TORT REFORM AND THE MEDICAL INDEMNITY 'CRISIS'

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For every complex problem there is an answer that is clear, simple, and wrong.[1]

I INTRODUCTION

A perceived 'crisis' in medical indemnity insurance has precipitated a number of legislative changes and other proposals for tort 'reform' intended to deal with the 'problem'.

Many of the legislatively enacted tort 'deforms' and other present proposals seek to achieve a relatively simple solution to what is in reality a complex problem. The first wave of reforms, initially enacted in NSW but now being advocated in other jurisdictions, is intended to curtail, abolish or discount damages entitlements. Such solutions are not only unfair, in that they limit or take away the legal rights of innocent victims of medical negligence, they also fail to deal with the real causes of the crisis. The second wave of 'reforms', including those emanating from the recent *Review of the Law of Negligence Final Report* ('Ipp Report'),[2] seek to restrict rights and remedies. Modifications to the substantive law have been proposed which, if enacted, will turn the clock back on changes in the law of negligence which have developed incrementally over many years by careful and cautious appellate courts, including the High Court.

II CAUSES OF THE 'CRISIS'

Contrary to political and popular rhetoric, and contrary to the views of significant sections of the medical profession, the real causes of the medical indemnity crisis are not:

(a) an unduly benevolent legal system;

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1 H L Mencken.

2 Panel of Eminent Persons, *Review of the Law of Negligence Final Report* (2002).

(b) judges and jurors 'playing Santa Claus';
(c) 'blaming and claiming' victims with unmeritorious claims; or
(d) plaintiffs' lawyers.

The real causes of the medical indemnity 'crisis' are much more complex.

A starting point of any analysis is the volume of claims arising out of alleged medical negligence. It would appear that claim numbers have increased, at least over the past 10–15 years.[3] A broad estimate is that claims have doubled.[4] However, as noted by others, some of this increase is likely to be directly related to the increase in the number of services provided, both under Medicare (up 60 per cent in 15 years) and in hospitals (up 76 per cent in 15 years). Moreover, these statistics need to be seen in the context of the empirical fact that there are still very many more preventable adverse events resulting in harm to consumers where no legal action is pursued.[5]

Conclusions that recent increases in premiums are mainly the result of increased litigiousness among consumers are not supported by empirical data. The reality is that there has been endemic underfunding of liabilities relating to known and anticipated claims for a considerable period of time. This is discussed further below.

Although there is evidence that the quantum of damages for claims has increased, this issue requires careful consideration given that:

(a) future care costs comprise 60–80 per cent of multi million dollar awards;
(b) better medical care means people are more likely to live rather than die;
(c) the population is living longer; and
(d) the maximum awards for general damages have not really increased for over a decade and are relatively low.

The fact is that a number of significant changes in the medical defence organisation/insurance industry have led to substantial premium increases which have precipitated the perceived 'crisis'.

III MEDICAL DEFENCE ORGANISATIONS

According to Dr Richard Tjiong, former Chairman of the Board of United Medical Protection ('UMP'), 'there has been no real ... accountability by ...

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3 Australian Health Ministers Advisory Council Medical Indemnity Working Group, *Why Premium Costs Have Increased for Professional Indemnity in Health Care*, Background Paper (2002).

4 Ibid. See also Paul Nisselle, 'Managing Risk in Medical Practice' (1999) 7 *Journal of Law and Medicine* 130.

5 See Ross Wilson et al, 'Quality in Australian Health Care Study' (1995) 163 *Medical Journal of Australia* 458. See also Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York: A Report by the Harvard Medical Practice Study to the State of New York* (1990); Linda Kohn, Janet Corrigan and Molla Donaldson (eds), *To Err is Human: Building a Safer Medical System* (2000), <http://www.nap.edu/books/0309068371/html> at 21 November 2002.

[medical defence] organisations'.[6] Historically, claims liabilities have not been stated in the balance sheet or the accounts. Many organisations have tended to resort to cash rather than accrual accounting. The only explanation usually offered for steep subscription increases in recent years has been so called claims escalation. Accountability is also lacking with respect to management of corporate affairs, especially management of claims and investment of members funds.

Moreover, historically medical defence organisations have not adopted a uniform minimum standard of accounting for known claims or estimated liabilities.

Regulatory scrutiny has also been lacking. Medical defence organisations, because they are discretionary mutuals rather than insurers, were not covered by the *Insurance Act 1973* (Cth) and have not been monitored by insurance industry regulators, including the Australian Prudential Regulation Authority. By way of contrast, authorised insurers are required to comply with solvency margins and reserve requirements (although the recent collapse of several general insurers appears to indicate inadequate compliance by such companies).

Many if not most medical defence organisations have historically failed to set aside adequate reserves. Moreover, notwithstanding the increase in claims, premiums remained relatively low throughout the 1970s and 1980s. In part this was due to competition amongst medical defence organisations which led to underpricing of premiums to obtain new business from competitors and increased market share. In some instances, these problems were exacerbated by inadequate financial management and, in the case of the largest medical defence organisation, the failure to make provision for incurred but not reported claims. Further difficulties arose out of increased prudential margins imposed by regulators and the financial collapse of reinsurers (for example HIH). As the annual report of the Medical Defence Association of Western Australia notes:

> Under funding can easily be dismissed as the result of claims costs being unpredictably high ... the legal profession is also targeted as an additional cause. However, underfunding may also be caused by poor business operations and inadequate advice on subscription pricing.[7]

Recent accounting provisions for incidents incurred but not reported ('IBNRs') has artificially created or exacerbated the so called insurance 'crisis'. It is only in recent years that some medical defence organisations have started to bring their IBNR liabilities to account in their financial statements. UMP did not made any provision for IBNR liabilities in its financial accounts published to 2001. However, the attempt to make provision for potential *future* claims has led to a substantial increase in estimated claims liabilities and the consequential call on UMP members who were required to pay an additional years subscription over five years. This reinforced political pressure for tort reform measures which have the effect of taking away the rights of victims in order to reduce insurance

6 Richard Tjiong, *Medical Indemnity Reform: Position Paper* (2001) <http://www.unitedmp.com.au/800/Tort/position.htm> at 30 March 2001.

7 Medical Defence Association of Western Australia, *Annual Report* (2000), quoted in Janine Mace, 'Making Sense of the MDO Market', *Australian Doctor*, 23 February 2001, 43, 45.

premiums payable by doctors. The belated accounting provision for IBNRs is one of a number of factors which would appear to have precipitated the recent 'crisis'.

These problems were compounded by a decline in investment earnings due to market and economic factors. The events of 11 September 2001 have had an adverse affect on investment earnings and international reinsurance costs. Most insurers, including medical indemnity insurers, derive substantial income from earnings on investments. Due to general changes in economic circumstances, investment earnings have declined rapidly in recent years and the impact of this has been felt not only by insurers but by the investment community generally, including superannuation funds which have recently had negative returns.

Decline in investment earnings has been effected not only by the decreased rate of earnings on funds invested but by a reduction in the period during which claims reserves were held pending resolution of claims. Improvements in the administration of justice and more efficient case management have led to an increase in the rate of claims processing by courts. Not long ago it was reported that medical indemnity cases took an average of nine years to resolve.[8] Between 1980 and 1989 it has been reported that the average claims settlement delay period was six years. This period apparently shortened to 2.9 years for the period 1990–99. In New South Wales cases can now be heard in the District Court much more quickly. Cases in the Supreme Court are now also being resolved much more expeditiously.

As recently noted in *Australian Doctor* 'in the past, slower claims settlement meant more time to accumulate funds to pay and allowed inflation to reduce the cost'.[9] As the same author notes, faster claims settlement means less return on investment of premiums and member subscriptions.[10]

A further factor has been the spiking of claims as a result of foreshadowed legislative change. Claims which historically would have taken some significant time to investigate prior to a decision to commence legal proceedings have been accelerated in order to ensure that proceedings were commenced prior to the legislative curtailment or abolishment of rights.

IV SYSTEMIC PROBLEMS IN THE HEALTH CARE SYSTEM

In considering the medical indemnity 'crisis' it is important to bear in mind that claims do not just arise out of allegedly negligent errors of individual professional judgment. In many instances, systemic problems are the cause of avoidable injury and resulting litigation. Many hospitals, both public and private, and medical practices have not developed adequate procedures designed to reduce or avoid the risk of injury.[11]

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8 Tjiong, above n 6, citing a 1995 paper by O'Dowd.

9 Mace, above n 7, 43–6.

10 Ibid.

11 See, eg, Lionel L Wilson and Max Fulton, 'Risk Management: How Doctors, Hospitals and MDOs can Limit the Costs of Malpractice Litigation' (2000) 172 *Medical Journal of Australia* 77.

In many instances where claims arise, issues of informed consent become problematic in the absence of reliable records of communication concerning risk. When an event occurs, many doctors do not provide frank disclosure of how and why things went wrong. This failure of disclosure is compounded by an unwillingness to say sorry. The culture of concealment has been fostered by medical indemnity insurers and their lawyers, on the legally specious premise that somehow saying sorry translates into an admission of 'legal' responsibility or liability. The problem is exacerbated by the refusal of doctors in private practice to provide access to medical records and reports. The attempt to find a judicial solution to this problem failed.[12]

V OTHER FACTORS AFFECTING THE COST OF CLAIMS

Once a claim has been notified or once litigation has been commenced, all too often meritorious claims are defended without justification or settled only after substantial costs have been incurred.

Also, claims costs include costs incurred in relation to matters other than professional negligence, including a variety of legal services provided by medical defence organisations to doctors in respect of overservicing, fraud and allegations of sexual impropriety. A significant amount of the expenditure is incurred in providing legal and other services to members of medical defence organisations unrelated to civil claims for negligence. These services include the provision of assistance in relation to complaints to the Health Care Complaints Commission; the investigation of complaints in relation to overservicing; disciplinary proceedings; coronial inquiries; complaints and other proceedings arising out of alleged sexual misconduct with patients relating to ethical matters and misconduct. UMP provided a 24 hours a day, seven days a week hotline for its members. The cost of providing services in relation to these matters are included in the costs incurred by medical defence organisations which have led to the so called 'crisis'.

Another factor which has contributed significantly to the perceived 'crisis' is the way in which medical indemnity premiums have been rated. Historically, most medical defence organisations charged each member the same premium for cover. In recent years, concerns about cross-subsidisation have led to substantially increased premiums for certain specialist groups at high risk of claims or at high risk of large claims. Certain specialty groups have been levied premiums which are more than 20 times higher than the average premium for professional indemnity cover for doctors. This has served to undermine one of the fundamental rationales for insurance: the spreading of cost. Moreover, in setting premiums, no adequate allowance is customarily made for either the income of the insured doctor or the volume of services provided by him or her. Thus, the method of premium rating has exacerbated the pain for various specialist groups who have become extremely vocal in their campaign for

12 *Breen v Williams* (1996) 186 CLR 71.

reform. The increased cost of indemnity insurance for such groups has been made worse by restrictions on income, including through the failure of Medicare rebates to keep up with inflation, and restrictions on the ability to pass on the cost directly to patients.

A further problem is that most medical indemnity insurers have not required payment of an excess when a claim is made, unlike most other categories of insurance. Additional financial problems have arisen out of bad management practices by those conducting the business of some medical defence organisations and reinsurers. The cumulative effect of these economic, accounting, insurance and management factors has led to the present medical indemnity 'crisis'.

VI THE ROLE OF LAWYERS

Whilst it is true that changes in the substantive law, an increased willingness on the part of lawyers to take cases on a speculative basis and an increased awareness of legal rights on the part of patients have all played a part in the genesis of claims for compensation, such developments are neither the real cause of the 'crisis', nor problematic in policy terms.

However, the perception amongst certain sections of the public and the medical profession, which is shared by some ill-informed politicians, is that there has been a litigation explosion, that damages are out of control, and that people sue for 'falling off chairs' (Joe Hockey) or 'at the drop of a hat' (the Prime Minister). The media all too frequently portray plaintiffs as the winners of jackpots in a forensic lottery. Judges and juries are all too often subject to ill informed criticism for making unduly generous awards to undeserving plaintiffs. This compensation culture is said to be fostered by greedy, unethical and ambulance chasing plaintiffs' lawyers. According to a recent editorial in the *Daily Telegraph*, it is the 'unbridled avarice of lawyers that has fuelled the current crisis in professional indemnity and public liability insurance'.[13] Such perceptions have driven the war on the rights of innocent victims and on plaintiffs' lawyers.

As in any war, the first casualty is truth. Some politicians appear to have followed the practice of the British War Office during the Second World War. As Herbert Asquith observed, the War Office had three sets of figures. One to mislead to public, the second to mislead the cabinet; and the third to mislead itself.[14]

The public, the medical profession, and some politicians have been clearly misled as to the causes of the present medical negligence 'crisis'. Neither innocent victims nor plaintiffs' lawyers should be singled out for blame or punishment. Plaintiffs' lawyers often play an important, but seldom acknowledged, role in screening out unmeritorious and low value claims,

13 'Henry Had a Remedy for the Lawyers', Editorial, *Daily Telegraph* (Sydney), 13 August 2002, 14.

14 Alistair Horne, *The Price of Glory: Verdun, 1916* (1962) ch 2.

facilitating the settlement of meritorious claims and explaining to patients what went wrong and why. In many instances, claims which may have otherwise been brought against members of the medical profession are directed to drug companies which have been held responsible for injuries arising out of defective drugs and therapeutic devices.

Contrary to much of the bad press about litigation, medical negligence and product liability litigation has improved clinical standards, served as a deterrent to negligent conduct, accelerated the pressure for quality control and risk management practices, diverted the forensic focus from the medical profession to drug companies, and led to the removal of numerous dangerous drugs and devices from the market. It also serves to recoup costs otherwise borne by health and welfare organisations and victims' families. Notwithstanding this reality it has become politically fashionable to blame victims, plaintiffs' lawyers and the legal system for various insurance 'crises', including the current medical indemnity crisis.

VII CONCLUSION

Some politicians appear to have a propensity for pursuing apparently simple solutions to complex problems. The abolishment or curtailment of the rights of innocent victims of injury negligently inflicted by others is neither fair nor a solution to the problem. Particularly unfair is the attempt by some sections of the media, aided and abetted by an army of lobbyists and public relations consultants engaged by the insurance industry, to blame plaintiffs and their lawyers. The real causes of the medical indemnity crisis are apparent to those with an interest in the reality rather than the rhetoric. The truth is that the current crisis has primarily arisen out of a variety of complex commercial and economic factors.

The present politically expedient 'solution' to the problem, which involves the taking away or the erosion of the rights of innocent victims of medical negligence and the scapegoating of their lawyers is misguided. An appropriate political response to the medical indemnity crisis requires the real issues to be addressed rather than blaming lawyers or taking away the rights of innocent victims. Moreover, as Dr Richard Tjiong has observed: 'A responsible profession such as the medical profession ought to own up to its obligations to compensate patients for the true negligence of its members'.[15]

15 Tjiong, above n 6.