. In the public liability area this has left many businesses without access to insurance or with very expensive premiums, which may mean that the business is no longer financially viable. There have also been some cases, which have received publicity, where the finding of negligence and the circumstances of the case may not have accorded with the community’s view of what is fair and just.

6.25 The terms of reference of the Negligence Review Panel recently established by the Government reflects a desire to move the pivot point, both to reduce costs to the community and to ensure that the law accords more appropriately with current community expectations and sentiments about what is fair and just. As with all readjustments reflecting community concerns, there is a risk of over-reaction. The effect of this over-reaction may be that some people injured in situations involving negligence do not receive compensation. They will either bear their own losses, or their costs will be borne by the community as a whole, for example through the social security system.

### **Judging the standard of care**

6.26 There has been considerable debate in Australia over the past ten years about who makes the decisions about the appropriate standard of care in a medical negligence case. There are two main areas where there has been debate - disclosure or risk to a patient before treatment and cases involving diagnosis, care and treatment.

### ***Rogers v Whitaker***

6.27 In the High Court case of *Rogers v Whitaker*,<sup>88</sup> the High Court looked at three main questions:

- who should judge the standard of care in cases involving “failure to warn” a patient of the risks associated with a procedure and in cases involving treatment and diagnosis;
- what should be the standard of care in such cases; and
- what should be the required proof of causation.

Each of these issues has been the subject of further litigation after *Rogers v Whitaker* and will be discussed separately.

6.28 The facts of the case were that Mrs Whitaker had lost the sight in her right eye when she was 9. She lived a normal life, working, marrying and raising a family. Almost 40 years later, she was preparing to return to the workforce after caring for her injured son for a number of years. She sought an eye examination. Eventually she was referred to Dr Rogers, who suggested to her that surgery on her right eye could improve its appearance and probably restore significant sight to it.

6.29 Mrs Whitaker asked questions about the procedure, including questions about possible complications. Because the procedure was essentially cosmetic and elective, she was most concerned about potential damage to her left eye in the surgery. An entry in her hospital notes the day before surgery indicated that she was apprehensive about the

wrong eye being operated on. Dr Rogers also recollected that she asked for the good eye to be covered to avoid any damage in surgery.

6.30 The surgery was uneventful but did not restore any sight in her right eye. Unfortunately for Mrs Whitaker, a known but rare complication of the surgery called sympathetic ophthalmia occurred. This inflammation affected her left eye and, in the end, rendered her virtually blind in both eyes. She had not been warned of this complication. Mrs Whitaker sued Dr Rogers for, among other things, not properly informing her of the risks in the procedure. There was ample evidence that, had she known that there was any risk at all of total blindness, she would have refused to have the surgery.

### *Who should determine the standard of care?*

6.31 Dr Rogers argued that the risk of developing sympathetic ophthalmia was so small (1:14,000) that he had no duty to disclose this information to her. He provided evidence that there was a significant body of his peers who would not have told Mrs Whitaker of the risk and argued that the *Bolam* principle meant that he had therefore not been negligent. The *Bolam* principle is a principle in English law that was first stated in 1957. It is that:

“...a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgement.”<sup>89</sup>

6.32 In *Rogers v Whittaker* the High Court of Australia rejected this approach and affirmed the decision in the 1983 South Australian Supreme Court case of *F v R*<sup>90</sup>, in which Chief Justice King had 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 is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.”

6.33 The High Court confirmed that it was the court, rather than “a responsible body of medical opinion” which would determine whether the doctor had breached the standard of care relating to the disclosure of risk, on all the evidence before it.

6.34 The High Court was equally clear that it was for the Court to determine the standard of care in cases of treatment and diagnosis. The majority judgment said:

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied.<sup>91</sup>

6.35 Later cases have confirmed the proposition that it is the court which determines the standard of care in treatment and diagnosis, on the basis of the evidence before it. This will include evidence from expert medical practitioners. The 1997 Report of the Victorian Law Reform Committee set out the principle clearly:

... it has been settled in Australia that whether or not the conduct in question meets the standard of care is to be determined by the court and not by the



medical profession. However, it is important to emphasise that in coming to a decision as to whether the standard of care has been breached, evidence from medical practitioners can be highly persuasive and at times decisive in determining the issue.<sup>92</sup>

6.36 In this area, there have often been significant misunderstandings about the basis on which particular decisions have been reached. The Victorian Law Reform Committee Report provides a good analysis of two frequently misunderstood cases of *Woods v Lowndes* and *Burnett v Kalokerinos*.<sup>93</sup>

6.37 Although the *Bolam* principle has not been the law in Australia for almost twenty years there has always been some discomfort among doctors about the move away from it. The AMA supports a return to the *Bolam* principle on the basis that “courts cannot provide justice to the parties under the application of the current law. It supports use of College-accredited medical experts, in order to overcome problems about partisan experts giving evidence on behalf of the plaintiff or the defendant”.<sup>94</sup> Members of the Legal Process Reform Group, other than Counsel for the AMA, Ms Pam Burton, do not support a return to the *Bolam* principle.

6.38 Even in the UK, the law has moved away from the *Bolam* test. The 1998 decision of the House of Lords in *Bolitho v City and Hackney Health Authority*<sup>95</sup>, relating to diagnosis and treatment, is seen as indicating a weakening of the *Bolam* principle. In that case, Lord Browne-Wilkinson said:

The court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant’s treatment or diagnosis accorded with sound medical practice...the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.<sup>96</sup>

This case evidences a movement towards the Australian position.

6.39 The shift in Australia from *Bolam* through *F v R* then *Rogers* and subsequent cases are also symbolic of the changed status accorded to doctors over those decades, as the shift from paternalism to partnerships in decision-making occurred. It also reflects a change in the broader health care environment, where “best practice care” has moved away from simply being a loose consensus of specialists to a focus on evidence-based care. The *Rogers* approach also recognises the reality that, from time to time, a responsible body of providers may not be basing their care on good practice but on tradition or even on incomplete information. A move back towards *Bolam* would be inconsistent with the move to improved quality and safety through systemic change based on data and more evidence based care. It could lead to the unacceptable result that a practice favoured by a small body of doctors would not be regarded as negligent, even if a substantial majority of doctors were critical of that practice.<sup>97</sup>

6.40 In answering whether the law relating to the standard of care should change in 1997, the Victorian Law Reform Committee considered that the “Australian common law standard of reasonable care in medical negligence cases is appropriate and should not be replaced by a statutory standard, other than in the limited ways recommended in this report.”<sup>98</sup> The AHMAC Legal Process Reform Group agrees with this view.

6.41 So far as appropriate clinical input into what the standard is in a particular case, in practice courts make decisions on the standard of care with the assistance of medical experts. The AHMAC Legal Process Reform Group believes that this reflects the community's view of an appropriate balance between due deference to medical knowledge and skill and the role of the Court as an independent arbiter of often conflicting evidence between experts. Often the decisions about the standard of care that are to be made by a court are complex. However, as the operations of medical panels and experts in court have shown, there are often diverse views between doctors, some of which may be more evidence-based than others. Having the court make these decisions as they do in other complex cases involving alleged professional negligence reflects the community's desire that the conduct of doctors be scrutinised in the same manner that other people are through the court process.

6.42 Suggestions have been put to the Legal Process Reform Group that the law could be made more certain in this area by creating a legislative presumption applicable in "treatment and care" cases, that where a doctor produces evidence from a reputable body of peers, the plaintiff would be required to provide evidence that treatment was negligent. In the Group's view such a provision is unlikely to have any practical effect because the plaintiff always bears the burden of proving their assertion of negligence. Such a statutory restatement of the existing law may be appropriate if, for example, the Negligence Review Panel were to suggest a statutory codification of the law of negligence.

*Reform template for standard of care issues*

The AHMAC Legal Process Reform Group does not recommend any change to the present law under which it is for the court to determine on all the evidence before it, what the standard of care is and whether the standard was breached.

In cases where negligent treatment and diagnosis is alleged, the views of relevant experts will be influential or even decisive, depending upon the facts of the case, but are not legally conclusive.

*Disclosing risks*

6.43 In *Rogers v Whitaker* the High Court determined that a doctor's duty of care in "failure to warn" cases is to warn a patient of a material risk inherent in the proposed treatment. It went on to say that:

a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.<sup>99</sup>

6.44 The Court stated that it would be inappropriate to require a patient to ask a specific question about a particular complication, before there was a duty on the doctor to tell the patient about it. The Court decided that Mrs Whitaker had clearly indicated that she would attach significance to the complication - that is, she satisfied the "particular patient" limb of the definition of material risk. The Court went on to say that it is also likely that Dr Rogers would have had a duty to disclose the information under the "reasonable patient" part of the definition, though they did not need to determine this.

6.45 The obligation to disclose risks is a consequence of the move to greater patient autonomy and the law's respect for patient self-determination. From the perspective of a patient or potential patient, a greater danger is unrealistic optimism about what health care deliver, because risks have not been adequately disclosed. The "disappointed expectation" is frequently a precursor to litigation.<sup>100</sup> A more open disclosure of risks will ensure that patient's expectations of the system are more realistic and, if the patient has accepted the risk of an occurrence which then actually materialises, the chances of the person litigating about it at all are likely to be very small.

6.46 Doctors may be unsure about what is required of them. They may need assistance in working out both how to adequately disclose risk and to be sure that the consumer has genuinely given "informed consent". Doctors often argue that the duty to disclose risk is too onerous and that if all risks are disclosed some patients may choose not to have treatment.

6.47 It is unlikely that this practical problem can be remedied appropriately by any modification to the common law. Of much greater significance will be continuing medical education to help doctors communicate better with patients, and greater focus on communication in the primary training of doctors and other health care professionals. The NHMRC general guidelines for medical practitioners on providing information to patients may also assist doctors to put this duty into practice.<sup>101</sup>

6.48 The concept of two-way communication in a discussion on risk may not be the same for a doctor and a consumer, and there is a need often for further opportunities to ask questions. There is anecdotal evidence that these discussions sometimes occur after a person is admitted to hospital for an elective procedure and sometimes even when they have already been prepared for the procedure and are sedated. Consumers' expectations about what they should be told often exceed that of clinicians. A cooperative effort is required to ensure better risk disclosure processes are followed, particularly for elective procedures or situations where there are a number of treatment options. Such processes need to have regard to consumer expectations as well as provider perceptions.

6.49 If an acceptable process could be developed with the support of both consumers and doctors, the fact that a doctor has followed this process could be a defence in a failure to warn case. Doctors and consumers should work together to develop such a process.

*Reform template for risk disclosure processes*

The AHMAC Legal Process Reform Group recommends that

- (a) primary medical education and continuing medical education should place emphasis on doctor-patient communication. It should include programs to assist doctors to fulfil their obligations to disclose risks to consumers in a meaningful way.
- (b) The Committee of Presidents of Medical Colleges, MDOs and consumers should work together to develop Codes of Practice to improve the provision of information on risk, benefits and treatment options, which build on existing policies on informed consent and disclosure of risk.
- (c) States and Territories should consider legislation to support the declaration of Codes of Practice governing disclosure of risks for specified procedures. Where the doctor has followed the Code of Practice, this could provide a defence for an action for damages based on failure to warn.

**Causation and “failure to warn” cases**

6.50 A patient cannot recover damages simply because he or she was not warned of a material risk inherent in a procedure. The plaintiff also has the onus of proving, on the balance of probabilities that the failure to warn caused the injury which the patient suffered. In *Rogers v Whitaker*, the procedure was an elective one, which was intended to improve the cosmetic appearance of the patient’s eye. The trial judge and Court of Appeal both found that Mrs Whitaker would not have undergone the surgery had she been advised of the risk of sympathetic ophthalmia. This meant that the injury was caused by the failure to warn. Dr Rogers produced no evidence to the High Court to question the findings of the lower courts.

*The test for causation*

A SUBJECTIVE APPROACH

6.51 The “causation test” has considered in a number of later cases. These cases show that the question of whether the patient would have undergone the procedure if the risk was disclosed to them is based on the subjective intentions of the patient. In other words it depends on what the particular patient would have done if the information had been given to him or her. The courts have looked at the perceptions of the particular patient and not an objective “reasonable patient”.

6.52 For example, in *Berger v Mutton*,<sup>102</sup> an oncology nurse had a diagnostic laparoscopy because her symptoms gave rise to a fear that she may have cancer. Her bowel was perforated in the procedure, and she claimed that she had not been warned about this complication. The plaintiff was unsuccessful on the grounds of failure to warn because the Court found that she had been warned, and also that her fear of cancer was so great that, even if she had been given a more detailed warning of this complication than she was, she would still have had the procedure. A similar subjective test was used in *Butos v Hair Transplant Pty Ltd and Peter Wearne*<sup>103</sup> where the patient’s original desire to treat his baldness was considered sufficiently strong for him to have the procedure, regardless of any warning. While in both these cases, the Court found that warnings had been given, they discounted the plaintiffs’ current statements that they would not have gone ahead

with the procedure if they had been warned, on the basis of evidence of their state of mind at the time of the procedure.

6.53 Although the question whether the patient would have had the procedure if they had been warned is subjective, the court can take account of the likely behaviour of a reasonable patient in assessing the credibility of the particular patient's evidence that he or she would not have had the procedure. In *Rosenberg v Perceval*<sup>104</sup> Kirby J commented that

If a reasonable person would have undergone treatment, regardless of disclosure, then in the absence of personal characteristics or circumstances which would explain a refusal, it must be difficult for a court to conclude that the plaintiff would have rejected the treatment no matter what the plaintiff now genuinely believes that he or she would have done.

#### WHAT IS THE LEGAL TEST FOR CAUSATION?

6.54 It is a factual question whether or not the harm suffered by the patient was caused by the failure to warn, so that the decision that a particular patient would not have had a particular procedure if they had been warned does not offer any guidance as to whether a patient in another case would have had the procedure.

6.55 however the legal test for causation has been considered by the courts in some detail. Historically courts often applied a "but for" test of causation. Under this test the defendant's negligent act was considered a cause of the injury if it would not have happened "but for" the defendant's negligence. The "but for" test works well in many situations, but sometimes creates difficulties. One problem is that it may prevent recovery of damages where the injury has multiple causes. For example suppose that two people acting separately light fires which combine to burn down a house. The "but for" test could prevent a plaintiff from recovering damages from either of the negligent fire lighters if they could show that neither of the separate fires would have been sufficient to produce the harm. In such a situation the "but for" test unfairly disadvantages the plaintiff.

6.56 The "but for" test may also unfairly disadvantage a defendant. Suppose that a mechanic negligently repairs a car. Because the car breaks down, the driver is caught in a storm and struck by lightning. Here it could be said that the injury would not have occurred if the driver had not been in the particular place, that the driver's presence in that place was due to the car breaking down and that therefore the mechanic is liable for the driver's injury. To avoid this result Australian courts have applied a "common sense approach" to causation, which places limits on the operation of the "but for" test. This common sense approach may mean that even a plaintiff who can show their injury would not have occurred but for the defendant's act or failure to act will be unable to recover damages. The common sense approach allows the court to temper the results of the "but for" test by making a value judgement about whether the plaintiff is entitled to recover damages for the defendant's negligence.<sup>105</sup>

6.57 The case of *Chappel v Hart*<sup>106</sup> is a controversial example of the application of the commonsense approach, in the context of medical negligence. The facts of the case were that Mrs Hart had a progressive condition of her throat which would have required surgery at some stage to prevent her losing her voice. Mrs Hart had surgery, which was performed without negligence. However, Dr Chappell perforated her oesophagus in the surgery and she developed an infection post-operatively, which affected her vocal chords, leading to her losing her voice. Dr Chappell had not warned her of this risk, even though she had specifically referred to wanting to know about the risk which actually materialised. The question in dispute was whether this failure had caused the loss.

6.58 The High Court proceeded on the basis of findings of fact by the Supreme Court of New South Wales and the New South Wales Court of Appeal that Mrs Hart would not have had the surgery at that time and would have had it performed later by a more experienced surgeon if she had received a warning. Because Mrs Hart would have needed to have the surgery at some time and the fact that the condition was a known consequence which could occur without any negligence in carrying out the treatment whoever provided the treatment, the doctor argued that the only harm suffered was a “loss of opportunity” to go to someone else.

6.59 The High Court struggled with the case, with the 5 judges providing different reasons for their decision. Three judges (Gummow, Kirby and Gaudron JJ) said that on the basis of the commonsense approach the failure to warn had caused the injury, so that Mrs Hart was entitled to compensation. Mrs Hart would not have had the operation at that time if she had been warned and the chance of the injury occurring if she had been operated on by a more experienced surgeon at another time was very small. The injury caused was precisely the injury about which the warning should have been given and the common sense approach did not require refusal of a remedy to Mrs Hart. The other two judges (McHugh and Hayne JJ) said that the failure to warn did not cause the injury, because the operation did not materially contribute to the plaintiff suffering the injury. This was because her oesophagus could have been perforated, and she could have been similarly injured, even if she had been operated on later, by a different surgeon. In effect these judges treated the injury as a coincidence, (equivalent to the lightning strike in the example above) rather than a consequence of the defendant’s failure to warn the plaintiff.<sup>107</sup> To a large extent this case should be seen as a decision on its unique facts. Its importance extends beyond these facts so far as all judges used a “common sense” test of causation, rather than relying on the “but for” test which had been used in these earlier “failure to warn” cases. The court treats the “but for” as a necessary but not sufficient test of causation.

#### SHOULD THE “COMMONSENSE APPROACH” BE CHANGED?

6.60 In *Chappel v Hart* the High Court applied a “commonsense approach” in determining causation. At least one member of the Legal Process Reform Group (James Murray) believes that the “common sense” test is too subjective and dependent upon the potentially variable view of individual judges about what “common sense” is. He supports a different test of causation recently applied by the House of Lords in the case of *Fairchild v Matthews*.<sup>108</sup> This test was based on “increased risk of harm”. A claimant had suffered asbestos induced mesothelioma after being negligently exposed to asbestos dust during employment by several employers, in circumstances where he could not prove which defendant’s breach was the cause of the disease. The House of Lords held that it was sufficient for the claimant to prove that a defendant materially increased the risk of injury to prove causation - the claimant did not have to satisfy the “but for” test.

6.61 It is possible that under this test and the facts in *Chappel v Hart* that Mrs Hart would have not recovered, because she could not have demonstrated a material increase in risk because of the failure to warn, even though the consequence which she was not warned about, despite asking, was in fact what occurred. However this test would not produce a different outcome in many medical negligence cases. The *Fairchild v Matthews* approach seems more relevant to industrial injury cases where it may be difficult for workers exposed to dangerous substances to satisfy the ‘but for’ test, than to failure to warn cases. The results of applying it to failure to warn cases are unpredictable. It is arguable that the House of Lords test is encompassed within the scope of the High Court’s broader view of a “common sense” test of causation.

6.62 Another concern about causation in failure to warn cases is that people who suffer adverse outcomes may retrospectively convince themselves that they would not have had the procedure if they had been warned of the risks. Thus they are likely to give self serving testimony in court. The counter-argument is that plaintiffs already face a heavy onus in convincing courts that they would not have had the procedure if they had been warned, particularly in cases where a reasonable person would have had the procedure despite a warning. In addition courts have the capacity to assess the credibility of plaintiff's claims that they would not have undergone particular procedures.

6.63 The Legal Process Reform Group was unable to formulate an agreed view on whether or not the causation test should be a "common sense" one like the High Court or a "materially increased risk" test like the House of Lords. The question is one which the Negligence Review Panel will be considering soon.

#### LOSS OF OPPORTUNITY

6.64 In *Chappel v Hart* the defendant argued that the plaintiff was simply arguing that she had lost the chance to be treated by a more experienced doctor. Most members of the High Court did not regard this as an accurate analysis of the plaintiff's claim. At this stage the AHMAC Legal Process Reform Group does not regard it as necessary to enact legislation relating to loss of chance occasioned by a failure to warn. In our view such an argument is likely to be made only rarely, is unlikely to succeed and can be left to the courts to deal with.

## CHAPTER 7

# Fair Compensation - the Assessment and Payment of Damages

### Introduction

7.1 Chapter 6 discussed the fault-basis for awarding compensation. This Chapter examines the principles on which damages are based. There have recently been a range of proposals to modify the way in which damages are assessed or paid. Some States have already enacted legislation in this area, either in medical negligence cases or in personal injury cases more generally. Such proposals are often based on the assumption that they will reduce insurance premiums. Some of the main proposals will be discussed here. These have been described as “tort reforms”, and they may well be considered so by a health professional concerned about MDO contribution rates. However it should be recognised that for a patient harmed through a negligently caused adverse event, these reforms are primarily intended to cut the costs of negligence for health professionals.

7.2 While consumers, like everyone else, have an interest in sustainable solutions to the problems that have arisen due to the escalation in MDO contribution rates, they may not see the solution of cutting benefits to consumers as a “reform” of the system.

7.3 Changes focussed solely on cost cutting may simply transfer costs away from health professionals either to the community as a whole or to the injured person and their family. While in some cases, this may be a reasonable balance of the competing interests in the system, the AHMAC Legal Process Reform Group believes that it is crucial for the community to understand:

- whether the proposed change is likely to lead to cost savings or not;
- if costs to one system are to be reduced, where will these savings lie and whether they will give rise to costs for others; and
- what the likely “size” of any cost impact might be, wherever it lies.

7.4 There are some reforms which the Legal Process Reform Group believe make good policy sense, whether or not they save costs. We have indicated views on these issues under each proposal. We have also sought to measure these against the purpose and goals set out in Chapter 1. In particular, reforms should balance

- the public interest in ensuring that people injured as a result of negligence receive fair compensation; and
- the public interest in ensuring that premiums are affordable and sustainable and that an appropriate level of medical services to the community can be maintained.

### Caps and thresholds

7.5 Caps impose a limit on the amount of damages which can be recovered. Thresholds require people to have reached a certain level of loss, before they are entitled to damages. Caps and thresholds are principally cost containment measures. The AHMAC Legal Process Reform Group believes that there is no social or ethical justification for absolute caps covering all forms of loss. A simple limit on all kinds of damages disadvantages those who have the most serious disabilities or suffer the greatest economic losses, more than people who suffer lower levels of disability. This is contrary



to the purpose and goals we have proposed for the reform process. There are, however, arguments for some caps and/or thresholds in three main components of damages: damages for loss of earnings/earning capacity, damages for non-economic loss and damages payable under the principle in *Griffiths v Kerkemeyer*.

### *Loss of earnings or earning capacity*

7.6 A number of jurisdictions have moved to place upper limits on the weekly amount of damages claimable for loss of earnings. The figure which seems to be emerging as a “standard” is 3 times average weekly earnings (AWE), with full-time adult ordinary time earnings being the chosen index figure.<sup>109</sup> Using national figures, in August 2001, AWE was \$837.60,<sup>110</sup> making the standard cap for calculation of loss of earnings just over \$2,500 per week.

7.7 The number of people who will have their damages reduced as the result of this cap is likely to be very small. Even at twice AWE, the most recent Census showed that less than 3.8% of the population aged 15 or more earned \$1,500 or more.<sup>111</sup> Even with the average at that level, the numbers are clustered down the bottom end. ABS figures show that the median income for people aged 15 years or over in the Census is \$300-\$399 per week.<sup>112</sup>

7.8 While there is no breakdown of the income earnings of people suing or being harmed by adverse events which may involve negligence, it is likely that very few people will be affected by a cap at the level of three times AWE. Even in cases such as Caloundre Simpson, where the Court had formed a view that her earning capacity, if the accident hadn’t happened, would have been in the upper income spectrum, the Court only awarded \$720,000 for future loss of earning capacity, which is a sum well under what would be expected if a figure at the cap level were used<sup>113</sup>.

7.9 The major purpose of a cap then does not appear to be to contain costs, but rather to create a certainty at the upper end of payouts for insurers and MDOs.

7.10 Another argument which supports this approach is that people with significantly higher levels of earnings are in a better position to provide for themselves above the cap level in case of catastrophic loss of earnings by purchasing “top-up” private insurance. However, there are problems with availability of products of this kind for high income earners who may have had some other health condition. While some people will have access to “income replacement insurance”, the Legal Process Reform Group is aware that these products are not always available to high income earners, particularly if they have had any ill health in the past. High income earners, who are already having medical treatment, may have particular difficulty in accessing top-up insurance. If this problem can be resolved the Group believes that the imposition of a cap on damages for loss of earnings/earnings capacity is justified.

7.11 The Group also considered whether a threshold should be imposed on damages for loss of earnings. It decided that, given other elements of the changes discussed below, there should be no “threshold” or waiting period. If a person has suffered a small loss of earnings as the result of medical negligence, the Group believes there should be compensation for the loss, though in practice many people will not seek compensation in these circumstances. Options considered but rejected included requiring people to access sick leave or to bear the costs of the first week of loss of earnings. The problem of very small claims for loss of earnings may be dealt with by the other components of the reform template.

*Reform template for caps and thresholds on compensation for loss of earnings or earning capacity*

While it is not expected to deliver any premium reductions, the AHMAC Legal Process Reform Group supports a high level cap on the weekly amount for loss of earnings at three times average weekly earnings, subject to ensuring the availability of “top up” cover for higher income earners to cover them for the excess loss above the award of damages. The AHMAC Legal Process Reform Group does not favour the imposition of any thresholds for recovery of lost earnings or other economic losses.

### *Non-economic loss*

7.12 Non-economic losses [often also called “general damages”] provide compensation for pain and suffering and loss of enjoyment of life. By definition these losses are not able to be objectively valued in dollar terms. Many people feel that those who suffer serious pain or loss of enjoyment of life should be entitled to some compensation for this loss. However, people have different degrees of adaptability to a similar disability. For example, someone who has enjoyed dancing but loses a leg may feel that their life enjoyment has been substantially reduced, while someone else in the same circumstance may simply find another activity which gives them similar pleasure.

7.13 Some argue that assessing damages for non-economic loss individually allows the damages to reflect the differences in human adaptability. Others express the view that paying a less adaptable person more may provide a financial incentive against exercising that human adaptability, which is seen as a virtue. Different people also have different experiences and tolerances of pain and suffering associated with different harms, and while these are not subject to the same degree of adaptability as “loss of enjoyment of life”, there are widely different experiences among people experiencing pain, depending upon individual tolerances and coping strategies.

7.14 The difficulty of addressing these issues, of measuring these losses and of attributing values to them has led to calls for more objective systems such as tables of impairment to ensure that people suffering similar harms receive similar amounts for compensation. The present assessment of damages recognises these concerns by having a “market price” range for this component of damages. Unlike the US courts, most amounts provided for non-economic losses in Australia are quite modest. For example, even in the *Simpson*<sup>14</sup> case, the amount awarded for general damages was only \$390,000.

#### A CAP FOR NON-ECONOMIC LOSS

7.15 So far as the question of thresholds and caps are concerned, the Legal Process Reform Group considers that the imposition of a cap at the upper end of where damages are currently paid is not unreasonable as a cost control measure. Given the modesty of such awards already and the small number of cases at this level, this is another change which is unlikely to produce significant savings in premium/contribution rates. However, it is also recognised that a ceiling will enhance certainty for insurers and MDOs. An indexed amount is required, to ensure that the ceiling maintains its value.

7.16 A number of jurisdictions have limits in the vicinity of \$350,000. There is no magic in the amount – it is simply a device which seeks to reflect the community’s sense of what is reasonable.

#### A THRESHOLD FOR NON-ECONOMIC LOSS

7.17 So far as cost-containment is concerned, the issue of thresholds for non-economic loss is an important one. The normal pattern of torts claims of all kinds is that the smaller the claim, the larger the proportion of non-economic loss and legal costs. NSW Health analysed the data and estimates in public hospital claim files for cases over

\$50,000 for a period up to 1999. This data confirmed similar data in other areas of tort, which showed a preponderance of the damages in small claims were for general damages.<sup>115</sup>

Table 7.1: NSW Treasury Managed Fund

**Medical Negligence damages - estimated breakdown**

	Proportion of Damages/settlements over \$1M	Proportion of Damages/settlements \$50,000 to \$100,000
General damages	7.80%	58.35%
Past economic loss	9.10%	2.66%
Future economic loss	5.10%	4.50%
Out of pockets (medical etc)	11.60%	4.25%
Future care	22.40%	0.20%
Gratuitous services	11.50%	0.94%
Plaintiffs legal	1.60%	12.26%
Defence legal	1.80%	16.62%

7.18 Research has also shown that the less serious the person's disability, the proportionally larger is the amount of damages for non-economic loss compared to the amount for this component in higher awards. This pattern of distribution is likely to be even stronger with smaller claims less than \$50,000.

7.19 While the individual cost of these cases is relatively small, the collective cost is significant. Various data also shows that there is a large number of small cases in this type of litigation. For example, the *Health and Other Services (Compensation) Act 1995(Cth)* (HOSCA) data shows that the median payment in medical negligence cases in 2000 was only \$40,000. With 50% of all cases being \$40,000 or less, the aggregated costs of small claims is an important area for any serious attempts at cost containment. The public sector data in the ACT also shows a similar and perhaps even stronger trend with 65% of cases over the past 10 years being for \$20,000 or less and 90% being for \$100,000 or less.

7.20 Combining these sources of information, it seems likely that non-economic loss thresholds which seek to limit the numbers of cases where such damages were available are likely to be an effective cost containment mechanism. Reform in this area will contain costs without directing resources away from those who are most seriously harmed.

7.21 Thresholds for general damages already apply in NSW. The NSW provision, under Division 3 of the *Health Care Liability Act 2001* provides that no damages for non-economic loss are payable unless the loss is "at least 15% of a most extreme case".<sup>116</sup> The notes to the legislation set out the process required to assess the non-economic loss payable. The claimant's damages are assessed as a proportion of the most extreme case and a statutory scale is applied to determine the amount payable. If the person suffers an injury causing a non-economic loss of between 15% and 32% the amount payable is discounted.<sup>117</sup> The New South Wales legislation does not indicate how the proportion of non-economic loss is to be ascertained, but leaves this to the common law principles for assessing non-economic loss. The New South Wales approach does not require that a

plaintiff suffer a permanent disability before they are entitled to damages for non-economic loss. Non-economic loss damages are payable if a person suffers a temporary loss which is at least 15 % of the most extreme case. This approach does not give priority to compensating people with people with long term non-economic losses because it treats temporary pain and suffering and permanent disabilities and disfigurement in the same manner.

7.22 An alternative approach, which is used in some workers compensation and motor accident schemes, is to provide that no non-economic loss is payable unless the person suffers a permanent impairment or disfigurement above a specified threshold, for example a 10% permanent impairment. The American Medical Association's Guide to Permanent Impairment, is often used to assess the extent of the impairment. This Guide is intended to achieve equity between people suffering different impairments by examining the effect of the impairment on the "whole person." Both the New South Wales approach and the AMA Guide are intended to provide a more objective way of measuring non-economic loss than occurs when non-economic loss damages are assessed under the common law.

7.23 The fundamental policy question here is whether it should be necessary to show that the person has suffered a permanent impairment or disfigurement above a certain level before they are entitled to damages for non-economic loss, or whether serious, but temporary losses should also entitle the person to compensation. Mr Bill Madden provided the group with a number of examples of cases where the patient suffered severe, but temporary pain and suffering, but would not be entitled to any compensation for non-economic loss under the AMA Guides, because they would not have suffered any permanent harm. For example a woman who underwent a unnecessary mastectomy because her normal pathology results were mixed up with those of another woman with breast cancer would have an impairment of the whole person of 0-5% under the AMA guidelines, which would not take her over a 10% threshold for compensation for non-economic loss. It has also been argued that there are likely to be difficulties in applying the AMA Guide in cases where a person has suffered permanent impairment as the result of medical negligence. The Guide assumes impairment of a "whole person". However many people injured by negligent medical treatment will have already have had some impairment before the injury occurred.

7.24 Instead of applying the New South Wales approach, or using the AMA Guide to assess impairment of the whole person, another approach would be to limit the payments to cases where someone has a permanent impairment or disfigurement, to impose the cap on damages for non-economic loss and then to set out the factors which need to be considered within the assessment, including a duty to mitigate the loss on the part of the plaintiff. For example, the provision could provide that when determining the level of non-economic loss payable where someone has a permanent impairment or disfigurement, the following factors are to be considered:

- the likely impact of the impairment or disfigurement on the normal activities of daily living of a person, including self-care and family/household participation;
- the likely impact of the impairment or disfigurement on the capacity of that person to participate fully in the community; and
- where a potential defendant offers appropriate rehabilitation or counselling services to a potential plaintiff, then the plaintiff is under a duty to use these services to mitigate the damages suffered. If a potential plaintiff refuses to use these services, damages (including those for future loss of earnings and non-

economic loss) will be adjusted to take account of the likely effects of the failure to mitigate.

7.25 Some members of the group raised concerns that this option would prevent a larger number of injured people from recovering damages for non-economic loss than those excluded by the present NSW threshold. They are also concerned about the difficulties an injured person may have in establishing that their injury is permanent. A “permanence” requirement may also create difficulties where there is an interrelationship between physical and psychological harm. These concerns raised a number of outstanding questions that are considered here.

- **When should a condition be considered permanent?** This will be clear in some cases from fairly early on, whereas in other cases it may take a long time for the person to recover to the maximum extent possible, but it would not be desirable to require a long period for assessment where only marginal improvement will occur. A useful test is that a physical or mental impairment will be considered permanent where it is clear that it is unlikely to improve significantly with time. Alternatively, the condition should also be considered permanent where the person is still suffering impairment at 12 months and it is unlikely that they will recover their pre-accident condition in the foreseeable future.
- **Should anyone with a permanent disability be entitled to this compensation, or should there be a severity test?** It is arguable that no damages for non-economic loss should be payable where the permanent impairment or disfigurement is minor and the impact on the life of a reasonable person would not be significant.
- How should such a provision deal with permanent psychological impairment unaccompanied by permanent physical impairment or disfigurement? This question has arisen in those systems where there are quite high percentage impairment thresholds. People with low level physical disabilities may argue that they have reached the threshold because the physical disability is combined with a psychological one. Most systems make the existence of a permanent physical disability or disfigurement a pre-requisite. Such a threshold does not prevent such information being used to assess the overall damages payable if there is a permanent disability. It simply prevents cases where there is only psychological harm from accessing this form of compensation.

7.26 The majority of the AHMAC Legal Process Reform Group supports the imposition of a threshold for general damages. However it is unable to agree on whether to recommend

- the approach taken in New South Wales under which no damages are payable unless the loss is “at least 15%” of a most extreme case;
- that non-economic loss is only payable in cases of permanent impairment or disfigurement, along the lines suggested above.

7.27 The majority of the Group favoured an “impairment” threshold approach, while a minority favoured either no threshold or the NSW one, on the basis that it was more flexible and fewer claims for non-economic loss would be excluded. It is important to distinguish between the recommendations made here, and those made in relation to thresholds for loss of earnings and in fact other costs associated with negligently caused harm. These thresholds only apply to claims for non-economic loss – all other claims remain available.

*AHMAC reform template for caps and thresholds on compensation for non-economic losses*

The AHMAC Legal Process Reform Group recommends:

- (a) an indexed cap on the maximum level of damages for non-economic loss commencing at the level of \$350,000;
- (b) the imposition of a threshold on access to non-economic loss based either on
  - (i) the approach taken in New South Wales;
  - (ii) proof of permanent impairment or disfigurement, which would allow consideration of both physical injury and the psychological effects of that injury.

If the threshold for non-economic loss is proof of a permanent impairment or disfigurement, the AHMAC Legal Process Reform Group recommends the following factors be considered:

- (a) the likely impact of the impairment or disfigurement on the normal activities of daily living of a person, including self-care and family/household participation; and
- (b) the likely impact of the impairment or disfigurement on the capacity of that person to participate fully in the community.

In determining whether an impairment or disfigurement is permanent, it will be considered permanent on the earlier of the following two dates:

- (a) when is clear that it is unlikely to improve significantly with time; or
- (b) when the person is still suffering the impairment or disfigurement 12 months after onset, and it is unlikely that the person will recover his or her pre-accident condition in the foreseeable future..

A plaintiff who does not reach these thresholds can still recover damages for loss of earnings and other economic costs associated with the harm suffered.

7.28 The Group believes that the imposition of a threshold on general damages should be combined with provisions designed to encourage rehabilitation, by allowing the defendant to pay for rehabilitation or other costs without making an admission of liability. This should be combined with a provision requiring the consumer to take up the rehabilitation option or otherwise mitigate their losses.

*AHMAC reform template for the duty to mitigate losses*

The AHMAC Legal Process Reform Group recommends that where a potential defendant offers appropriate rehabilitation or counselling services to a potential plaintiff, then the plaintiff is under a duty to use these services to mitigate the damages suffered. If a potential plaintiff refuses to use these services, damages (including those for future loss of earnings and non-economic loss) should be adjusted to take account of the effects of the failure to mitigate.

### Gratuitous services (*Griffiths v Kerkemeyer*)

7.29 Under common law, damages for care services provided gratuitously by relatives and friends (so-called “*Griffiths v Kerkemeyer*” damages) are recoverable by the injured person. Damages are based on the commercial costs of their provision.<sup>118</sup>

7.30 The policy reasons for this approach are that:

- a defendant’s liability to pay damages should [not] be reduced at the indirect expense of the provider, by invoking notions of marital or family obligations to provide the services free of charge or at less than market rates;
- there [is] no guarantee that the person [will] continue to provide the services gratuitously – the marriage may fail, the difficulties of full-time caring may be too much, a spouse may wish to return to employment; and
- the plaintiff [needs] the option to be able to “buy-in” respite care or assistance, to give the person caring gratuitously time to do other things or just to have a break.<sup>119</sup>

7.31 Governments have struggled with the common law position relating to these services. On the one hand, there is a recognition that these services are commercially valuable and that the person providing them does do at considerable “opportunity costs” to them, even though they are not “charging” the person for whom they are caring. In addition, the provision of these services gratuitously may be the only option other than institutional care for a person with a catastrophic disability, where they or their family have limited financial resources prior to payment of compensation. On the other hand, insurers and defendants have argued that these costs “overcompensate” for the losses, given that the services were provided gratuitously.

7.32 Governments have responded to these tensions in some jurisdictions by imposing both legislative caps and thresholds on *Griffiths v Kerkemeyer* damages. These most often act to limit damages awards for care provided before damages are awarded, because plaintiffs present their case on the basis that, after receipt of the damages, commercial care services will be used. The NSW *Civil Liability Act 2002* extended the threshold and caps already applying to these services under the NSW motor accident compensation arrangements to all personal injury litigation. Section 15(3) provides a threshold under which no compensation for gratuitous attendant care services is payable if the services provided are for fewer than 6 hours per week and for less than six months. Sections 15(4) and (5) provide caps on the hourly and weekly rates of attendant care services, both by reference to an average weekly earnings standard, based on a 40 hour week maximum.

7.33 The main concern with these current provisions is their regressive operation for those people with the highest levels of need, i.e. those with needs in excess of 40 hours per week, where they are unable to pay for care. The Legal Process Reform Group stresses here that it is concerned with necessary and reasonable services required by the person solely as a result of their injury, not services which the person would have received even if they had not been injured. In situations where a person has very high level disabilities, such as where someone would be eligible for institutional care if the gratuitous care was not provided, the current limits on gratuitous service provision impose a heavy burden on the plaintiff and their volunteer carers to the benefit of the defendant. A fairer split between plaintiff and defendant would be to link the overall limit on gratuitous care payable to the alternate cost of reasonable and necessary institutional care rather than to average weekly earnings. This would mean if someone needed two or three people to support them at home, the recoverable costs would not be

limited to just one person, but rather by an overall limit associated with the full costs of institutional care

7.34 However, the Legal Process Reform Group also considers that limiting the amount payable for each carer to a maximum of 40 hours per week should also encourage more sustainable patterns of caring and respite. There are many studies which show that the burden on carers is excessive and that respite care access and use is important to sustainable long term care arrangements.<sup>120</sup>

7.35 The Legal Process Reform Group believes that to a large extent its recommendations below relating to future care costs will obviate the need to award damages in this area for future care at all. However, if the eligibility for care costs is based on proof of negligence, there may well be a delay while the person is waiting for compensation, during which family members provide services.

7.36 Therefore, it is proposed that limits similar to the existing NSW (and some other jurisdictions) provisions be imposed, requiring proof of both the need and hours of provision, a minimum weekly number of hours, an upper hourly rate of recoverable costs and limits on total hours per carer. The AHMAC Legal Process Reform Group proposes that where the level of disability of the person is so high that their need for care exceeds 40 hours per week and they would otherwise be required to live in institutional care, then if more than one person can provide gratuitous care, the defendant is liable to pay these costs up to the full costs of providing reasonable and necessary institutional care for that person. To ensure certainty, such a figure should be specified in the regulations, and be linked to the actual costs of care in an appropriate facility providing similar assistance eg hostel care if the person does not require nursing assistance.

7.37 The majority of the Group also proposes that

- so far as past care costs are concerned, the legislation should require payment of the sums by the defendant to the relevant person who provided the services, not to the plaintiff, unless the person who provided the services wishes the funds to be paid directly to the plaintiff eg to allow them to purchase a larger structured settlement; and
- so far as past costs are concerned, these provisions should also apply to other non-family or friend service providers (such as Government or charity run community services) which provide the services at no cost to the plaintiff, but nonetheless, incur the costs of the services themselves.

7.38 It will be necessary to consider the tax effects of a provision requiring payment to the service provider. There is also a need to ensure that the interaction between social security refund provisions and preclusion periods operate appropriately in this area.

*AHMAC reform template for compensation for gratuitous care provisions*

The AHMAC Legal Process Reform Group recommends that where a person who has suffered negligent harm requiring more than one hour a day or 7 hours a week personal care and assistance, solely because of the disability caused by that harm, and that care has been provided without cost, for six months or more, then for the period after the six months, compensation may be claimed by the plaintiff for the number of hours reasonably and necessarily required by him or her, subject to the following conditions:

- all care is to be paid at an hourly rate equivalent to one fortieth of the Average Weekly Earnings for Full-time Adult ordinary-time earnings as calculated by the ABS from time to time;



- the total liability of the defendant is the estimated cost of equivalent institutional care, as specified from time to time in the regulations; and
- the court should be able to order payment of compensation for past care which has been provided to the plaintiff to the person or body who provided those services, on the application of that person or body.

## Long term care costs options

### *Costs of long term care in the current system*

7.39 The number of large medical indemnity claims incurred in any one year is small, but the financial impact of these cases is significant. Some of this data was summarised in Chapter 3. The ACT public sector data shows that in the past 10 years, only three cases commenced over that time have been paid or estimated at over \$1M, but the costs associated with the cases exceeds 45% of the total cost.<sup>121</sup>

7.40 The contribution of care costs to this total is also very significant. Results of the NSW survey of its Treasury Managed Fund (TMF) cases set out in Table 6.1 show that 45.5% of costs of cases over \$1M were related to care costs. In the recent *Simpson* judgment in NSW, \$6.5 million was awarded for future attendant care costs. If all past and future care and rehabilitation-related expenses were included, the proportion of damages payable in this case for these costs exceeded 80%. It has been estimated by Trowbridges that care costs comprise around 25% of MDO premium costs.<sup>122</sup>

7.41 NSW TMF data showed settlements for severe brain damage of neonates or infants increased from around \$2 million in 1992 to \$7 million in 1999, which is broadly consistent with the pattern of award increases. The single biggest component in these increases is ever growing amounts awarded for care costs, including home, vehicle and other modifications, rehabilitation expenses and the traditional “personal and attendant care” costs. These have been increasing for a range of reasons.

7.42 Courts are said to now be more reluctant to assume an early death in assessing damages for future care, because of the catastrophic impact an error may have on the person’s quality of life and access to assistance. A very recent study on life expectancy for people with cerebral palsy<sup>123</sup> indicates that overall mortality has not improved since the 1950s, despite the improvements in health care for people with severe disabilities. The author suggests this may be because improved neonatal facilities are allowing the survival of babies with increasingly severe disabilities and thus a greater risk of mortality. The study does show that if a person survives to adulthood, then their longer term survival may well be quite good, even if they have severe impairments. Of particular relevance to cases like *Simpson*, where the young woman has severe physical impairments but normal intellect, the study says:

Nonetheless, the 20% of people with severe motor impairments who have normal or near normal intellect are at low risk of death<sup>124</sup>

7.43 The actual costs of care services which must be paid by injured people have also increased. Even at the community services level, government policies are placing increasing emphasis on full cost recovery, where people with disabilities have assets or are eligible for compensation, though in practice such recovery often does not occur. In addition, the availability of gratuitous family care is often less, as more families have both working age parents in the work force.

### *Problems with current arrangements*

7.44 Currently, money for care costs is awarded as a single lump sum, in the vast majority of cases. The relatively rarity of these cases and their high costs results in enormously volatile payment patterns within the MDO and insurance industry. This also serves to increase premiums, as insurers seek to cushion their organisations from the volatility. It is also one of the key factors which makes long tail business less commercially attractive to many insurers.

7.45 A single lump sum payment for care costs also creates problems for injured people and their families. The need to make a once and for all assessment requires any assessment of damages to wait until a person's condition stabilises sufficiently to allow better predictions of life expectancy and the extent of care likely to be needed. This often results in extensive delays in the finalisation of the case. This, in turn, places an enormous burden on families and often results in great hardship when their need for assistance is greatest (ie when the person first comes home after their injury).

7.46 Once money is provided through a court award or (more commonly) a settlement, families and sometimes the injured person have to work out how to invest the money to be able to draw on the interest and capital over the person's lifetime. Difficulties in managing funds to produce the desired results are magnified in the vast majority of cases which are settled. The settlement process will often involve reducing the amount required to meet future care costs, because of uncertainties about whether liability can be proved.

7.47 Settlement at a discount is most likely in cases where causation may be problematic, as is often the case for "brain damaged baby" cases involving cerebral palsy. As discussed earlier, research has shown over the last decade that the vast majority of cerebral palsy cases do not arise from medical action or inaction during birth. The evidentiary signs of whether or not this is so in any single case, however, are often unclear. The record of cases going to judgement, whether before a judge or jury over the last decade, is generally not positive for the plaintiff in these cases, because it is the plaintiff who bears the burden of proof. This results inevitably in significant pressure on plaintiffs to settle for a substantial discount on the amount estimated to meet his or her future needs. This in turn magnifies the investment problems in trying to ensure money is available for care over the person's lifetime. Almost inevitably, the person at some point ends up having to access publicly funded care services.

7.48 Even in less problematic cases, only a very small number of cases actually go to judgement. The vast bulk of plaintiffs settle their cases at some discount - either because of doubts and fears about the outcome of the case, stress around the case itself or just being tired of waiting for any money at all to be received. These discounts for certainty and finalisation can be substantial, because at a time when the plaintiff and their family are under financial strain the settlement figure at will seem large and people believe that it will go further often than it does.

7.49 Extensive research in both England and Australia following up people several years after receiving their damages reinforces the prediction that in many cases the money received does not meet their long term needs.<sup>125</sup> Sometimes this is because money is wasted or used for purposes other than the provision of care and replacement of lost income. Sometimes it is because of poor investment advice or lack of success in a business venture or because a family relationship which had been central to "making ends meet" has broken down. Sometimes it is because the apparently "large" sum was inadequate for the purposes it was intended. Unless someone dies earlier than expected, damages paid in jurisdictions with higher discount rates will almost always be inadequate, as is discussed below. In a small number of cases, money is squandered by the injured

person, their relatives or “friends” or the person is the victim of fraud. The use of public trustee and protective commissioner arrangements can sometimes assist, though there are examples of significant dissatisfaction with these processes as well.<sup>126</sup> Follow-up research often indicates that, while there is initial satisfaction with a lump sum, over time this significantly reduces, as people become aware of the actual costs arising from their injuries.<sup>127</sup> With hindsight, injured people and their families often think that a combination of a lump sum to purchase an appropriate place for the injured person to live and buy a means of transport, and periodic payments for on-going care needs would have been preferable.<sup>128</sup>

7.50 Courts’, lawyers’ and families’ capacities to accurately predict levels of care needed are also notoriously inaccurate, and not always on the “low side”. A United Kingdom study of catastrophically injured people several years after finalisation of their cases showed that the court and lawyer predictions of how much care was needed were often too high when the actual service usage of injured people was examined.<sup>129</sup> People tended not to purchase full time care because the costs were high and so they worked out other ways of “getting by” when they could. This was particularly the case with parents of children with disabilities. They would often continue with the same punishing routines of care that they had undertaken during the pre-payment period, on the basis that they needed to maximise the amount available for the child’s later needs, when perhaps they would no longer be able to care for them.

7.51 In summary, the current arrangements for meeting the long term care needs of people who are severely disabled through a negligently caused adverse event are not satisfactory to anyone. They cause problems for injured people and their families, are costly and ineffective. They may mean that the community is required to pick up the long-term costs of a person who has already been compensated under the common law system. Costs are often shifted between parts of the community in a non-transparent and administratively expensive manner eg from insurers to taxpayers. If a person with severe disabilities dies prematurely, then his or her estate benefits. If they live longer than expected, the damages will be inadequate to meet their needs.

7.52 These problems are not confined to damages payable in medical negligence cases - they apply to all major personal injury negligence cases whatever the cause. The issues are also closely related to the level of access to services for people with severe disabilities within a community. Even people who have sufficient money may be unable to purchase the services they need, particularly in the long term. In these cases, people are often admitted to acute or nursing home facilities to meet their non-medical care needs either temporarily or permanently. These are costly and often inappropriate arrangements.

### *Other ways of managing future care costs*

7.53 There is a range of different ways that future care costs could be managed, other than a single lump sum award of damages.

- People who are currently unable to obtain damages rely on community based treatment and care services either specifically for people with disabilities or for people in the community more generally, including disability accommodation and support services (such as attendant care); Medicare and sometimes private health insurance. In some areas, there are chronic shortages of services and access to assistance may be limited by budget constraints eg respite care. In other areas, the funding is “demand driven” and so it may be easier to integrate compensable people into these services eg medical and hospital care.

- Structured settlements may be used to meet the future loss of earnings and care costs of a compensable person through provision of a lump sum, which is used to purchase a stream of periodic “repayments” of capital to be paid over the person’s lifetime. The Commonwealth has a Bill before the Parliament which amends the tax law to encourage their use, and some State governments have indicated that they will pass legislation to enable courts to award periodic payment arrangements in appropriate cases.<sup>130</sup>
- Various different compensation schemes in Australia provide for future care to be provided on an on-going basis. These include the Motor Accidents Insurance Board in Tasmania, the Transport Accident Compensation Commission in Victoria and the Motor Accidents Compensation Authority in the Northern Territory, as well as various workers-compensation jurisdictions. Similar proposals have been made by the NSW Motor Accidents Authority.

7.54 The first option – inclusion of compensable people under community-based programs from which they are currently excluded by their compensable status - will be discussed below in the collateral benefits part of this Chapter. The second option – structured settlements - is likely to be more attractive in the future, with the tax changes that are proposed, but these arrangements still require a once-and-for-all assessment. This reduces their capacity to adjust for changed circumstances. The model currently preferred by the AHMAC Legal Process Reform Group is one similar to the Tasmanian Motor Accidents Model, which removes care costs from the tort system and provides these benefits under a statutory entitlement regime.

7.55 The elements of the model being developed at the moment are to:

- remove damages for future care from common law and provide it through statutory benefits;
- provide people with an entitlement for services rather than a lump sum eg through contracted services with community providers;
- establish standards for both quantity and quality of care eg like the NSW Motor Accidents Authority work on the care needs of people with spinal injury and brain injury;
- where there are gaps, encourage the development of appropriate service networks with contestability between potential providers based on outcomes and cost effectiveness; and
- create a new entity to oversee the management of this arrangement.

7.56 Discussions are also underway as part of the AHMAC Long Term Care Costs Reform Group’s work to look at the synergies to be gained by pooling future care funds from all accident compensation schemes into a managed trust(s) funded by way of a levy based on a scheme’s catastrophic claims experience. This recognises that the needs of all people suffering catastrophic disability need to be provided appropriately and consistently, and that issues of what is “reasonable and necessary” are possibly even more important under a system of statutory entitlements. The issue of whether such an arrangement will be no-fault (and thus at least partly funded from community sources) or fault based (whether funded by defendants, or partly or wholly by governments) is part of this work and will not be discussed further here.

**“Reasonable and necessary “costs”**

7.57 In the *Simpson* case, there were a number of additional amounts that may well not be available to many other people who recover damages under the tort system. For example, more than \$500,000 for home modifications were awarded for the modifications of two of the families’ three houses, and \$330,000 was awarded for additional annual holiday costs, on the basis that the plaintiff came from a very wealthy family with a high standard of housing, that generally went overseas each year. To some extent, this illustrates one of the difficulties in determining what is “reasonable and necessary” in providing future care.

7.58 Courts have also struggled with this issue:

In examining the question of reasonableness, the courts have grappled with the same issues as the rest of the community about the options of home-based versus institutional care. In many cases, home-based care will be less expensive than institutional care and so the court will allow damages for home-based care. However, where the person’s disability is so severe, that they require round-the-clock care, this can be very expensive. Where the person seeks damages they are bound by a test of reasonableness, rather than what is the “ideal”. Determination of reasonableness requires a comparison of costs with the health benefits to the plaintiff. A plaintiff’s preference is not sufficient. This comparison is also undertaken in cases where different types of institutional care are possible.<sup>131</sup>

7.59 In the 1993 case of *Christensen v Pannikote and St Georges Hospital*, Justice Sharpe of the NSW Supreme Court said:

Compensatory damages, although sometimes expressed as aimed at restitution can never perfectly compensate the victims of serious bodily or mental injury. What is called for is an approach whereby the damages awarded is reasonable to both parties. The cost is to be matched against the benefits to the plaintiff.<sup>132</sup>

7.60 In the small number of cases where damages may be determined by the court, damages may provide a standard of assistance considerably different to that which is provided in the community for people with similar injuries or disabilities, whether or not this is in the best interests of the individual person. For example, for someone with a high level of disability, damages may be claimed for 24 hour in home nursing care. Depending upon the person, some form of group accommodation, where the person may be able to socially interact with others may be preferable, but because the damages may be less for this form of care, the plaintiff’s lawyer may argue for the earlier option as it gives the plaintiff maximise damages and potentially greater flexibility. Where someone is in a vegetative state and so unlikely to benefit at all from other care options, institutional care may be what is sought.

7.61 The NSW Motor Accident Authority has begun work to develop guidelines with consumers and providers about what is reasonable and necessary care for people with different levels of spinal cord injury. Additional work has commenced to develop similar guidelines for people with brain injury. This is crucial work for future statutory long term care arrangements.

*AHMAC reform template for long term care costs*

The AHMAC Legal Process Reform Group supports the approach being considered by the Long Term Case Costs Reform Group. It recommends that long term care costs be removed from the tort system and provided through statutory entitlements for people with catastrophic disabilities.

These benefits should cover such things as attendant care, rehabilitation needs, home and vehicle modifications, aids and appliances and other services needed to assist people with catastrophic disabilities.

Options for these arrangements, including scope, costs, funding and administrative arrangements are being developed through the AHMAC Long Term Care Costs Reform Group.

**Collateral benefits**

7.62 Collateral benefits are benefits which may be available, in addition to damages, to meet someone's accident related needs. There are two main areas where issues arise about collateral benefits:

- where there are Commonwealth or State/Territory programs providing assistance;
- where a person is entitled to assistance under a private contractual arrangement, either directly eg through paying an insurance premium, or indirectly eg through salary sacrifice like superannuation.

7.63 In developing appropriate solutions to medical indemnity related tort difficulties it is necessary to consider the interaction between Commonwealth and state community assistance programs. The examination should also include employment related assistance such as sick leave, disability assistance under superannuation arrangements (including invalidity retirement) and private insurance. An advantage of having a compensable injury is that the person has the financial capacity to purchase services, which may not have been available from community programs.

Finding other ways of increasing the financial resources available to a person, when they develop a disability, can affect their need for direct government assistance, and their capacity to meet their own needs from other resources. Thus consideration of all these elements need to be included, if arrangements are to mesh neatly, and maximum benefits are to be gained from the funds available from these sources.<sup>133</sup>

There are complex, inconsistent rules – both legislative and governed by case law - relating to all these interactions, and these will not be detailed here.

***Government programs***

7.64 The interaction between Commonwealth and State/Territory programs and compensation is complex and has been the subject of review and legislative action over many years. These issues were considered by the Professional Indemnity Review (PIR).

7.65 Changes to these arrangements since the completion of the PIR's work have simply aggravated the problems identified. The existing arrangements are complex, confusing and administratively cumbersome, with some people receiving double

assistance, and some receiving none. This has been an area where *ad hoc* incomplete solutions have proliferated, often through reactive changes as Commonwealth and States/Territories jockeyed to shift financial responsibilities between them. This has created inequities and inconsistencies between programs, across programs and significant administrative waste and duplication between government programs, compensation and other arrangements

7.66 The situations in individual programs are too complex to discuss here, but they need to be systematically examined to develop an integrated longer term solution. A co-operative Commonwealth/State approach to the following issues is required urgently across a range of areas covered by the work of the AHMAC Working Group on Medical Indemnity.

- Medical costs;
- Hospital costs;
- Domiciliary nursing care and attendant care;
- Home and Community Care (HACC) and Disability service programs of different kinds;
- Home, vehicle, workplace modifications
- Rehabilitation services;
- Accommodation options for those requiring residential care;
- Income support for people who are harmed and people who care for them..

7.67 Without being prescriptive, the AHMAC Legal Process Reform Group considers that any review of these should be guided by the aim of preventing double provision to meet an injured person's needs, and should enable the broadest access to assistance for those who have needs. Such a review should consider:

- whether the relevant government program should be the "first port of call" so that this component should be excluded from changes, and what the cost impacts of this would be; and
- whether cost-recovery from damages is a preferable approach, so that resources can be freed up to meet the unmet needs of people who are not compensable in fixed budget government programs, such as HACC and disability services.

### ***Private contractual arrangements***

7.68 Private contractual arrangements may provide an alternative source of support for people who suffer injury. These include:

- private insurance, which usually provides a lump sum or stream of income or both on the occurrence of a specified event or harm;
- superannuation disability benefits which may be provided either as a condition of employment or as an option purchased by an employee; and
- sick leave arrangements – sick leave is a condition of employment for most workers, and may be based on statute, in industrial agreement or in employment contract, and is accessible if a worker is harmed.

7.69 The general legal rule in Australia is that if the person has contributed to the premiums or other funding mechanism, then it does not "count" for the purposes of damages reduction. The public policy reasons given for this are:

- that defendants should not be able to opportunistically reduce their costs through the providential existence of arrangements paid for by the plaintiff;

- that a plaintiff should not be required to rely on these collateral benefits, where at some later stage they may need to draw on them, but would be unable to because they have been “used up” on providing support for disability associated with the negligent harm;

7.70 On the other hand, there may be public policy reasons to prevent double provision, especially where a combination of benefits exceeds what can be earned and thus may well act as a disincentive to return to work.

### *Need for a systematic approach*

7.71 The AHMAC Legal Process Reform Group considers that these complex issues need to be addressed as part of the current reform agenda. The ad hoc, conflicting and inconsistent approaches to these issues and the “turf disputes” between different levels of government have prevented a sensible set of arrangements being put in place.

7.72 These require the recognition of the context in which decisions on compensation are being made and a conscious societal decision about who should pay what and when. Greater consistency and certainty in these areas will allow a more reasonable and certain allocation between these arrangements, to the benefit of both people with disabilities and the broader community of funders and citizens. Such provisions would remove opportunities for double provision while laying sound foundations for the transparent allocation of costs between the private sector and various levels of government.

7.73 However, the complexity of the issues and the need for broader input across government and other sectors precludes the capacity of the AHMAC Legal Process Reform Group from undertaking this important work itself.

#### *AHMAC reform template for collateral benefits*

The AHMAC Legal Process Reform Group recommends the establishment, through AHMAC and under the auspices of the Council of Australian Governments, of a Commonwealth/State/Territory review to determine rational directions for reform in relation to the allocation of provision of assistance through government funded programs; compensation systems and private contractual arrangements with the aim of ensuring:

- best use of government funding;
- the prevention of “double-dipping”; and
- greater certainty and transparency about where costs lie.

### **Discount rate adjustments**

7.74 One consequence of using lump sums to pay all future costs has been the need to adjust for the net return on invested funds to ensure that a plaintiff is not over-compensated. The complexity and uncertainty of determining the discount rate and the costs associated with undertaking this assessment on a case by case basis led the High Court in the 1981 case of *Todorovic v Waller*<sup>134</sup> to set a “common law” discount rate of 3%.

7.75 Over the 1980’s, a number of States enacted legislation to alter this discount rate, sometimes in one area of compensation only eg motor vehicle accidents. Discount rates were increased to 5-7%. There has been a further push to increase the level of the discount rate in the recent round of tort reforms following the public liability review. The introduction of higher discount rates is often supported by insurers and MDOs because



it directly reduces their liabilities. The impact of such changes on the size of compensation awards “can be very substantial, with the more profound and long-term the injury, the greater the reduction in the level of the compensation provided”.<sup>135</sup>

7.76 With the current level of return on investments, the appropriateness of a high discount rate must be questioned. A high discount rate acts as a form of cap, which is regressive because it has the greatest effect on people with the greatest level of needs. Far from acting to prevent over-compensation, an inappropriately high discount rate almost inevitably leads to under-compensation.

7.77 Because most jurisdictions are introducing discount rates in excess of the common law 3% (or have already increased discount rates), the AHMAC Legal Process Reform Group feels somewhat constrained in recommending the lowering of the discount rate to more appropriate levels consistently across jurisdictions. However, we can see no philosophical reason (other than consistency) for supporting a move to a higher level in jurisdictions that have not already legislated. Given our focus on better meeting the needs of people with the highest levels of disability, the desire for national consistency may be too high a price to pay for people with catastrophic disabilities. Some of the goals sought to be achieved by increasing the discount rate may be achieved in a more equitable way by the removal of care costs from the tort system.

7.78 In the area of structured settlements, which will be an important means of providing lost earnings even if the future care costs arrangements are changed as we recommend, the discount rate has a further pernicious effect. It reduces significantly the purchasing power of a lump sum to purchase a suitable structured settlement. This in turn is likely to make plaintiffs less likely to accept structured settlements.

#### *AHMAC reform template for the discount rate*

The AHMAC Legal Process Reform Group recommends that discount rates should not be further increased because such a change has its greatest impact on people with the highest levels of disability.

### **Legal costs issues**

#### *The data on legal costs and some cautions*

7.79 The issue of legal costs in the tort system, particularly in the area of medical negligence has been a long term concern. For example, in its 1994 Interim Report, the Professional Indemnity Review reported the following from its study of MDOs conducted by the Australian Bureau of Statistics:

The total costs of the medical negligence system which are attributed to the legal profession, either through defendants' or plaintiffs' costs, is not absolutely clear. However, it appears to be quite significant. The direct legal costs of MDOs which responded to the ABS Study were between 16.7-36.7% per year of gross payments over the survey period. The ABS Study of MDOs further reported that individual organisations's legal defence costs were even higher than these percentages would indicate. On top of these costs, in successful claims, an element of the money paid to plaintiffs went to their legal costs. The total payments to plaintiffs and their legal advisers was between 34.3-62.8% of gross payments. It seems likely from these figures that between 20-40% of MDO payments go to the legal profession. This does not include figures for the legal

services provided to public and private hospitals in defending claims, nor for other health care professionals who may be sued.<sup>136</sup>

7.80 In a 2000 Paper prepared for the ACT Minister for Health and AHMAC by an insurance consultant, claims costs were estimated to be around 55% of premium received, and within that 55%, the magnitude of legal costs were estimated as :

- 40% of claims cost for claims up to \$100,000;
- 25-30% of claims cost for claims above \$100,000 to \$1 million; and
- 20-25% of claims cost for claims \$1 million and above.<sup>137</sup>

7.81 The NSW Treasury Managed Funds data set out in Table 7.1 shows a lower level of legal costs in the higher level claims, with the costs attributed to legal costs for cases over \$1M being only around 3.5%.

7.82 While some of the cost estimates from those noted by the Professional Indemnity Review in the early 1990s are said to have been reduced through greater use of internal legal advisers in MDOs, it is estimated that legal costs still contribute between 20-40% of all costs in the indemnity arena.

7.83 It is also a well-recognised general pattern that the proportion of legal costs in a case varies inversely with the size of damages awards. Costs constitute a much larger proportion of smaller damages payments. For example, in the United Kingdom Audit Committee's 2001 Report *Handling clinical negligence claims in England*, it was stated that in 65% of settlements in 1999-2000 below £50,000, the legal and other costs of settling claims exceeded the damages awarded.<sup>138</sup> The exact proportion of costs which were attributable to costs paid to lawyers, compared to costs paid to expert witness and to other doctors for reports is not stated, but the latter are usually significant.

7.84 While estimates of a defendant's legal costs are quite startling, it is important to note that they include administrative and legal costs outside the negligence system. For example:

- some of these figures include costs associated with complaints, disciplinary and coroner's processes. As a proportion of MDO business, these non-litigation matters can be quite significant - for example United Medical Protection's Annual Report for 1999-2000 indicated that of the 230 new matters handled by their in-house legal staff, 117 were civil matters, 42 were disciplinary processes and 52 coronial cases<sup>139</sup>; and
- some include the costs of general advice and education about adverse events and litigation, as well as risk management costs, all of which can potentially reduce the incidence of claims and patient harm;

7.85 It is also important to remember that legal costs used in legitimately defending a claim may reduce the total amount paid as compensation. The costs of defence in these cases may be significant to the MDO or insurer. Even if defendants are successful in court, their costs may not be recoverable because the plaintiff who may well be "too poor" to be able to meet them.<sup>140</sup>

7.86 Another important factor is the number of defendants that may be involved in a case. Often these defendants may be seeking to shift blame between themselves and this can add significant legal costs. In these cases, the size of the legal costs may well relate to inefficient management of the liabilities in the cases between defendants, rather than by any one defendant. It might also simply relate to the complexity of many of these cases, where causation becomes a key issue.

### ***Legal costs and access to justice***

7.87 Changes to legal costs may result in savings. It is important, at the same time, not to arbitrarily remove or limit costs without considering the impact on access to justice. For many consumers with medical negligence claims, there are problems accessing the legal system already. Ensuring that changes to costs arrangements do not aggravate this problem is important in balancing stakeholder and public interests.

7.88 Ideally, plaintiffs with potentially meritorious claims should have access to legal aid. The UK's system of having a panel of accredited lawyers for plaintiff work and handling the defendant work through the Litigation Authority brings about greater cost control within a framework of ensuring legitimate access. However, in the absence of any or adequate funding for medical litigation cases through legal aid, the AHMAC Legal Process Reform Group has looked at a range of other ways of reducing legal costs while maintaining appropriate access to justice. It is also important to remember that many of the recommendations in Chapters 4 and 5 will also reduce legal costs by reducing the need to litigate and reducing the costs and delays involved in litigation.

### ***Legal advertising and “No win, No fee” Arrangements***

7.89 Doctors often complain about lawyers advertising for business in an entrepreneurial manner in the medical negligence area. There are concerns about where the legitimate provision of information for consumers ends and inappropriate touting for business starts. This is of particular concern to potential defendants, MDOs and insurers because it is well known that the number of people with potential claims far exceeds the number who litigate.

7.90 Some States have chosen to address this by limiting advertising by lawyers in various ways.<sup>141</sup> When considering the desirability of introducing these changes more broadly, there was a range of views in the Group. On one hand, most people agreed that advertising which sought to promote a “lottery win” or “enough for a new car” idea on compensation was inappropriate. However, there was not general support for a ban on advertising, because it was seen as one way of providing consumers with the ability to access firms with skills, expertise and interest in the area. A regulatory framework relating to legal advertising exists in most jurisdictions. There are National Competition Policy requirements of minimal regulation limiting competition, unless the limits are in the public interest, applying in all jurisdictions. The Group's views particularly diverged about whether “no-win, no-fee” advertising should be allowed. Some of the substantive issues are discussed below in relation to contingency fees.

7.91 The AHMAC Legal Process Reform Group considers that limitations on advertising need to be based on better data than the irritation of doctors. There is a lack of consistent trends in claims increases across jurisdictions and so it is unclear if new legislation banning lawyer advertising is required or if the concerns about potential increases in litigation can be more directly addressed through the other reforms. On balance, the Group favours a limitation on any advertising which promotes the idea that compensation is a lottery win or that uses personal or other stories about “getting money” as a bonus, combined with a move to specialised accreditation so that consumers know can find out more directly whether the lawyer they are seeking to use has appropriate skills and/or experience in a more reliable way than is possible through advertising.

### *Contingency fees*

7.92 The national introduction of “up-lift” contingency fees in the 1990s was seen by some as an important move to increase access to justice in the absence of adequate legal aid. However it has also been criticized as an encouragement of litigious behaviour and resulting in pursuit of unmeritorious cases. The 1994 Justice Statement addressed this when these fees were proposed:

The risk being borne by the lawyer on a contingency fee arrangement will discourage lawyers from running worthless cases. Moreover, the increased access to the courts that contingency fees may allow will enable people of limited means to use the law, quite properly, to protect their rights or to be compensated for harm.<sup>142</sup>

7.93 The UK Lord Chancellor’s Department in April 2000 sought to use these arrangements (called “conditional fee arrangements”) to widen the access to justice and to look towards removing access to legal aid for clinical negligence cases.<sup>143</sup> In Australia, thus far, there is no evidence that the availability of these fees have caused an increase in inappropriate or unmeritorious litigation and the uplift fee is modest.

### *Small claims*

7.94 As we have noted earlier, small claims constitute the numerical bulk of claims in health care litigation, with a significant proportion of the claims cost going to legal costs of either plaintiffs or defendants. One way of discouraging litigation may be to limit the level of legal costs in small claims. Limiting costs could also protect plaintiffs against having to pay out a substantial part of their damages to meet their solicitor/client costs. Both New South Wales and Queensland have introduced limits on legal costs in small claims. In New South Wales, in claims less than \$100,000, legal costs can only be charged up to \$10,000 or 20% of the amount recovered, whichever is the greater. The limitation applies to other plaintiffs and defendants and the barristers and solicitors. These limits do not include disbursements such as the costs of medical expert reports, filing fees or photocopying costs. Limits do not apply if a client enters a cost agreement with a solicitor or a barrister.<sup>144</sup> The Queensland Government has also introduced limitations on the level of damages payable for small claims.<sup>145</sup>

7.95 The AHMAC Legal Process Reform Group believes that the effect of limiting legal costs in small claims should be evaluated, before similar legislation is enacted elsewhere. The New South Wales legislation may simply result in a higher proportion of clients making costs agreements, which provide for a higher level of costs than the legislation permits. Imposing a threshold on non-economic loss claims is likely to considerably reduce any incentive to initiate small claims. With the gathering of better data under the State and National medical litigation data base collections, better information should be available about whether direct limitations on legal costs will also be required.

### *Specialist legal accreditation*

7.96 Medical litigation involves more complex issues than motor car and work accidents, where the cause of harm is often much clearer. This is one of the reasons that defendants and plaintiff advocates often suggest that there should be specialist accreditation of lawyers to undertake this form of litigation. The research of the Professional Indemnity Review (PIR) in its Case Study work identified the issue of access to appropriately skilled legal advice as being a real “access to justice” issue for plaintiffs.

7.97 In its Final Report the PIR confirmed what it saw as the need for specialist accreditation of medical negligence lawyers, notwithstanding the small size of the market and other professional barriers.<sup>146</sup> The AHMAC Legal Process Reform Group considers that this issue needs to be explored with the various law societies on a jurisdiction by jurisdiction basis, given the variety of accreditation arrangements in place in different States.

### ***Medical advertising***

7.98 Medical advertising of elective procedures such as cosmetic surgery and laser eye surgery may encourage unrealistic attitudes on the part of consumers. One member of the Legal Process Reform Group believes that AHMAC should give consideration to a national framework governing advertising standards for medical practitioners and associated health practitioners.

#### *AHMAC reform template for legal costs, advertising and specialist accreditation*

The AHMAC Legal Process Reform Group recommends that

- (a) States and Territories should evaluate the effect of New South Wales and Queensland legislation imposing limits on legal costs in small claims, before introducing similar legislation;
- (b) legal advertising that promotes the idea that compensation is a lottery win should be prohibited;
- (c) the Standing Committee of Attorneys-General's consideration of a framework for a national legal profession should include standards for advertising by lawyers;
- (d) legal professional organizations should establish specialist accreditation for lawyers with expertise on medico-legal issues.

## CHAPTER 8

# Ensuring affordable and sustainable premiums

### Introduction

8.1 The current “medical indemnity crisis” has, to a large extent, been one precipitated by medical indemnity industry related factors. In addition to the cost factors discussed in Chapter 2 which have contributed to premium rises, industry-related elements include:

- increases in premiums in some specialties caused by a move away from mutuality to small risk pools;
- the rapid escalation in premiums arising from the need to address long term underfunding of MDO liabilities;
- the collapse of HIH which provided some degree of reinsurance for a number of MDOs in Australia;
- the voluntary provisional liquidation of the largest MDO in Australia, United Medical Protection and its subsidiary insurer (UMP/AMIL); and
- international issues relating to the reinsurance market.

8.2 These have all lead to increased upward volatility in MDO contribution levels, and some have contributed to the exit from the Australian market of the small number of private insurers operating here. The consequences of these events have been that doctors are fearful that they will not have access to affordable medical indemnity cover for their private patient business. Consumers and the community are concerned that people may not be able to access appropriate health services and that the service provider may not have adequate cover if something goes wrong.

8.3 Some of the solutions which have been used to address these issues have themselves created further problems within the medical indemnity industry, and for consumers and health care providers (particularly but not only doctors). For example, the move from claims-incurred to claims-made cover may have created greater predictability for some MDOs, but the move has created greater uncertainty for both doctors and patients.

8.4 There are also a number of characteristics of the market, which have affected the availability and affordability of products, in the Australian market. These include:

- the “long tail” nature of the business, where claims are able to be lodged over a long period and where the costs payable may include losses over a long period; and
- the small size of the total Australian market and the number of organisations competing with each other and “cherry-picking” low risk doctors from each other.

8.5 Some of the reforms proposed in this Options Paper may reduce the level of uncertainty. The removal of care costs from the system and their replacement by statutory benefits could contribute to the stability of the industry and a reduction in premiums. These costs could be subsidised by government in whole or in part. Alternatively, the care costs could be funded by a levy imposed on all MDOs, which would spread the cost across all doctors.

8.6 This chapter looks at other mechanisms aimed at providing affordable and sustainable premiums and/or MDO contribution rate. It deals with

- product-related reforms to meet the needs of doctors and consumers;
- changes to statutes of limitations to shorten the time period within which a legal action can be brought, which will meet the MDO and insurer needs for greater certainty; and
- market regulation reforms.

## **Product reform**

### ***Prudential supervision***

8.7 One of the reasons that the MDO industry has experienced financial difficulty is that it has not been subject to same prudential scrutiny as insurers. The difficulties faced by UMP were of a kind which may well have been identified and acted on earlier if there were a regulatory regime in place. Some of the key problems of competitive underpricing of products and a failure to adequately reserve for potential liabilities are likely to have had to be addressed at an earlier stage. The lack of a regulatory regime has arisen because of a technical difference between the cover available from an MDO compared to an insurer.

8.8 Traditionally medical indemnity in Australia has been provided by medical defence organisations (MDOs), which are non-profit “mutual organisations”, that is, they are owned by their members, not shareholders and any “profit” goes towards reducing contributions or providing improved benefits. They are not insurance companies, because they do not offer a doctor contractually defined cover. Coverage of a doctor’s professional indemnity liability is at the discretion of the MDO. It is often called “discretionary cover” and contrasted with “insurance cover”, because the latter is based on a contract.

8.9 While in theory discretionary cover could provide little security for doctors, there have been few examples where cover has been refused retrospectively. Sometimes this has occurred where doctors have died. In some cases, MDOs have refused to accept any claims made after the estate of a doctor is finalised. This has had a bad outcome for the injured patient, but no effect on the deceased doctor or his or her surviving family. MDOs argue that discretionary cover has allowed their members (and indirectly consumers) many benefits, which would not be available through a contract of insurance.

- Cover is not limited to a “contractual amount”. Insurance contracts generally specify an overall financial limit on liability for any one claim and all claims made under the policy. They may also specify an indexation of cover provision or some other way of “adjusting for delay”, but this will be specified in the contract. This means if a case takes a long time to be settled or heard, the amount specified in the contract may be too low to cover the doctor’s liability. MDOs on the other hand can accept liability without any of these limits – in the end, the cover is limited, but only by the MDOs overall capacity to pay, rather than by an individual contractual limit.
- Insurance contracts always have lists of exclusions from cover. MDO’s discretion allows them to look at specific cases and to agree to pay them. MDOs have over the past several years moved to create exclusions from certain types of cover eg damages in sexual misconduct cases. For plaintiffs, this means that they

are dependent on the resources of the doctor defendant, who may well have structured his or her business and financial arrangements in such a way that it makes it very difficult for a plaintiff to recover. An insurance product may extend this problem to other areas, depending upon the nature of the contract offered.

- Insurance policies attract certain financial imposts, such as stamp duty and other government levies. Discretionary cover does not attract these imposts. In some cases, this can be a significant saving to members.

8.10 On the other hand, consumer protection provisions currently exist under the Commonwealth's Insurance Contracts Act 1984, which prevent insurers from using the letter of the contract to unfairly refuse payments to insurance contract holders. No such provisions apply to MDOs in the exercise of their discretion.

8.11 The AHMAC Medical Indemnity Working Party initiated work to ensure that an effective regulatory framework was put in place to cover the industry, whether the organisations were required to offer insurance or whether discretionary cover remains. A National Workshop was held on 12 September 2001 to address this issue.

### *Claims incurred and claims made cover*

8.12 In the past the MDOs generally provided "claims incurred" or "occurrence based" cover. This means that a doctor is covered for any claim arising out of care provided in the year the premium is paid (ie the year the claim is incurred), whenever that claim is lodged. The contribution is calculated to cover the full liability incurred for that year regardless of when the claim is made, with the money being held by the MDO until the claim has to be paid out. Theoretically, this provides maximum security to both doctors and patients, because so long as a doctor has cover when he or she provides a health service, both the doctor and the patient know that they have professional indemnity cover. It also has the advantage that, in theory at least, doctors pay a premium sufficient to cover all their future claims, and so those in practice at the time pay for their own potential claims.

8.13 However, it is difficult to estimate premiums accurately, when a claim may come in many years after treatment was provided. Claims which are made later and where potential for the claim is not known shortly after the care was provided are called "incurred but not reported" or IBNR claims. Sometimes, the aggregate of all the IBNRs and those claims that have been reported but not yet paid is called "the tail". The "unfunded tail" has been an important factor in the current UMP crisis.

8.14 By comparison, insurers have generally provided "claims made" cover. This means that a doctor must hold insurance cover for the year a claim is reported by the doctor to the insurer or the year the claim is made by the plaintiff, whenever the service giving rise to it occurred. The key issue generally is that the insured needs to notify the insurer of a possible claim within the period of insurance to be certain of cover<sup>147</sup>. This form of cover provides greater certainty for the insurer or MDO as there are no IBNRs by definition, there is only a requirement to set aside adequate reserves to meet known claims.<sup>148</sup>

8.15 On the other hand, "claims made" cover provides less certainty for both doctors and patients. Proof of cover at the time of a health service being provided is almost irrelevant to whether or not the doctor will be covered when a claim is made, unless the claim is made or the incident notified to the insurer in the premium year.



8.16 It is argued by supporters of claims-made policies that some of these problems with claims made policies can be overcome by the doctor being required to purchase “tail” or “run-off” cover when they retire or cease practice for a short period. In recommending against the move to “claims made” cover, the Professional Indemnity Review addressed this argument in the following manner:

Insurers have further argued that a claims made policy can be altered to overcome some of the inherent defects identified here. This can occur through, for example, requiring the purchase of run-off cover. However, such a proposal can leave a person who is no longer earning with the requirement to continue to meet premium levels of a similar level to that when they were working for some years, and reduced premiums thereafter. Such a person is not able to write-off the costs against their income, as it is no longer related to income they are earning. Insurers then argue that these problems can be overcome by building the product into the premium while they are working. Similar adjustments can be also made at the front end to ensure claims have coverage. The conclusion of the PIR however, is that once adjustments are made to make the protection of claims made cover as certain as claims incurred cover is for health professional and health care consumers, the same uncertainties which make some insurers reluctant to issue claims incurred policies arise again.<sup>149</sup>

8.17 However, where a doctor does not buy “tail” cover, or an insurer refuses to renew a doctor’s cover and new cover cannot be obtained, then it is possible that a consumer who used the service when the policy was on foot will be unable to recover because the doctor has no cover when the claim is made. The risk for both consumers and doctors would be that the general move towards “claims made” cover will potentially result in gaps in cover.

8.18 Most other professional indemnity insurance is “claims made”. However, these products generally provide damages for business losses, rather than those associated with personal injuries. By comparison, compensation for personal injuries eg workers compensation or motor vehicle compulsory third party is funded on a “claims-incurred” basis. To that extent then, the issues in medical indemnity products are the same as those in personal injury insurance.

8.19 Of particular concern for all personal injury insurers and MDOs is the potential for “late claims”, which may not be lodged for many years after the incident occurs. For many motor vehicle and work accidents, the period in which unexpected claims arrive is shorter than the medical indemnity arena. The problem is similar to that which occurs with industrial diseases or conditions of gradual on-set in the workers compensation area. Statutes of limitations place time limits on the period within which legal action may be commenced. Time limits vary between States.<sup>150</sup> However, in the case of children, time does not generally start running until the child becomes an adult. In the case of people under a mental incapacity it does not begin until the person recovers. Where damage occurs to a child at birth, there is a potential period of between 21 and 24 years in which a claim can commence, depending upon whether the statute of limitations is 3 or 6 years. Where someone remains legally incompetent beyond their majority due to intellectual impairment or some other reason, then theoretically at least the limitation period never ends, unless there is an absolute end point provided by statute. This issue is claimed to be one reason why some MDOs have moved away from claims incurred cover. Reform in this area is discussed below.

8.20 The AHMAC Legal Process Reform Group considers that it is important to ensure certainty of cover for both doctors and consumers at the time care is provided. Providing cover on a claims incurred basis means that people who are practising at a

particular time pay the potential costs of any negligence at the time they are practicing which creates an incentive to improve safety. Claims incurred cover creates a closer temporal link between the premium cost and the cost of negligent actions. Perhaps more importantly, consumers and providers know that they are covered in the event of a negligently caused adverse outcome at the time the service is provided. Cover at the time of practice only provides such protection if the cover is available when the claim is made. The only way of ensuring this is by requiring provision of claims incurred cover.

8.21 If MDOs provide claims incurred cover, there may be a need to provide them with greater certainty by shortening the statute of limitations. This is discussed below. Given that some organisations have moved to “claims made” there is a need for a transitional “tail cover” product to be available to cover the claims arising from events occurring in the claims made period. This can be separately costed, so that those who have continued to hold claims incurred cover, often at a higher price, will not have to pay for those who have gained the transitional premium savings benefit of the move to claims made cover, identified in Graph 3.1 and discussed in “Addressing industry underfunding” in Chapter 3.

8.22 The AHMAC Legal Process Reform Group sees no reason why this requirement should be limited to doctors – all indemnity products for self-employed health professionals should be “claims incurred” to provide adequate protection for providers and consumers alike.

#### *AHMAC reform template on liability cover*

The AHMAC Legal Process Reform Group recommends that MDOs and any insurers or other organisations providing professional indemnity cover for health care providers be required to provide “claims incurred” cover to individual health care providers, because it provides greater certainty of cover to providers and consumers. “Tail cover” for those providers who have used “claims made” cover in the past should be made available.

#### **Statutes of limitations reform**

8.23 In medical negligence litigation, claims sometimes take considerable time to be lodged. It appears that the situation has improved over the past few years due to efforts to encourage early notification by MDO members. The UK data from their Litigation Authority shows delays of 1.6 years in the time from incident to claim<sup>151</sup> (though anecdotally it seems to be somewhat longer in Australia).<sup>152</sup> There has also traditionally been a significant period of time between the claim being lodged and paid.<sup>153</sup>

8.24 The “down side” of delays for MDOs, particularly those offering claims incurred cover, is that they cannot be sure that they have collected sufficient premium income to cover liabilities incurred in any one year. In the past, the “upside” was that delays in payment often gave them a lengthy period between being unsure of a potential claim and having to meet it. This has allowed them time to supplement funds with investment returns and set new premiums to cover any shortfalls in the premium they had collected for the year in which the claim was incurred. It also meant that liabilities were substantially reduced if the claimant died. MDOs now argue that the advantages of delaying payment are outweighed by the difficulties of calculating the amount of reserves to meet future claims, and that they require greater certainty.

8.25 In acknowledgement of the problems faced by MDOs in formally being able to “close off their books”, the Interim Report of Professional Indemnity Review recommended consideration of a shortened three year statute of limitations for medical negligence cases.<sup>154</sup> This was to be combined with better information to consumers about the occurrence of an adverse event and what to do if negligence was suspected.<sup>155</sup> Provision for better information to consumers has already been supported in Chapter 3, relating to open disclosure requirements.

8.26 There are many reasons favouring early lodgement of a claim for both a plaintiff and a defendant:

Substantial delays in the lodgement of cases causes many problems. The lack of fresh evidence, the disappearance of witnesses and even the death, or in the case of an institution, dissolution, of a party may make a case very difficult to run for either side. It will be difficult to judge the relevant standard of care if the time of injury is long past and this is particularly so in the rapidly changing areas of medical practice. More particularly, long delays make it impossible to use the tort system to prevent further occurrences of a similar negligent act and to get a plaintiff into rehabilitation as soon as possible, and to provide prompt access to compensation or other assistance as appropriate. In the medical area, the complex issues of causation become almost impossible to discern a long time after the event.<sup>156</sup>

8.27 The Professional Indemnity Review sought submissions and evidence from MDOs about the numbers of cases commenced outside the time limits, but no substantial evidence was able to be produced to show that these were anything but a handful of these cases. Most of the long term cases were in fact lodged in time, but took a great deal of time to resolve. The Final Report of the Review went on to reject the move to a shortened statute.

8.28 The AHMAC Legal Process Reform Group has also been unable to obtain clear evidence that substantial numbers of cases are being commenced outside the limitation period, though members are aware of some cases where this has occurred. However if there is evidence that the commencement of claims outside the limitation period is having an adverse financial impact on MDOs and insurers, it may be justifiable for the reform package to include provisions shortening the period alongside

- open disclosure requirements, including the provision of information about legal rights to patients;
- improved processes for early resolution of claims; and
- requiring insurers and MDOs to provide claims incurred cover.

8.29 It is essential that these other elements are combined with provisions reducing the limitation period, in order to provide adequate protection to those injured as a result of medical negligence. Shortening the limitation period (if this is supported by data about the financial impact of the current period) combined with these other changes will address many of the problems caused by late lodgement of claims and provide some support for a more sustainable industry. As a package, these reforms will facilitate and encourage earlier access to assistance and where necessary, the justice system, at a time when the evidence in a case on both sides is likely to be better available.

8.30 It would be unfair if time began to run before an injured person knew, or was in the position to know, that they have suffered an injury, which may give them a right to bring a legal action. Although we have proposed that the limitation period should be three years for those who are injured as adults, our recommendation is that time should

not run until the person was aware of an injury, which may be due to negligence. This provision will provide an incentive for open disclosure.

8.31 Some special difficulties arise in the case of minors and people who lack the capacity to bring legal action (because they are mentally ill). Under the current law, time does not begin to run until a minor reaches adulthood and can decide for him or herself whether or not to sue. For mentally ill people, or otherwise incapable people, time begins to run when, and if, they recover. Some States and Territories have an absolute time limit beyond which legal action can be commenced, even if the person has not recovered. Any legislation shortening the time limit must provide adequate protection for people who cannot act on their own behalf. However many of the same arguments for encouraging early notification and commencement of claims apply in situations involving children and any other person under a legal disability. In fact, for most children with disabilities, early access to assistance can be particularly important in minimising the disabling effects of the harm.

8.32 For these reasons, the AHMAC Legal Process Reform Group has come down on the side of reducing the time within which action may be brought on behalf of children and incapable adults. However our recommendations propose that the court should have a discretion to extend the limit period. The factors to be taken into account in extending the time limit allow the court to take account of circumstances which explain why no legal action was commenced on the part of the child or the person under the disability.

*AHMAC reform template on Statute of Limitations*

The AHMAC Legal Process Reform Group recommends changes to limitation of actions legislation to:

- (a) require commencement of an action within three years from the date when the cause of action accrues in the case of adults;
- (b) require commencement of an action within five years from the date when the cause of action accrues, in the case of a minor, or a person who is incompetent to bring legal action on their own behalf;
- (c) in the case of an adult plaintiff who is not under a legal disability, the cause of action accrues when the plaintiff knows or ought to have known that they have suffered an injury which may be due to the negligence of the defendant;
- (d) in the case of a minor, the cause of action accrues when the child's parent or guardian knew or ought to have known that the child has suffered an injury which may be due to the negligence of the defendant;
- (e) in the case of a person under a legal disability (for example a person who is mentally ill) the cause of action accrues when the person's guardian or administrator knew or ought to have known that the person has suffered an injury which may be due to the negligence of the defendant;
- (f) an overall limitation period of 15 years applies, subject to the provisions allowing extension of the limitation period;
- (g) the court should have power to extend the limitation period when it is in the interests of justice to do so because
  - (i) the plaintiff is a minor or a person under a disability who had no parent, guardian or administrator to institute proceedings on the plaintiff's behalf;
  - (ii) the parent or guardian of the minor or the guardian or administrator of a person under a legal disability is a potential defendant in the legal claim, or has a personal

- relationship with the potential defendant (for example where they are the spouse (including de facto spouse), parent or child of the potential defendant;
- (h) the power of the court to extend the limitation period in the case of a minor cannot be exercised more than three years after the minor attained their majority or 15 years after the event on which the claim is based occurred, whichever period is the longer;
  - (i) the power of the court to extend the limitation period in the case of a person under a legal disability cannot be exercised more than 15 years after the event on which the claim is based;
  - (j) in determining whether it is just and reasonable to extend the limitation period under (f) the court must consider whether the passage of time would preclude a fair trial;
  - (k) where a person dies after having suffered an injury, the limitation period applicable to an action under survival of actions legislation is three years from when the plaintiff knew or ought to have known that they have suffered an injury which may be due to the negligence of the defendant (subject to (l) below);
  - (l) where a person dies after having suffered an injury in circumstances where they did not know, and ought not to have known, that they suffered an injury which may be due to the negligence of the defendant, the limitation period is three years from the date when the plaintiff's personal representative knew, or ought to have known, that the plaintiff suffered an injury which may be due to the negligence of the defendant.

### Compulsory Cover

8.33 The other concern that consumers have about the adequacy of cover held by a health professional is that in situations where doctors are facing very high premiums, some doctors may choose to “go bare”, that is, not to insure themselves. Public policy supports Government requiring health professionals to hold adequate professional indemnity cover.

- There is a public policy interest in ensuring that if someone has been negligent and caused harm to someone else, then the person who is injured by that negligence will be adequately compensated. Consumers need to know when they attend a health care professional that they have adequate professional indemnity cover (either in their own right or through their employer).
- There is a public financial and policy interest in ensuring the otherwise compensable costs are not shifted onto government support and assistance programs because of inadequate or non-existent compensation. This can occur either when a health professional or institution: chooses not to have any indemnity cover and has inadequate assets; chooses to purchase inadequate cover because it is less expensive; is unable to obtain cover because of a bad claims record; or is otherwise unable to obtain a suitable product at a reasonable price.
- The government has a policy concern in ensuring that compensation payable for negligence does not lead to financial ruin in the case of individual health professionals or the need for the liquidation of health care institutions to meet the costs of awards.<sup>157</sup>

8.34 Concerns are often raised about the relationship between compulsory cover and the effect this may have on clinicians who are considered poor risks and are not able to access cover. MDOs expressed concern that this could result in them acting as surrogate “registration boards” as people could not practise without cover. In NSW, where cover

was made compulsory (either through direct cover or coverage as an employee), Part 2 of the *Insurance Regulation Order* under the *Health Care Liability Act 2001* allows an MDO or insurer to charge an additional premium for a poor claims history or incident history, that is up to twice the normal premium for that kind of doctor. Where any loading exceeds that, it can be deemed to be a refusal, and a deemed or actual refusal allows the doctor whose cover was refused the option to go to the Medical Board for consideration of the issue. Under section 19 of the *Health Care Liability Act 2001*, the Board cannot register someone unless they have approved cover. This creates the link between the processes, while still keeping registration responsibility with the Board. It is also considered to be unsatisfactory professional conduct to practice without cover.

8.35 The NSW provisions provide an excellent model for a single state and for registered health professionals, but other broader options might be possible, at least so far as doctors are concerned. In its Final Report, the Professional Indemnity Review suggested a range of ways of implementing compulsory cover:

There are a number of options for ensuring such cover is compulsory. One way for covering registered health professionals would be through state legislation, making it a condition of registration. Another option would be to make it an offence for someone to offer or provide health care services without holding adequate professional indemnity cover. The Commonwealth could also act in relation to services it funds, in the case of Medicare services, through making it a condition for issuing a provider number or administratively through making it a condition on any grant which the Commonwealth contributed financially. It could also make the putting in place of state legislation a condition on the next Medicare agreements. Obviously, the best option would be a co-operative one, where nationally consistent legislation was developed to achieve this end in all states. It would be important to have such a national approach to avoid all those who were unable to get cover because of poor claims history gravitating to those states without such legislation, and thus causing harm in these communities.

*AHMAC reform template for compulsory health professional liability cover*

The AHMAC Legal Process Reform Group recommends

- (a) the introduction of compulsory professional indemnity cover for all registered health professionals, along the lines of the NSW provisions; and
- (b) MDOs and insurers should be able to charge an additional premium for poor claims or incident history. There should be provision allowing health professionals to appeal to the relevant registration board against a refusal to provide cover based on a poor claims or incident history.

### **Data provision requirements**

8.36 Another key issue is the need to ensure better access to data. Chapter 2 indicated the poor quality of the data. A separate project is continuing under the AHMAC process to develop a national data collection for medical indemnity. It was hoped originally to do this cooperatively between the public and private sectors, and possibly even with the involvement of the Australian Prudential Regulatory Authority. This process is continuing, but it is likely to take some time and there is no guarantee that the MDO industry will be willing to provide data to a combined National data base on a voluntary basis or that they are willing to provide it to the State and Territory governments without regulatory requirements.

8.37 National data allows the mapping of trends over the whole of Australia so far as claims pattern and incidence are concerned, but State and Territory governments require even more information to understand fully what is happening in their jurisdictions both so far as policy information is concerned and claims information. For example, State and Territory governments may have a much greater interest in the insurance cover being offered through MDOs and insurers, as well as the claims being made.

8.38 To better meet State and Territory data needs, to improve the data collection process and increase the consistency of available data, jurisdictions could supplement the AHMAC work with a provision similar to the NSW mandatory data reporting requirements. These were introduced by section 21 of the *Health Care Liability Act 2001* and implemented through the Insurance Regulation Order, Part 5 and Schedules 3 and 4. In NSW this data must be provided on a 6 monthly basis for the body to remain an approved body to provide medical indemnity cover. There is additional data required to be reported on an annual basis and this is set out in Schedule 5.

8.39 Given the fact that almost all MDOs operate in NSW to some extent, the imposition of this requirement across other States and Territories seems unlikely to impose additional difficulties. Practical difficulties about data transfer are already being tackled in the NSW context, so it is expected that the extension to other States and Territories may be relatively easy. The creation of an insurer approval process is likely to be required to implement other obligations suggested in this Chapter. The additional benefit is that the claims data provided could be fed into a National Database.

8.39 A similar regime could be introduced to include insurers covering health professional indemnity and hospital liability for private hospitals, other private health facilities and other health professionals to ensure a full picture across the health care negligence area.

#### *AHMAC reform template on data provision from MDOs and insurers*

The AHMAC Legal Process Reform Group recommends the implementation of data collection requirements consistent with Schedules 3, 4 and 5 of the NSW *Health Care Liability Act 2001*, *Insurance Regulation Order*. The data reporting requirements should initially be imposed on MDOs and insurers, but at a later stage, on all providers of health professional and health organisation health care negligence liability cover.

### **Premium Affordability**

8.40 As was mentioned in Chapter 2, the size of medical indemnity premiums has increased dramatically from the end of the 1980's, when there was a single flat rate in most medical defence organisations (MDOs). At that point MDOs moved away from the concept of a single flat rate for all doctors to a specialty risk rating system, which has seen some doctors, such as those practising obstetrics and gynaecology, paying very much larger premiums. NSW recently introduced a form of cross-subsidisation back into the system by limiting the differential between the premium for an obstetrician or neurosurgeon to 20 times the rate applicable to a non-procedural general practitioner. However practitioners in these upper level categories are still paying more than \$80,000 a year. Different MDOs have different premium levels across the other States and Territories.

8.41 For medical practitioners with lower levels of earnings, indemnity cover of this size is a significant financial burden. At the lower income earning levels, most MDOs have reduced rate contributions, but for those "in the middle", the financial burden of a full rate premium can be quite significant. For some doctors, it may also be a significant

barrier to continuing in practice. These include practitioners with limited numbers of patients, including some doctors in rural areas, and doctors whose patient base may be unable to meet significant co-payments because they are located on low income areas.

8.42 It is also claimed that younger doctors are seeking to avoid some higher risk areas of practice, though it is unclear if this is because of the anticipated costs of MDO subscriptions, because of the concern that premium levels reflect a high frequency of litigation, or whether there are other reasons such as areas of higher remuneration or better conditions making other areas of work more attractive. It is more than likely a combination of these reasons.

8.43 In all jurisdictions now, MDO subscriptions cover private patient liability and State or Territory governments cover public patient liability, either through a system of insurance or self-insurance. Those with self-insurance arrangements in place may have “catastrophe” insurance cover, which is obtained from the commercial market. While jurisdictions vary in their experiences, there are overall concerns about rising premiums or at least long term upward pressure in medical indemnity costs. Where premiums or payments have increased, this makes less funds available for the provision of public health care services.

8.44 At the broadest level, the effects of these costs may include:

- higher co-payments required of patients, particularly in some specialties;
- more financial pressure on funders eg the Commonwealth government through Medicare rebates, and State and Territory governments through public patient indemnity costs;
- reduced service options in some areas; eg when a doctor withdraws from a rural location, or where a self-employed midwife is unable to obtain professional cover to enable her or him to practice; and
- potential long term health care workforce and practice implications because of these costs and/or concern about being sued; eg reduction of number of practitioners in high cost areas, and so-called “defensive medical practices” to ensure patient reassurance and satisfaction.

8.45 These concerns have been pivotal in the work being undertaken by the AHMAC Working Party on Medical Indemnity. However, another key requirement in considering the claims of doctors for the need for direct subsidy or other assistance in relation to medical indemnity premiums is to obtain better information about the question of premium affordability. This is a key issue when balancing the interests in such a complex area – the level of earnings needs to be compared with the level of premium to judge whether there is genuine hardship which justifies government intervention. Otherwise there is a risk that governments will respond to pressure from various lobby groups, whether or not their concerns are supported by the data.

8.46 The States and Territories could undertake work on premium affordability. Alternatively, the Commonwealth could look at the Medicare earnings data, as was done by the Professional Indemnity Review, to determine affordability.<sup>158</sup> For some specialty groups, Medicare billed income is not an appropriate income measure. For example, cosmetic surgeons may do a significant proportion of their work outside of Medicare. Similarly, neurosurgeons and some other doctors do a substantial component of “compensation work” under workers compensation or motor vehicle accident arrangements.

*AHMAC reform template on premium affordability*



The AHMAC Legal Process Reform Group recommends that analysis be undertaken by the AHMAC Working Party about the affordability of MDO premiums across the various different specialty groups, looking at practitioners private sector income under Medicare and also taking account of additional income outside Medicare.

### **A Need for Premium Regulation?**

#### ***The move away from mutuality***

8.47 Since the late 1980s there has been a move away from mutuality and risk pooling across all doctors in the late 1980s. This has significantly contributed to specialty-specific premium increases in the late 1980s. Premiums ranged between \$1,000 and \$2,000 per doctor, depending upon the jurisdiction<sup>159</sup>. Over time, MDOs have moved to create further and smaller risk groupings. This has been on the basis that it was a “good idea” to remove so-called “cross-subsidisation” among doctors, although cross-subsidisation is in fact the basis of insurance.

8.48 Of most concern was the cross-subsidisation between low-earning doctors and high-earning doctors, often exemplified by the GP vs other specialist divide. However, given the relatively small size of the whole MDO market in insurance terms, this has led to “risk pools” which are so small as to be essentially unsustainable. The high contributions being requested from specialist obstetrician/gynaecologists are an example. One MDO’s premium for this group exceeded \$80,000 in January 2002, while the average MDO premium throughout Australia for the year ended 30 June 2001 was estimated to be \$4,100.<sup>160</sup>

8.49 Not all health care providers are as averse to risk pooling as medical practitioners have become. For example, the Royal Australian College of Midwives is exploring an arrangement to adopt a single rate for all midwives including those who are self-employed, to avoid self-employed midwives having to pay premiums at a level which may make their practices uneconomic. The two proposals put to midwives were a scheme where all midwives paid \$250 or one where employed midwives paid \$100 and self-employed midwives paid around \$3,000. The overwhelming response from members was to explore the first option.

#### ***The negative impact of small risk pools***

8.50 Reductions in the size of risk pool have been directly responsible for bringing about unsustainable specialty-specific increases. These have been on top of increases in the liability pool, which have been driven by the increased size of claims and other cost factors which are being addressed in the work of the AHMAC Medical Indemnity Jurisdictional Working Group.

8.51 At a practical level, it is useful to look at why mutuality “broke down” in the late 1980s. At that time, insurers began to offer a low cost product to low risk GPs. A small number of doctors purchased these products, and MDOs began to fear that they may lose their low risk financial base – a practice known in the industry as “cherry-picking”. While there is no evidence of a mass exodus, the small trickle was sufficient to move the industry to move away from the principle of a single contribution rate which had previously applied.

8.52 In addition, up until the mid 1990’s, the MDO market had operated partly through overseas UK-based MDOs which had members throughout the country and

smaller Australian based organisations, generally operating within single states. In the mid 1990s, the UK-based groups began to move out of the market and there was a struggle between the Australian based MDOs for market share, as well as competitive moves into other states. There was a real fear of “cherry picking” between MDOs, and some evidence that this was and still is occurring.

### *Using earnings as a basis for premiums*

8.53 Doctors have always argued against moving back to a single subscription, because it results in lower earning, lower risk doctors (often GPs) cross-subsidising high-income, higher risk doctors (often other specialists). Within the non-GP specialist group, similar arguments exist between lower earning lower risk groups and higher risk higher earning groups.

8.54 However, an option which looked at premiums that are linked or partially linked to earnings could address at least part of this perceived inequity, while bringing about a greater spreading of risks. Earning levels are at least partly linked to the number of services provided so a partial link to risk exposure would remain under such an arrangement, even though it would not be specialty specific. Earnings-related premiums could be used in a number of ways to achieve both a large “risk and cost spread” without the apparent financial inequity associated with a single flat rate across all doctors. Two possible approaches are:

- imposing a single premium based on a percentage of income on all doctors, regardless of specialty. This option would be closest to the original concept of mutuality that applied prior to the 1990s;
- creating a small number of risk bands eg 3-5 to which different percentages of income could apply. This reduces the degree of cross subsidisation between risk categories but could still include sufficient risk pooling to gain some of the premium stabilisation effects of greater pooling.

8.55 Decisions would need need to be made about how income was to be determined, but this is already done by MDOs which have income bands in their contribution setting process. The income needs to be related to the private sector earnings of a doctor eg from Medicare services on private patients, from non-Medicare services and compensable services. As it was not possible at the moment for the Legal Process Reform Group to look at this range of income, we did some preliminary estimates using Medicare Billed income data and the Trowbridge average premium estimate, to roughly ascertain what income figure might be needed. It is important to note that this does not include the recent increases in the premium pool, but was based on the \$200M Trowbridge estimate for the premium pool at 30 June 2001. The percentage might need to be larger to cover the bigger premium pool which now exists. Equally, there will be downward pressure on the figure if the income base were widened to include non-Medicare income. Medicare Billed income for the 2000-01 year is estimated as \$8,152.7M.<sup>161</sup>

- If a single rate were adopted across all doctors, the premium collection for 2000-2001 would be exceeded by a collecting premiums at a rate of 2.5% of billed income, using the above figures.
- A single rate could be seen as creating “too much” cross-subsidisation. If this were the case a different percentage could be applied to low, medium, high and very high risk specialties.

- If there were concern about the potential “disincentives” to increased safety and risk management within such an arrangement, some models used in other professional areas, like professional indemnity for lawyers, require a person who is covered to pay the first part of any claim.

8.56 There is provision for front end deductibles in the NSW *Health Care Liability Act 2001* arrangements. The “downside” of this option is that it would make data for claims under the deductible almost impossible to capture except through a self-reporting requirement, like that which exists in South Australia under their *Medical Practitioners Act 1983*, section 72. Under this provision a doctor is required to report specified details of any settlement or judgement, relating to an alleged act of negligence in medical practice, whether or not there is any admission of liability, within 30 days. It should be noted that the above calculation does not take account of any reductions in the cost of claims flowing from recommendations made earlier in this Paper.

### *Outstanding issues for an earning-related premium model*

8.57 One problem with such a form of funding on earnings related premium model is that it requires some level of legislative support, because otherwise low risk doctors may choose to “go bare” and not take out any cover and this would reduce the overall size of the premium pool without reducing the risk exposure significantly. The earlier recommendation supporting compulsory cover addresses this.

8.58 Equally, the capacity for MDOs to “cherry-pick” members by income or risk be very limited to ensure adequate sharing of risks and premiums across the industry. This could be addressed by legislating that an MDO would be required to offer cover to all comers, regardless of specialty group or income band.

8.59 While there could be power to impose loadings for poor claims history and to even refuse cover potentially in some cases, MDOs would otherwise be required otherwise to accept business from all comers, who were registered medical practitioners.<sup>162</sup> If an MDO is required to offer to all comers at approximately the same price, then other devices may be used to discourage membership by higher risk or lower income doctors.

8.60 An uneven spread of high risk and/or low income doctors and the inability to charge them more could lead to different MDOs having unbalanced risk and income portfolios with corresponding negative financial impacts at least in the short term. This can have a particular impact on MDOs with small portfolios of business (thus the NSW small insurer/MDO provisions, where they did not have to underwrite all comers but were limited in their capacity to increase market share). A mechanism is required to ensure that all insurers carry their fair shares of risk and income groups. This can be done through:

- claims equalisation pools (eg the private health insurance model);
- assigned market shares; or
- having a monopoly insurer

8.61 The percentage of income approach to premium setting could either be specified by government in legislation or regulation in a nationally consistent manner or on a state by state differential basis to take account of the variable litigation experiences between states. Price regulatory bodies such as state based utility pricing bodies could be used to set the rate if this method were considered best.

8.62 Alternatively, legislation could require any MDO or insurer offering medical indemnity cover to offer it at a consistent rate of earnings across all professional

categories within that jurisdiction, and allow MDOs to compete on price. To avoid a repetition of previous problems, this would need to be within a strong prudential regulatory framework. This may also disadvantage those with an exceptional risk/income profiles, because their premium rate would be higher than their competitors, and so they could lose more of their market share and compound the problem.

*AHMAC Legal Process Reform Group Recommendation for further work on premium regulation*

The AHMAC Legal Process Reform Group recommends that further work be undertaken to explore better approaches for premium-setting including:

- (a) reducing the number of risk bands;
- (b) provision for premiums based on percentage of incomes (with or without risk banding);
- (c) the use of front-end deductibles in order to achieve a balance between ensuring an adequate risk pool size and equity between doctors in different areas of practice with different income levels.

## Endnotes for Chapter 1

- <sup>1</sup> Strictly speaking, doctors who belong to a MDO pay a 'subscription' rather than a premium. However the expression premium is used throughout this Paper.
- <sup>2</sup> This is likely to include other non-litigation related defence advice and costs associated with defending a claim where no payment is made.
- <sup>3</sup> There had been a difference in VMO pay rates between those states and Territories which covered medical indemnity for public patients and those that did not, with the pay rates for VMOs who had to pay their own medical indemnity being considerably higher.
- <sup>4</sup> *Simpson v Diamond & Anor* [No. 2] [2001] NSWSC 1048 (21 November 2001)
- <sup>5</sup> Much of UMP's larger claims are covered by reinsurance, so the actual financial impact on their own reserves is not clear.

## Endnotes for Chapter 2

- <sup>6</sup> The "discount rate" is the rate by which an amount of lump sum damages is reduced to take account of the fact that the plaintiff receives compensation immediately for losses which occur over a longer time. For more discussion see Chapter 7.

## Endnotes for Chapter 3

- <sup>7</sup> Review of Professional Indemnity for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report* November 1995 Australian Government Publishing Service Canberra: page xv.
- <sup>8</sup> Review of Professional Indemnity for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report* November 1995 Australian Government Publishing Service Canberra: page xvi.
- <sup>9</sup> AHMAC Medical Litigation Working Party *Why Premium Costs have increased for Professional Indemnity in Health Care*, prepared by Fiona Tito, Consultant to the AHMAC Working Party.
- <sup>10</sup> MPS and MDAWA and MDAV were involved in extended litigation over who was responsible for the tail. The matter was finally settled in the later part of 1990s and the data for that period may contain some cases but not all relating to this disputed period.
- <sup>11</sup> See the NSW Supreme Court Professional Negligence List section and the section on Shorter term premium inflationary effects later in the Chapter.
- <sup>12</sup> United Medical Protection *Annual Review 2000-2001*, page 15.
- <sup>13</sup> National Audit Office (UK). *Handling clinical negligence claims in England*. Report by the Comptroller and Auditor General HC 403 Session 2000-2001: 3 may 2001: page 1.
- <sup>14</sup> National Audit Office (UK). *Handling clinical negligence claims in England*. Report by the Comptroller and Auditor General HC 403 Session 2000-2001: 3 may 2001: page 19.
- <sup>15</sup> Australian Accounting Standards Board. Urgent Issues Group Issue Summary 01/11 (Update #2, 5/3/02) *Professional Indemnity Claims Liabilities in medical Defence Organisations*, Appendix J
- <sup>16</sup> Review of Professional Indemnity Arrangement for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995, Table 10.2, paragraph 10.57, page 276.
- <sup>17</sup> United Medical Protection. *Annual Review 2000-2001*, page 32.
- <sup>18</sup> Medical Defence Association of Victoria. *Cover from the bush to the city –Annual Report 2001*, page 6.

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<sup>19</sup> Medical Defence Association of Western Australia. *Annual Report 2001*, page 22.

### ***Endnotes to Chapter 4***

- <sup>20</sup> Wilson RM, Runciman WB, Gibberd RW et al (1991) The Quality in Australian Health Care Study *Medical Journal of Australia* 163: 458–71. Equivalent studies in the US were the Harvard Medical Practice Study in 1984 and the Utah Colorado Study in 1992 and more recently other studies have been undertaken elsewhere. While the figures for the frequency of adverse events has varied, it is accepted that most of this variation is likely to be explained by methodological differences about what was counted, rather than on significant differences in frequency of adverse events.
- <sup>21</sup> Wilson RM, Runciman WB, Gibberd RW et al (1991) The Quality in Australian Health Care Study *Medical Journal of Australia* 163: 458–71; see also Vincent C, Neale G, Woloshynowych M. (2001) Adverse events in British Hospitals: preliminary retrospective record review. *British Medical Journal*, 322(7285): 517-519.
- <sup>22</sup> Harvard Medical Practice Study. *Patients, doctors and lawyers: medical injury, malpractice litigation, and patient compensation in New York. The report of the Harvard Medical Practice Study to the State of New York.* Harvard 1990: page 3.
- <sup>23</sup> PIR (1994) Interim Report, para. 2.60.
- <sup>24</sup> Mulcahey L, Selwood M, Netten A. *Mediating medical negligence claims: an option for the future?* University of London 1999, see Figure 2.1 at page 12 especially.
- <sup>25</sup> Leape L. (1994) Error in Medicine. *Journal of the American Medical Association* 272 (23) 1851-1857.
- <sup>26</sup> Review of Professional Indemnity Arrangements for Health Care Professionals (PIR). (1995) *Compensation and Professional Indemnity in Health care – A Final Report.* November 1995 Commonwealth Department of Human Services and Health Canberra, para. 5.15-5.16.
- <sup>27</sup> For a good summary of the literature on open disclosure, see the Open Disclosure Project's Literature Review. Walton M. *Open Disclosure to patients and families after medical errors – a Literature Review* November 2001. See especially page 32 and following, which describes research into the patient/family experience of medical error.
- <sup>28</sup> Taskforce on Quality in Australian Health Care. *The final report of the Taskforce on quality in Australian health care.* June 1996 Australian Health Ministers' Advisory Council: paras. 4.26 – 4.28.
- <sup>29</sup> Wu A.(1999) Handling Hospital Errors: Is Disclosure the Best Defence? *Annals of Internal Medicine* 131(12): page 970.
- <sup>30</sup> This statement was in the South Australian Supreme Court decision of *FvR* (1983) 33 SASR at 193, where the Court said "the paramount consideration is that a person is entitled to make his own decisions about his life".
- <sup>31</sup> (1992) 109 ALR 625.
- <sup>32</sup> PIR (1995) Final Report: para. 2.56.
- <sup>33</sup> PIR (1994) Interim Report, paras 6.60-6.66
- <sup>34</sup> PIR (1994) Interim Report, recommendation 20 at para 6.66 and recommendation 35 at para 8.99.
- <sup>35</sup> PIR (1995) Final report, paras 4.51-4.52
- <sup>36</sup> Taskforce on Quality in Australian health care. *The final report of the Taskforce on quality in Australian health care.* June 1996 Australian Health Ministers' Advisory Council : recommendation 30.

- 37 National Expert Advisory Group on Safety and Quality in Australian Health Care. *Implementing safety and quality enhancement in health care – national actions to support quality and safety improvement in Australian health care – Final Report to health Ministers*. July 1999. See page v and section 2.3, from pages 8-10.
- 38 National Open Disclosure Project. *When things go wrong – an open approach to adverse events – Issues Paper*. Prepared by the Public Interest Advocacy Centre. February 2002: see page 3.
- 39 Kraman S, Hamm G. (1999) Risk Management: extreme honesty may be the best policy. *Annals of Internal Medicine*. Vol 131 (12); 963-967: page 964.
- 40 National Open Disclosure Project. *Open Disclosure Project: Legal Review* Prepared by Corrs Chambers Westgarth, January 2002: see section 4.4, page 31 and following.

## Endnotes for Chapter 5

- 41 Review of Professional Indemnity Arrangements for Health Care Professionals. *The Health/Medical Care Injury Case Study Project – A Research Paper*. 1993 Australian Government Publishing Service Canberra: pages 78-79.
- 42 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra: paragraphs 7.14-7.15, page 169.
- 43 Schedule D, clauses 5-8 of the Australian Health Care Agreements 1998-2003 with each State and Territory.
- 44 Commonwealth Attorney-General's Department. *The Justice Statement*. Attorney-General's Department May 1995 Canberra.
- 45 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra: paragraph 8.55: page 210.
- 46 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra: para 5.230. page 132.
- 47 For further discussion of ADR in the medical litigation context, see Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994 Australian Government Publishing Service Canberra: pages 190-195.
- 48 Australian Law Reform Commission. *Review of the Adversarial System of Litigation : ADR - its role in federal dispute resolution*. *Issues Paper* 25 ALRC IP 25. June 1998. Para 2.13, page 23; see also pages 23-33 for discussion of these processes.
- 49 The following paragraphs describing the different ADR processes draws heavily on the general work of the Australian Law Reform Commission in its *Review of the Adversarial system of litigation : ADR – its role in federal dispute resolution* *Issues Paper* number 25, chapter 2: paragraphs 2.15 – 2.49 and adapts this to the medical negligence environment.
- 50 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra, Chapter 8, paragraphs 8.41-8.79, pages 208 - 214.
- 51 Lord Woolf. *Access to Justice – Final Report*. Available on the internet at <http://www.lcd.gov.uk/civil> : Chapter 15, paragraph 50.
- 52 Mulcahy L, Selwood M, Netten A. *Mediating medical negligence claims: An option for the future*. 1999 University of London: page xiv (hereafter Mulcahy)
- 53 Mulcahy, page xviii
- 54 Mulcahy, page 115-116.

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- 55 Supreme Court of NSW Practice Note No. 118.
- 56 Mulcahy, para 8.4, page 105.
- 57 Lord Woolf. *Access to Justice – Final Report*. Available on the internet at <http://www.lcd.gov.uk/civil> : Section1 -Overview, paragraph 9.
- 58 Family Court of Australia. *The Changing Face of the Expert Witness* – Discussion paper.
- 59 Sperling Justice H. “Expert Evidence: The Problem of Bias and Other Things.” Speech at the Supreme Court of NSW Annual Conference at Terrigal, 3-4 September 1999: pages 1-2.
- 60 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra, paragraphs 7.44 and 7.45, page 175.
- 61 Freckelton I, Reddy P, Selby H. *Australian Judicial Perspectives on Expert Evidence: An Empirical Study*. 1999 Australian Institute of Judicial Administration (AIJA) Melbourne
- Freckelton I, Reddy P, Selby H. *Australian Magistrates’ Perspectives on Expert Evidence: A Comparative Study*. 2001 AIJA Melbourne.
- 62 Australian Law Reform Commission. *Managing Justice: A Review of the Federal Civil Justice System*. Report January 2001: pages 418-436. See also, Adversarial Background Paper. *Experts*. Paper Number 6, January 1999.
- 63 Law Reform Commission of Western Australia. *Project 92: Review of the Criminal and Civil Justice System in Western Australia*. 1999: see Chapter 22.
- 64 For a useful discussion of the NSW reforms in relation to expert witnesses, see Abadee Justice A. “The Expert Witness in the New Millennium”. Paper delivered to the General Surgeons Australia 2nd Annual Scientific Meeting, 2 September 2000.
- 65 See National Board of Medicolegal Affairs Annual Report 1994 : 4 and 14-19. The National Board of Medicolegal Affairs can be contacted at Siltasaarenkatu 18 A, PL 265, 00531 Helsinki - phone 0011 358 90 1601, fax 0011 358 90 160 4102.
- 66 Davie Justice G. “The reality of civil justice reform: why we must abandon the essential elements of our system”, Paper delivered at the 20 AIJA Annual Conference, Brisbane, 12-14 July 2002.
- 67 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995 Australian Government Publishing Service Canberra, paragraph 7.57, page 178.
- 68 Sackville Justice R. “From Access to Justice to Managing Justice: the transformation of the judicial role”. Paper delivered at the 20th AIJA Annual Conference, Brisbane, 12-14 July 2002, page 13.
- 69 County Court Rules of Procedure in Civil Proceedings, Order 34A.
- 70 NSW Supreme Court Rules, Part 14C, see also practice note no. 104.
- 71 Abadee Justice A. “Professional Negligence Litigation: A New Order in Civil Litigation – the Role of Experts in a New Legal World and in a New Millennium”. Paper delivered to the Australian College of Legal medicine, 16 October 1999 at Canberra.
- 72 Letter from Ms Burton, 15 August 2002.

### ***Endnotes for Chapter 6***

- 73 Wilson R, Runciman W, Gibberd R, Harrison B, Newby L and Hamilton J. “The Quality in Australian Health Care Study. *Medical Journal of Australia*, vol 163 (9), 6 November 1995, pages 458-471: Box 3, page 465.
- 74 For a detailed summary of cerebral palsy, obstetrics and litigation, please see Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian



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- Government Publishing Service, Canberra: paragraphs 10.24-10.66, pages 270-278 and paragraphs 2.64-2.66 and the endnotes associated with these paragraphs, page 26 and 35.
- 75 Runciman W Moller J. *Iatrogenic Injury in Australia – A report prepared by the Australian Patient Safety Foundation (APSF)*. October 2001 APSF Adelaide: Table 4, page 23. These estimates are very conservative – based on a twice the health care costs estimate, when other data sources referred to that part of the text estimates these non-health care costs at more than three times the level.
- 76 This range is based on Trowbridge estimates of MDO premiums of \$200M (Harrex G, Johnston K. Pearson E. “Medical Indemnity in Australia.” presented to the Institute of Actuaries of Australia XIII General Insurance Seminar, 25-28 November 2001, section 2.8, and an estimate for the public sector of \$220M in payments in Runciman W Moller J. *Iatrogenic Injury in Australia – A report prepared by the Australian Patient Safety Foundation (APSF)*. October 2001 APSF Adelaide, page 24. It is likely that neither of these are accurate to assess claims payments – the Trowbridge premium estimates may or may not accurately reflect claims costs given the underfunding problems in the industry and the basis for the APSF estimate is one states partial experience. There is therefore large interstate variability in claims numbers and costs which could affect the accuracy of this estimate.
- 77 Fleming J G. *The Law of Torts* 6th edition (1983). Sydney The Law Book Company; pages 6-7 and 300.
- 78 For a full discussion of these theories, see the Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra, pages 40-45 and Appendix D, 313-322.
- 79 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra, paragraph 3.29. page 42.
- 80 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraphs 3.40-3.41, page 45
- 81 Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent – A research paper*. May 1993. See also Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraphs 3.34 – 3.39, page 44.
- 82 AHMAC Medical Indemnity Working Group. *Why Premium Costs have increased for Professional Indemnity in Health Care – Background Paper*. Distributed as one of the background papers for the Commonwealth’s Medical Indemnity Forum in Canberra on 23 April 2002: page 1
- 83 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraph 3.45.
- 84 Fleming J. *The Law of Torts*. 5th edition. 1977 The Law Book Company: page 2.
- 85 Daniels S and Andrews L. The shadow of the law : jury decisions in obstetrics and gynaecology cases. from Institute of Medicine. *Medical Professional Liability and the Delivery of Obstetrical Care - Volume II An interdisciplinary review* : prepared by the Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care. National Academy Press 1989 Washington DC : 161-193. In this study, while the success rates in medical malpractice cases which went to trial varied considerably between states and types of cases, the overall success rate for sites with 50 or more cases per year ranged from only 10.3 per cent to 48.2 per cent. In Australia, available data would indicate that the proportion of medical negligence cases where payments are made, whether by judgment or settlement, may be even lower than these figures.
- 86 An example of this sort of case is the *Lowns & Another v Woods* (1996) Australian Tort Report ¶81-376. The single judge initially found one of the defendant doctors negligent on the basis

that he had not advised a mother on the administration of rectal valium for her child who had severe epilepsy. There was evidence that this was not part of Australian specialist paediatric practice at the time of the harm, though it was used overseas in that manner. The drug was not, in fact, authorised by the Therapeutic Goods Administration for rectal administration. On appeal, the primary judge was found to have erred in law, in finding that doctor negligent.

87 While MDOs still generally confirm this, the PIR,s Final Report drew attention to the following study by one of the then Australian MDOs. “In its editorial, the Secretary of the former Medical Defence Union provided the results of a study of claims relating to incidents which occurred in 1985. Only 3% of these cases went to court, and 90% of those which did were resolved in favour of the doctor.” 1994 *Medical Defence Union Journal* 8(4) : 49.

88 (1992) 109 ALR 625

89 *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871 at 881

90 (1983) 33 SASR 189 at 193.

91 (1992) 109 ALR 625 at 631

92 Parliament of Victoria Law Reform Committee. *The Legal Liability of Health Service Providers – Final Report* May 1997 Victorian Government Printer Melbourne: paragraph 2.16, page 13.

93 Parliament of Victoria Law Reform Committee. *The Legal Liability of Health Service Providers – Final Report* May 1997 Victorian Government Printer Melbourne: paragraphs 2.29-2.36; pages 17-19.

94 Letter from Ms P Burton,

95 [1998] AC 232

96 [1998] AC 232 at 241-2.

97 See, for example, the practice at the National Women’s Hospital in New Zealand, under which women who had positive Pap smears were not treated: *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women’s Hospital and Other Related Matters*.

98 Parliament of Victoria Law Reform Committee. *The Legal Liability of Health Service Providers – Final Report* May 1997 Victorian Government Printer Melbourne. The Committee’s recommendations suggested a different standard related to screening programs.

99 (1992) 109 ALR 625 at 634

100 For a detailed discussion of these issues, see Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraphs 2.3-2.11, pages 9-11.

101. National Health and Medical Research Council (NHMRC). *General guidelines for medical practitioners on providing information to patients*. AGPS 1993 Canberra (NHMRC patient information guidelines).

102 NSW District Court, 22 November 1994.

103 NSW District Court, 20 December 1996.

104 [2001]HCA 18, para 159

105 See for example Kirby J in *Chappel v Hart* [1998]HCA 55, para 3

106 [1998] HCA 55, 2 September 1998.

107 See for example Hayne J who commented that in effect the only connection between the failure to warn and the harm suffered by the plaintiff is that “but for the failure to warn she would not have been in harm’s way” see para 120

- <sup>108</sup> House of Lords, 20 June 2002, reported on the Internet at : <http://www.publications.parliament.uk/pa/ld200102/ldjudgmt/jd020620/fchild-1.htm> and cited as [2002] UK HL 22.

#### Endnotes for Chapter 7

- <sup>109</sup> See, eg, *Personal Injuries Proceeding Act 2002 (Qld)*, section 51.
- <sup>110</sup> Australian Bureau of Statistics. *Average Weekly Earnings – Australia*. August 2001. Cat. No. 6302.0: page 1, August 2001 Key Figures.
- <sup>111</sup> Australian Bureau of Statistics. *2001 Census of Population and Housing*. Table B 13 – weekly individual income by Age and Sex.
- <sup>112</sup> Australian Bureau of Statistics. *A Snapshot of Australia 2001 Census Basic community profile and snapshot*: page 3 – Income.
- <sup>113</sup> *Simpson v Diamond (No. 2)* [2001] NSWSC 1048 (21 November 2001) , page 13, Damages summary
- <sup>114</sup> *Simpson v Diamond and Another [No 2]* [2001] NSWSC 1044448 (21 November 2001), paragraph 70, damages summary.
- <sup>115</sup> NSW Law Reform Commission *Accident Compensation – Report on a Transport Accidents Scheme for New South Wales- Vol 1 of 2*. 1984 LRC 43/1: para 11.23 & Table 11.1, pages 279-280.
- <sup>116</sup> *Health Care Liability Act 2001* (NSW), section 13(1).
- <sup>117</sup> These provisions have now been applied more generally to civil claims under the *Civil Liability Act 2002* (NSW).
- <sup>118</sup> *Griffiths v Kerkemeyer* (1977) 139 CLR 161; the concept of market value was confirmed by the High Court in *Van Gervan v Fenton*, 1992 Full Court 92/041, 28 October 1992. 175 CLR 327.
- <sup>119</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraph 4.69; page 83.
- <sup>120</sup> Gibson D, Butkus E, Jenkins A, Mathur S, Liu Z. *The Respite Care Needs of Australians* AIHW Respite Review Supporting Paper 1 – July 1996. See also: Carers Association of Australia, , *Listen to the Carers! The Many Voices of Care*. Report of the National Carers Consultation to the International Year of the Family Council, Canberra 1994: page 30. which reported that after the need for money, respite care was the most important issue for carers.
- <sup>121</sup> Estimated from data supplied by the ACT Insurance Authority to ACT Department of Health
- <sup>122</sup> Estimate provided to the AHMAC Working Group on Medical Indemnity.
- <sup>123</sup> Blair E. Watson L. Badawi N. Stanley F. Life expectancy among people with cerebral palsy in Western Australia. (2001) *Developmental medicine and child neurology*. Vol 43, page 508-515.
- <sup>124</sup> Blair E. Watson L. Badawi N. Stanley F. Life expectancy among people with cerebral palsy in Western Australia. (2001) *Developmental medicine and child neurology*. Vol 43, page 514.
- <sup>125</sup> Colin Bass Human Resources. *Lump Sum Accident Compensation : Volume 1*. 1983, prepared for the NSW Law Reform Commission; NSW Law Reform Commission. *Accident Compensation Research Report 1 : Traffic Accident Case Studies* 1984 NSW Government Printer Sydney; Casey H. Charlesworth S. *Like it or Lump it: A study of workers compensation settlements awarded to Liquor Trades Union members January 1980 to December 1983*. Federated Liquor and Allied Industries Employees Union; Neave M. Howell L. *The Adequacy of Common Law Damages*. University of Adelaide Law School 1992; Law Commission (UK). *Personal Injury Compensation : How Much is Enough? A study of the compensation experiences of victims of personal injury*. Law Comm No 225. 1994 HMSO London.

- 126 COPPA (Carers of Protected Persons Association Inc), *COPPA News*. Interview between Helen Daley and Mascot Blake, mother of actor Jon Blake: at <http://www.coppa.com.au/johnblake.html> accessed on 25 July 2002.
- 127 NSW Law Reform Commission *Research Report 2: Case Study Booklet 1984 RP2* : see for example, para 4.19
- 128 Colin Bass Human Resources. *Lump Sum Accident Compensation : Volume 1*. 1983, prepared for the NSW Law Reform Commission: pages 84-89. The results are also reported in the NSW Law Reform Commission. *Accident Compensation – Report on a Transport Accidents Scheme for New South Wales- Vol 1 of 2*. 1984 LRC 43/1: paras 3.51-3.53.
- 129 Cornes P. *Coping with Catastrophic Injury - a follow-up survey of personal injury claimants who received awards of £150,000 or more in 1987 and 1988*. 1993 University of Edinburgh Scotland
- 130 In some states, there are already provisions allowing courts to award periodic payments that have been in place for a considerable period. These include: the South Australian *Supreme Court Act 1935*, which allows the Court power to enter declaratory judgements for liability and to order the defendant to commence periodic payments to the plaintiff prior to the quantification of full damages; the Western Australian *Motor Vehicle (Third Party Insurance) Act 1934*; and the NSW *Motor Accidents Act 1988*. More recently, additional provisions have been introduced as part of the public liability reform process. Often these provisions are limited to circumstances where both parties consent eg *Civil Liability Act 2002* (NSW), section 22; Queensland *Personal Injuries Proceedings Act 2002*, section 61.
- 131 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraph 4.63. page 81.
- 132 1993, NSW Supreme Court, 9 August 1993, No 12016/88. Reasons for Judgement at page 15.
- 133 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian Government Publishing Service, Canberra: paragraphs 6.39-6.41.
- 134 (1981) 150 CLR 402
- 135 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – An Interim Report*. February 1994. Australian Government Publishing Service, Canberra: paragraph 4.141, page 101.
- 136 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report*. February 1994 AGPS : para 6.103. page 166.
- 137 *Medical Negligence Indemnity Cost Considerations - The Way Forward*. Prepared for Minister Michael Moore and presented to AHMC. April 2000: section 9, page 23.
- 138 Report of the Comptroller and Auditor General. *Handling clinical negligence claims in England*, HC 403 Session 2000-2001 : 3 May 2001: page 1 and Table 17, page 24.
- 139 United Medical Protection. *Annual Review 1999-2000* : page 22.
- 140 Haysom G. "A verdict for the defendant with costs: what does this mean for you?" *United Journal* Issue 1 2001: pages 20-21.
- 141 See, eg, *Personal Injuries Proceedings Act 2002 (Qld)* Chapter 3, Part 1 – restriction on advertising of personal injury services and touting.
- 142 Commonwealth Attorney-General's Department. *The Justice Statement*. Attorney-General's Department May 1995 Canberra: page 49.
- 143 Report of the Comptroller and Auditor General. *Handling clinical negligence claims in England*, HC 403 Session 2000-2001 : 3 May 2001: paragraph 13, page 4.

- <sup>144</sup> See *Legal Practitioners Act 1987* (NSW), Division 5B, sections 198C-1981, see especially section 198D .
- <sup>145</sup> See *Personal Injuries Proceedings Act 2002* (Qld), section 56.
- <sup>146</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian Government Publishing Service, Canberra: recommendation 94.

## Endnotes for Chapter 8

- <sup>147</sup> In a recent High Court case *FAI General Insurance Company Ltd v Australian Hospital Care Pty Ltd* [2001] HCA 38 (27 June 2001) the Court allowed coverage of a claim, where it was not notified within the period of insurance but was known to the insured because of the wording of the contract and because of s. 54 of the *Insurance Contracts Act 1984*, which does not allow an insurer to avoid responsibility solely because of an act or omission of the insured, where to give the insurance contract force would not significantly prejudice the insurer.
- <sup>148</sup> Where insufficient funds are reserved for known claims, these are called “IBNERS” or “incurred but not enough reported” costs. This has also been an issue for the MDO industry, though it appears that they have all successfully addressed this issue.
- <sup>149</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian Government Publishing Service, Canberra: paragraph 9.88
- <sup>150</sup> In Western Australia the Attorney-General has recently recommended that in personal injury cases the limitation period should be six years from when the injury or disease first manifested itself. See Attorney-General’s Departmental Paper, *Limitations Law Reform*, 17 May 2002.
- <sup>151</sup> Report of the Comptroller and Auditor General. *Handling clinical negligence claims in England*, HC 403 Session 2000-2001 : 3 May 2001: Table 12, page 17.
- <sup>152</sup> United Medical Protection. *Annual Review 2000-2001*; page 22: UMP’s data showed a dramatic decrease in the average delay from about 5 years in the early 1990s to just over 12 months in 2000-2001.
- <sup>153</sup> For example, in United Medical Protection’s *Annual Review 1999-2000* (page 19), the average claim settlement delay was said to have dropped from 6.0 years between 1980-89, to 2.9 years 1990-99.
- <sup>154</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report*. February 1994 AGPS: page 231.
- <sup>155</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report*. February 1994 AGPS : page 232.
- <sup>156</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report*. February 1994 AGPS: paragraph 8.90, page 230.
- <sup>157</sup> These points are a summary of paragraphs 9.43-9.48 from Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian Government Publishing Service, Canberra.
- <sup>158</sup> Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995. Australian Government Publishing Service, Canberra: paragraph 10.92-10.100, pages 283-285.
- <sup>159</sup> Review of Professional Indemnity Arrangement for Health Care Professionals. *Compensation and Professional Indemnity in Health Care – A Final Report*. November 1995, Table 10.2, paragraph 10.57, page 276.

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- <sup>160</sup> Harrex G, Johnston K, Pearson E. *Medical Indemnity in Australia* Presented to the Institute of Actuaries of Australia, Xiii General Insurance Seminar, 25-28 November 2001 (the Trowbridge Paper), page 20. Averaged across all Australian doctor members, the average subscription at 30 June 2001 was \$4,100
- <sup>161</sup> This figure was calculated using the Medicare fees and benefits figure for 1998-99 in Australian Institute of Health and Welfare *Australia's Health 2000*, table S48, page 411, of \$7,861.8M fees charged for 206.3M services adjusted for recent HIC usage data for 2000-2001, which showed 213.9M services. Unfortunately the publicly available HIC data does not provide billed income figures – only scheduled benefit figures (which are in fact higher, because of the effect of bulk-billing on GPs). Rather than use the Scheduled Benefits figure, the billed income figure from the AIHW publication was adjusted using the 3.7% increase in service numbers shown. This is a more conservative figure for calculating earnings.
- <sup>162</sup> This will make the need for better links between claims information, registration and conditions upon practice even more manifest.