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### Litigation and the medical indemnity crisis

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*The medical indemnity crisis in Australia forced doctors, lawyers and insurers to re-appraise the way they handle claims for compensation for medical error. This article examines some of the new approaches available in Australia when patients claim compensation from their doctors.*

Doctors and lawyers may argue whether it was the lawyers or the doctors who caused the medical indemnity crisis, but it is clear beyond argument that both professions share responsibility for fixing it. The insurance industry has a key role as well. In responding to the crisis, the State and Commonwealth Governments have declined to introduce no-fault coverage for injuries caused by medical error. This means that, for better or for worse, medical negligence litigation will continue, albeit with some modifications to the law of professional negligence. The medical profession has no alternative but to make the most of this state of affairs. How can that best be done? The article describes an approach to handling claims for compensation for injuries caused by medical error. The approach is capable of reducing the cost of handling claims, reducing the cost of settling claims and making the experience of dealing with claims more palatable for doctor and patient alike.

#### Medical error

Medicine is not an exact science. The trust which the community reposes in its doctors is not diminished by the fact that patients are injured as a result of medical error. Most of the community understands the complexity of the doctor's task and accepts that mistakes sometimes happen in the best-regulated environments.

The following information about medical error gives context and background to the suggestions which follow.

- "Adverse events" resulting in disability or a longer hospital stay were found to have occurred in 16.6% of 14,000 hospital admissions to 28 hospitals in New South Wales and South Australia in 1992.<sup>1</sup> The adverse events were attributed to "a wide range of human and system-based failures". Half of the adverse events may have been preventable.<sup>2</sup>
- A similar study conducted in the United States found adverse events in 3.7% of admissions.<sup>3</sup> In the United Kingdom, the Department of Health estimates that adverse events occur in around 10% of admissions, with around half of these preventable.<sup>4</sup>
- According to the Chief Medical Officer of the United Kingdom, if the current level of mis-prescribing of antibiotics for respiratory infection were accepted in the airline industry, there would be a 1,000-fold increase in the risk of dying in an air crash.<sup>5</sup>
- Results such as these, which have only become available in the medical literature in the last 10 or 12 years, have led to the recognition that error in medicine and medical injury are widespread problems, which must be addressed systematically for the benefit of patients and doctors alike.<sup>6</sup>

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- Adverse events are more common in some specialties than in others. In Australia, claims for negligence against obstetricians were in the order of 10 to 15 times more common than claims against non-procedural general practitioners. For neurosurgeons and orthopaedic surgeons, claims were 15 times more common than for non-procedural general practitioners.<sup>7</sup> Corresponding Australian data for anaesthetists are not available,<sup>8</sup> although the results of the Quality in Australian Health Care Study suggest that adverse events were far less common in anaesthesiology than in surgery, obstetrics or gynaecology.<sup>9</sup>
- Many doctors accept that the medical tradition that doctors are infallible must be set aside: "Physicians and nurses need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of systems flaws not character flaws."<sup>10</sup>
- There are many ways of characterising the causes of medical error. If a patient is injured because he or she receives a wrong dose of medicine, the injury may be characterised narrowly as the result of the carelessness of the nurse who administered the wrong dose, or it may be characterised more broadly as a system error, brought about by the fact that the nurse had worked a double shift, or been instructed to look after more patients than he or she could safely handle.<sup>11</sup> This characterisation process may determine who is the correct defendant, if litigation follows. "Interesting times would indeed be ahead if lawyers sued those they perceived as truly responsible for adverse events, rather than the staff with immediate responsibility for the care of the injured patient."<sup>12</sup>
- Treating a medical error as an occasion to criticise, punish or comment adversely on the individuals involved may be counterproductive. Pressure to be perfect may lead doctors or staff to deny that errors occur, or to cover them up when they do occur.<sup>13</sup> The airline industry uses error reports as a means of improving safety. Pilots are encouraged to report errors, without risk of penalty. Responding to error reports plays a large part in maintaining airline safety.<sup>14</sup>
- Patients who suffer medical injuries are not necessarily intent on suing their doctors. Many continue to hold their doctors in high regard, despite their injury. In one survey of patients who sued their doctors, 41% of the patients might not have taken legal action if the doctors had responded more directly to their initial complaint. Most wanted an explanation and an apology. Many wanted the mistake corrected, so that it would not be repeated with other patients. Some wanted no more than an admission of negligence.<sup>15</sup>
- Many claims for compensation for medical error fail. A British study of 500 claims found that 46% of the claims were based on "misguided allegations".<sup>16</sup> If the study is representative, litigation may not be a satisfactory avenue for patients injured by medical error.
- A total of 95% of civil cases settle. Medical negligence cases are no exception to this rule. Only one case in 20 runs to a verdict.

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- Legal defence costs paid by Australian medical defence organisations (MDOs) in the decade to 2001 were between 25% and 50% of damages paid.<sup>17</sup> These costs include plaintiffs' costs borne by the MDOs.
- In the United Kingdom, legal defence costs incurred by the National Health Service (NHS) Litigation Authority in 2002-2003 were 10% of damages paid, down from 13% in 1995.<sup>18</sup> Whilst it is not entirely clear, the NHS figures probably do not include plaintiffs' costs.
- It would be highly surprising if plaintiffs' costs paid by the NHS were as high as defence costs, but if they were, total defence costs incurred by the NHS in 2002-2003 would have reached 20% of damages paid, still well below the Australian figures.

## Australian conditions

The insurance crisis is a worldwide phenomenon, but it is significant that local conditions have contributed to the medical indemnity crisis. These local conditions include the structure of the medical negligence insurance industry, the structure of the Australian medical profession and the Australian law covering compensation for injuries caused by medical error.

### The medical defence organisations

Historically, most Australian medical negligence cover has been provided by MDOs. One of the largest, United Medical Protection Ltd, failed under pressure from many different events. These included the increase of claims following the enactment of the *Health Care Liability Act 2001*

(NSW) ; an increase in the level of damages being awarded by the courts; the collapse of HIH Insurance Ltd, a major Australian insurance company; the "insurance crisis" which followed the 11 September terrorist attacks; failure to make adequate provision for future claims, including IBNR claims;<sup>19</sup> and problems with pricing and reserving.<sup>20</sup>

The MDOs commonly saw their roles as advancing the interests of members of the medical profession, when market conditions meant that the mutual structure and approach were of doubtful viability in Australian conditions. The constitution of United Medical Protection, for example, characterised litigation against members as an attack on their "professional character or interest" from which members must be protected, supported and safeguarded.<sup>21</sup>

Many MDOs were inclined to treat litigation by a patient claiming to have suffered a medical injury as an attack on the professional character or interest of the member involved, rather than as a claim for compensation for injuries which may have been caused by poor treatment. What drove their response to claims was the perceived need to defend the medical profession from unfair attack.<sup>22</sup>

Such an approach contrasted starkly with the approach which a professional negligence insurer, not bound by a charter to protect the interests of a profession, would take. It meant that factors other than the harsh economics of an insurance business influenced the manner in which the MDOs ran their businesses.

Patients with medical injuries who seek to recover compensation for their injuries are not mounting attacks on the medical profession. Their plight is an unfortunate fact of medical life, which needs to be addressed and resolved in a professional manner. In this regard, the medical profession is no different from any other profession.

### Structure of the Australian medical profession

The structure of the medical profession in Australia also contributed to the crisis. Most Australian doctors operate small, independent practices. The practices are not financially strong. They cannot

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fund sophisticated risk-management programs. They cannot afford to institute expensive quality control programs. They cannot afford large increases in professional negligence insurance premiums. Individual doctors are not readily amenable to control by management, or to risk-management disciplines, such as those which can be imposed in large accounting or legal practices.

The position in Australia may be contrasted with that in the United Kingdom. Whatever view is taken of the British National Health System, the central controls available in that system do permit management to assert tighter control over all aspects of management of the risk of medical injury. The English health authorities are also able to control the handling of claims for compensation for medical injury more directly than is possible in Australia.

The acceptance that there is a medical negligence crisis in Australia creates opportunities to drive changes which will help solve the crisis.

### Australian law

Whilst the enactment of the *Civil Liability Act 2002* (NSW) and the progressive enactment of similar legislation in other States and Territories will create a more favourable legal environment for doctors sued by patients seeking damages for medical injuries, it is not a panacea.

The reinstatement of a limited form of the *Bolam* test will make it more difficult for patients to prove the existence of a duty of care in some contentious cases. However, the new test does not apply to failure to warn cases – a significant limitation, given that [Rogers v Whitaker](#)

(1992) [175 CLR 479](#)<sup>[PDF]</sup>, *Chappel v Hart* (1998) [195 CLR 232](#)<sup>[PDF]</sup> and *Cattanach v Melchior* (2003) [77 ALJR 1312](#)<sup>[PDF]</sup> were all failure to warn cases.

The legislation will lead to a reduction in the quantum of damages awarded of, perhaps, 20%.

The legislation contains a dispensation for the making of apologies, which, properly managed, could have the effect of heading off many cases before lawyers become involved.

Amendments to the *Legal Profession Act 1987* (NSW) limiting the costs payable to lawyers on claims where the verdict is less than A\$100,000 will discourage small claims, and make it easier to settle claims falling around the A\$100,000 margin.

This legislation probably represents the limit of what the State Governments will be prepared to do to modify the common law covering compensation for medical injury.<sup>23</sup> There are opportunities for insurers to adapt their claims-handling procedures to capitalise on the opportunities offered by this new legislation.

## Approaches to claims for compensation

In response to the medical indemnity crisis, Australian doctors, lawyers and insurers have had to review their approach to the resolution of claims for compensation for medical error. This article discusses new approaches that are available, that have been adopted or that are under consideration. The discussion covers eight areas:

- handling initial complaints;
- immediate case evaluation;
- consultation when litigation is threatened;
- cooperation with patients and their lawyers;
- alternative dispute resolution and other settlement techniques;
- the decision to defend a claim in court;
- the future role of the MDOs; and
- driving premiums down.

Each of these elements is discussed in turn.

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### Handling initial complaints

There is evidence that many patients would not sue their doctors if their initial complaints were handled better. Historically, doctors have been reluctant to deal frankly and openly with initial complaints for fear of making admissions. Doctors feared that admissions might be used against them in litigation. Worse still, their insurers might decline to cover them if the admissions compromised defence rights. These fears made doctors reluctant to explain to patients what had caused their injury, or to apologise for what had happened.

In the United Kingdom, the NHS Litigation Authority recognised that the refusal to apologise and explain could do more harm than good. In 2002, it issued a circular in the following terms:

The NHS Litigation Authority will not decline indemnity or take any point against a member on the basis of an apology, explanation or expression of sympathy made in good faith.

It seems to us that it is both natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives and to express sorrow or regret at the outcome. Such expressions of regret would not normally constitute an admission of liability, either in part or in full, and it is not our policy to prohibit them, nor to dispute payment, under any scheme, solely on the grounds of such an admission of regret.

Patients and their relatives increasingly ask for detailed explanations of what led to adverse outcomes. In this respect they are no different from their equivalents in any other field. Closely linked to this desire for information is the frequently expressed view that they will feel some consolation if lessons have been learned for the future.

Whether this circular reflected a view of the law, or was merely the result of a commercial approach to resolving claims quickly, is not clear. Certainly, as a self-insurer, the NHS is freer to make concessions such as these than a regular insurer, with obligations to reinsurers. However this may be, it is difficult to dispute the NHS's view that patients who suffer medical injuries are entitled to an explanation and an expression of sympathy, whether fault is accepted or not.

Making an apology often implies acceptance of fault, whereas an explanation does not necessarily signify that any fault is accepted.

The evidence that litigation will be reduced if explanations are given and apologies made suggests that it would be beneficial if a version of the NHS policy could be implemented in Australia. Removing the fear of making apologies and giving explanations will go a long way towards preserving good relations between doctor and client and, in turn, to facilitating early settlement of valid claims.

The legislation enacted in New South Wales in response to the Ipp Reports provides that evidence of an apology is not admissible as evidence of the fault or liability of a doctor who makes the apology. "Apology" includes any expression of sympathy or regret, whether or not the apology admits or implies an admission of fault.

In New South Wales, there no longer appears to be any legal reason to avoid making apologies. Doctors faced with complaints from patients who have suffered medical injuries should be trained and encouraged to make apologies and give explanations, as appropriate.

This new practice will need to be clarified and explained. It will probably be necessary to include reference to the policy in the insurance policies which the MDOs will now be required to issue. It may be necessary for reinsurers to approve and endorse the new policy.

Care needs to be taken making apologies in other States and Territories. The legislation of some other States and Territories defines "apology" to exclude apologies which make or imply an admission of liability.

Overall, the adoption of this policy will place greater responsibility on individual doctors to improve the way they handle initial complaints.

It would be also valuable if doctors could be retrained in the handling of initial complaints.

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### **Immediate case evaluation**

If a complaint is not resolved at the stage of the initial complaint, and further action is required to resolve it, immediate evaluation of the claim is the next step in the suggested approach.

Immediate evaluation is a form of triage. It separates claims into three categories:

- those which will be defended on the issue of liability (category 1);
- those which will not be defended on the issue of liability (category 2); and
- those which require further investigation before being allocated to category 1 or category 2.

In many cases, the correct category will be readily apparent. Cases which require further investigation should be investigated promptly. When all relevant material has been gathered, they should be allocated to their correct category without delay.

As a general rule, cases which are difficult to categorise after investigations have been completed should be allocated to category 2, meaning that they will not be defended on the issue of liability.

Plaintiffs must only prove their cases on the balance of probabilities. This means that, when considering what happened in the past, civil courts treat anything that is more probable than not as certain.<sup>24</sup> This loads the dice in favour of plaintiffs.

Getting the triage process right is a key to containing legal costs. Nothing consumes legal costs faster than choosing the wrong cases to defend. Choosing the right cases to settle, and settling them quickly, keeps legal costs to a minimum. These are vital considerations when legal costs have been as much as 50% of damages paid by Australian MDOs.

There is only one basis for the decision to categorise a claim: will the patient be able to prove her or his claim in court?

There is no special treatment for claims that are thought to amount to a slur on the doctor's professional character or reputation. The doctor's account of the facts of the claim will be vital to the decision to categorise the claim, but her or his feelings about the claim, or the patient, however understandable they may be, carry little or no weight in the decision to categorise.

There is no category for cases which will probably not be defended at trial, but which will be defended for a while to apply pressure for settlement. Almost invariably, the amount spent on defending such cases will exceed the amount by which the settlement can be reduced.

At the time of categorisation, a preliminary estimate should be made of the amount that the court is likely to award as damages if the claim succeeds. This estimate should include damages, interest and an estimate of legal costs of the plaintiff and the defendant.

The immediate evaluation of the case is the foundation for future action to resolve the case.

### **Consultation when litigation is threatened**

When litigation is threatened, it is generally wrong to wait for the patient to commence legal proceedings to deal with the case.

Commencing proceedings costs money for the patient and, ultimately, the doctor. Positions become needlessly entrenched when allegations are formalised, as they must be when the statement of claim is drawn. Further, when litigation is commenced, control of the dispute passes from the parties to the court. All of these factors make it more difficult, and more expensive, to settle. Given that 95% of cases will settle, it is vital to eliminate all avoidable barriers to settlement.

In the United Kingdom, a Clinical Disputes Forum has been established with the backing of the Department of Health, the NHS, lawyers representing plaintiffs and defendants, the Lord Chancellor's Department, the Legal Aid Board and other interested organisations. The aim of the Forum is to find less adversarial and more cost-effective ways of resolving disputes about health care and medical treatment.

The Forum has established a protocol for the resolution of clinical disputes before litigation is commenced. The aims of the protocol are to restore or maintain the doctor-patient relationship and to resolve as many clinical disputes as possible without litigation. The protocol aims to encourage open

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communication about the dispute, establish a timetable for exchanging information to enable the parties to deal effectively with the dispute, and to promote awareness of the options available for resolving disputes. The elements of the protocol are:

1. A procedure is established by which patients may request copies of their medical records. Copies must be provided within 40 days of the request. The request is made on a standard form which outlines the general nature of the claim. This puts the doctor or hospital on notice of the claim, allowing them to commence investigating the claim.
2. If, following receipt and analysis of the records, the patient decides to proceed with a claim, the patient must send a letter of claim, again following a standard form. The standard form requires the patient to identify the treatment in question, the negligence alleged, the injuries and disabilities alleged and to outline the likely value of the claim. The form encourages the patient to offer suggestions for the resolution of the claim.
3. The protocol provides that proceedings should not be issued until three months after the letter of claim. This allows the doctor's insurer time to investigate the claim, and respond to the letter of claim.
4. The response to the letter of claim also follows a standard format. It must be a reasoned answer to the letter of claim. The doctor is encouraged to make any admissions at this early stage. In appropriate cases, the doctor may suggest a process for settlement, or make an offer of settlement.
5. Both parties are encouraged to explore settlement before proceedings are commenced. The protocol encourages the use of alternative dispute resolution.
6. The exchange of correspondence under the standard forms endorsed by the protocol is not made on a without prejudice basis, although any settlement discussions which ensue will be without prejudice.
7. In the United Kingdom, it is suggested that the court may impose sanctions on claimants who commence proceedings without following the pre-litigation protocol.

The protocol places the doctor's insurer in a position to investigate, assess and settle every claim before litigation is commenced. It is a valuable way of reducing legal costs.

A similar system is already followed in the Supreme Court of South Australia. Under r 6A of the *Supreme Court Rules (SA)*, a prospective plaintiff must give the defendant 90 days' notice of the proposed claim. The notice must give sufficient detail of the claim to allow the defendant a reasonable opportunity to settle the claim before it is commenced. This rule is said to have been very successful in resolving professional negligence claims.<sup>25</sup> The Ipp Report recommended its adoption in all jurisdictions in which a significant number of professional negligence actions are brought.<sup>26</sup>

There is no need to wait for courts to act on the recommendation. Australian MDOs could introduce a similar protocol in Australia by notifying plaintiffs' lawyers of its willingness to follow the protocol and inviting them to follow the protocol.

It would be more ambitious to seek to develop a consensual protocol, involving the court and other groups with similar interests to those represented in the Clinical Disputes Forum, but such a course would have the advantage of official endorsement.

**Cooperation with patients and their lawyers**

A protocol such as that adopted in the United Kingdom will only succeed if there is goodwill between patients and their lawyers and defendants and their lawyers and insurers. The level of animosity associated with the litigation of medical claims is well documented. The elimination of mistrust in health care disputes is one of the stated purposes of the United Kingdom protocol.

Elimination of mistrust not only reduces the "heat" in disputes, it produces financial benefits, because cases settle earlier, with consequent savings in legal costs. In this way, co-operating with patients and their lawyers makes good business sense for medical negligence insurers.

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### Alternative dispute resolution and other settlement techniques

Once litigation is threatened, the incidence of legal costs frequently makes settlement imperative. That is not to say that the defendant must always pay – far from it.

A defendant who has taken advantage of pre-litigation procedures to make an immediate evaluation of the case, but who has failed to settle the case before litigation is commenced, is in a position to make a payment into court. This shifts the burden of legal costs to the plaintiff. If the plaintiff does not achieve a verdict greater than the amount paid into court, the plaintiff will be ordered to pay the defendant's legal costs from the date of the payment.

This is but one example of the techniques available to encourage settlement. Alternative dispute resolution can also be used to encourage settlement. These techniques share one common element: they rely for their success on diverting money that would otherwise be spent on legal costs into payment of a settlement. They are, therefore, more effective the earlier they are used in the case.

Immediate case evaluation, pre-litigation protocols and the use of the techniques of alternative dispute resolution are all tools to facilitate the early resolution of cases. Used properly, they offer an opportunity to make large savings in legal costs.

### The decision to defend a claim in court

All litigants constantly confront one decision: is it better for me to settle now, or to push on to a hearing? In order to answer this question, litigants must assess how much money they will have to pay, or how much money they will receive, after all the costs have been paid. This is an important exercise, as costs awarded by a court are never a complete indemnity. When the court orders the losing party to pay the victor's costs, the amount which must be paid is often only half of the costs which the victor must pay her or his own lawyer.

Take the example of a woman who sues her surgeon. If she makes out her case, the proper verdict will be A\$150,000. Assume that both parties will pay their own lawyers A\$40,000 if the case runs to verdict, and that the court will order the defendant to pay the plaintiff's costs in addition to the verdict. If the costs payable under the costs order are 50% of the costs paid, and the plaintiff wins, her net recovery will be A\$130,000. If the plaintiff loses, she will be out of pocket by A\$60,000 (own costs of A\$40,000 plus defendant's costs of A\$20,000).<sup>27</sup> The knowledge that the best result, if the trial runs, is a win of A\$130,000 and the worst result is a loss of A\$60,000 affects the plaintiff's approach to settlement before trial.

The defendant's approach to settlement is similarly affected by costs. The defendant in this example will need to recognise that, if he or she loses at trial, the result will be a loss of A\$210,000 (verdict of A\$150,000, own costs of A\$40,000 plus plaintiff's costs of A\$20,000). The best result is a loss of A\$20,000 (own costs of A\$40,000, less costs recovered from the plaintiff of A\$20,000).

Knowing what the result of litigation will be after all the costs have been paid, the litigants should ask themselves, "Why can't we get that result today?" The answer to that question depends on economics, not emotion.

Legal costs are a key economic indicator. The plaintiff must risk losing A\$60,000 in order to win A\$130,000. The defendant wants to disprove the plaintiff's allegations, but that will cost at least A\$20,000, and may cost A\$210,000 in the worst case. Properly advised, neither party may wish to roll these financial dice.

Assessments of the prospects of success are another key economic indicator. These assessments will often depend on the views of the expert witnesses. The assessments must take account of the unpredictability of litigation. The surgeon and her or his insurers must also take account of three additional factors:

- the plaintiff has suffered a serious injury;
- the plaintiff has the advantage that she need only prove her case on the balance of probabilities; and

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- the judge will know that the surgeon is backed by an insurer.

In the words of Justice Michael Kirby:

Medical practitioners tend to see malpractice cases as involving a moral blight or stigma upon the practitioner concerned. From the point of view of the patient (and most lawyers), however, the issue is usually more basic. It is whether a person who has suffered in some way as a result of medical or hospital procedures will be cast upon the genteel poverty of the social security system or be entitled to recover compensatory damages from the medical practitioner's insurance. To gain insurance, the practitioner must pay premiums. These premiums become part of the costs of medical practice. In this way, all patients bear the cost of, and contribute to, the fund from which are paid damages when things go wrong.<sup>28</sup>

The current crisis has driven home the truth that it is possible to squeeze the insurance lemon so hard that premiums become unaffordable, and the fund for payment of damages disappears. Chief Justice Spigelman has drawn attention to the problems which have developed from the law of negligence being driven from compassion and "welfare state paternalism", without giving adequate weight to the principle that an individual should take responsibility for her or his own actions.<sup>29</sup>

The approach advocated by Kirby J probably has fewer followers now than it did in 1995 when he first expressed it, but it would be wrong to conclude that compassion, or even "welfare state paternalism", had disappeared from the legal system. Sympathy for an injured plaintiff will always be a factor in negligence litigation.

When considerations such as these are factored into the insurer's assessment of the case against the surgeon, the insurer may well reach the decision that a settlement made good economic sense. Equally, the patient may moderate her expectations of the case in order to avoid the risks of an adverse costs order.

By this process, agreement may be reached that it is reasonable for both parties to settle on a figure in the range from, say, A\$80,000 to A\$100,000. A settlement before litigation saves both parties paying a total of A\$80,000 to the lawyers. This not only eases the pain of the litigation experience, it demonstrates the critical importance of exploring settlement fully before substantial legal costs have been incurred.

Settlement is the outcome of most litigation. In fact, 95% of cases settle without going to verdict. This statistic shows that the litigant's question – Is it better for me to settle now, or to push on to a hearing? – must be answered in the context that it is almost certain that the litigant will agree to settle at some stage of the case.

### The role of the MDOs

Now that the MDOs are under the supervision of the Australian Prudential Regulation Authority, and are required to provide professional indemnity cover in the form of a contract of insurance, they will need to take on the mantle of a professional indemnity insurer. As previously discussed, there is an inconsistency between the MDOs' characterisation of claims for damages for medical injuries as attacks on the "professional character or interest" of medical practitioners and their playing the role of a professional indemnity insurer.

If it is accepted that the interests of Australian medical practitioners are best served by having the MDOs stand as strong and viable professional indemnity insurers, it must be understood that their benevolent objects will not prevent them acting in the hard-nosed way that other professional indemnity insurers act. That is not to say that the interests of members should be disregarded. Rather, it recognises that the decision to

run a case or to settle it is a financial decision, which the MDOs must make wearing the cap of an insurer, not of a protector of professional reputations.

### Driving premiums down

It is not the role of a medical indemnity insurer to dictate the way in which medicine is practised. However, it is a vital part of its role to help doctors manage their practices so as to drive down the cost of premiums. The cost of premiums is a function of the frequency and cost of claims. In their

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benevolent role, the MDOs have the opportunity to encourage initiatives which reduce the frequency of claims.

The Australian data indicate that the weight of claims and, hence, the best opportunities to drive down premiums, are found in obstetrics, neurosurgery and orthopaedic surgery. The MDOs and the medical profession should give priority to supporting risk-management and clinical governance initiatives in these specialties. One approach of value may be to ask whether these specialties can adapt the techniques by which the anaesthetists have managed to contain the level of claims against them.

The MDOs should look for opportunities to support the patient safety initiatives of the Australian Council for Safety and Quality in Health Care, as well as looking to benefit from overseas initiatives, such as those of the National Patient Safety Agency of the NHS.

The MDOs also have the opportunity to encourage the various specialties to take action to reduce the frequency of claims in what may be their area of greatest exposure – failure to warn claims. The States and Territories that have enacted reforms following the Ipp Report have adopted a modified form of *Bolam* test for professional negligence claims. This reform does not, however, apply to failure to warn claims.<sup>30</sup> The standard of care in failure to warn cases will continue to be fixed by the courts.

According to the High Court, doctors must warn their patients of material risks. A risk is material if:

- in the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to it (the objective limb); or
- the medical practitioner was, or should have been, aware that the particular patient would be likely to attach significance to it (the subjective limb).<sup>31</sup>

The warning required under the subjective limb will vary from patient to patient. However, the warning required under the objective limb could be standardised. There is no reason why individual specialties could not give guidance as to standard warnings for standard procedures which, in the view of an influential group of doctors practising in that specialty, warn of the risks to which a reasonable person in the patient's position would be likely to attach significance. For common procedures, the warnings could be reduced to writing, and made available for distribution to patients.

Even though the *Bolam* test does not apply to failure to warn cases, the opinion of a respected body of doctors will continue to be relevant to the court's decision. As Gleeson CJ has said, Australian courts have never denied the relevance of professional practice and opinion, they have only denied their conclusiveness.<sup>32</sup> An authoritative definition of the proper content of the warning which a reasonable person in the patient's position would require would, therefore, be relevant to the court's determination.

The development of standard warnings should help reduce the frequency of failure to warn claims against doctors, particularly those practising in high-risk specialties.

## Conclusion

The approach suggested in this article incorporates current thinking on the efficient resolution of claims for compensation for injuries caused by medical error. By promoting early investigation and settlement of claims, it provides maximum opportunity for claims to be resolved without the need for litigation. The approach recognises that error is a fact of professional life for doctors, just as it is for all professions. The approach seeks to facilitate prompt payment of meritorious claims, whilst relegating litigation to its correct position, as a last resort. The approach also seeks to limit, to the extent possible, the stress and anxiety which all litigants inevitably experience.

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- 13 Leape, n 6.
- 14 Leape, n 6. See also Sexton JB et al, "Error, Stress and Teamwork in Medicine and Aviation: Cross Sectional Surveys" (2000) 320 BMJ 745.
- 15 Vincent C et al, "Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action" (1994) 343 *Lancet* 1609.
- 16 Lynch B et al, "A Clinical Analysis of 500 Medico-legal Claims Evaluating the Causes and Assessing the Potential Benefit of Alternative Dispute Resolution" (1996) 103 Br J Obstet Gynaecol 1236.
- 17 Harrex et al, n 7. The figures have been converted from a percentage of total payments to a percentage of damages paid to facilitate comparison with the United Kingdom figures given in the next paragraph.
- 18 Department of Health, n 5, p 92.
- 19 Meaning claims which had been incurred but not reported to United Medical Protection Ltd.
- 20 United Medical Protection Ltd (Provisional Liquidator Appointed), *Preliminary Report into Solvency and Financial Position as at 3 May 2002* (29 August 2002).
- 21 See United Medical Protection Ltd, *Constitution*, objects 3(b) and (c).
- 22 Wilson LL and Fulton M, "Risk Management: How Doctors, Hospitals and MDOs can Limit the Costs of Malpractice Litigation" (2000) 172 MJA 77.

- 23 There may yet be movement from the Commonwealth Government on the levies currently being imposed on doctors.
- 24 *Mallett v McMonagle* [1970] AC 166 at 176.
- 25 *Review of the Law of Negligence, Second Report* (September 2002) p 57.
- 26 *Review of the Law of Negligence, Second Report* (September 2002), recommendation 9, p 57.
- 27 If the plaintiff's lawyer works on a "no-win, no-fee" basis, the plaintiff will not be liable for their costs (A\$40,000), but she will still be liable for the defendant's costs (A\$20,000).
- 28 Kirby M, "Patients' Rights – Why the Australian Courts have Rejected Bolam" (1995) 21 *Journal of Medical Ethics* 5 at 8.
- 29 Spigelman J, "Negligence: The Last Outpost of the Welfare State" (2002) 76 ALJ 432 at 433.
- 30 In New South Wales, see the *Civil Liability Act 2002* (NSW), s 5P .
- 31 *Rogers v Whitaker* (1992) 175 CLR 479 at 490; *Rosenberg v Percival* (2001) 205 CLR 434 at 458.
- 32 *Rosenberg v Percival* (2001) 205 CLR 434 at 439.

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