The medical indemnity crisis: a lawyer's perspective

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Many factors are involved in the current problems with medical indemnity insurance, including the increasing costs of providing long term care and regulatory requirements for insurers. Most claims are small but the very small number of high value claims substantially increases the total claims value.

During the past couple of months the primary topic for doctors must have been the medical indemnity crisis. At the time of press, United Medical Protection (UMP) had announced that it would go into liquidation and the 29,000 doctors it covered in New South Wales and Queensland were not confident that they would be covered for claims that had not yet come to light. The Commonwealth Government agreed to provide a capital guarantee up to $35 million until 30 June 2002, to allow UMP's captive insurer, Australian Medical Insurance Limited (AMIL) to maintain acceptable prudential margins. Yet neither that Government nor the NSW Government gave an assurance that it would back claims after that time, nor cover 'the tail' of claims incurred but not yet reported. Doctors are justifiably worried. It has been suggested that UMP has unfunded liabilities up to $500 million; the exact figure will not be known for years.

Most readers will be at least as familiar with these circumstances as I am, either from their own experience or from the media reports. As a lawyer, however, I want to question the widely expressed opinion, especially among doctors, that the current medical indemnity crisis has been brought about by 'the law' and 'the lawyers'.

Award sizes

It is true that in recent years the number of cases alleging medical negligence has increased greatly and the amounts of compensation awarded have escalated, especially in cases involving babies injured at birth. One of the reasons for the increased awards is the increased cost of the provision of care for a severely disabled person throughout the remainder of the person's life. Such patients may require 24-hour care by several carers for many years as medical advances have meant that disabled people live longer now than they used to. In addition, carers' salaries, together with all associated costs, have to be indexed for inflation.

Most medical negligence claims, however, are relatively small, and they are often much more problematic than many doctors realise. Only a small number of patients who suffer a 'medical injury' issue proceedings. It is always difficult for patients to find out what happened, even if they gain access to their medical records. (Under freedom of information legislation in most jurisdictions, patients have a statutory right to see records in public sector agencies and, in Victoria and the Australian Capital Territory, in the private sector. Also, recent amendments to the federal Privacy Act enable patients to see their records in both the public and private sectors.)

Proof of fault required

The discovery of an error in treatment does not give the patient the right to sue. Contrary to what has been suggested in the press, 'misadventure' is not compensable in itself. The patient must almost always prove that the doctor or hospital was at fault. The circumstances in which liability is established without fault are rare. For example, a patient may succeed in establishing 'trespass to the person' (battery, commonly called assault) by proving that something was done without the patient's consent, such as the wrong kidney being removed. It is no defence that the doctor was misinformed, or believed that the procedure was 'in the patient's best interests', for example, because the excised kidney was found during surgery to be more diseased than the designated one.

The great majority of claims against doctors and hospitals are brought in negligence or contract and require proof of all elements of the claim. One element is fault – that the doctor or hospital failed to take reasonable care. What is 'reasonable' in a particular case is a question for the court to determine. Almost always, the patient will need to call medical evidence and it is often difficult to find a doctor who is prepared to testify against a colleague. The so-called 'medical standard'

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of reasonable care was rejected by the High Court of Australia in *Rogers v. Whitaker* (1992).[1] That standard, sometimes called 'the Bolam principle', established that a doctor was not negligent when acting in accordance with a practice accepted as proper by a responsible body of opinion within the medical profession, even if other doctors might take a different view. Even if it is the role of the court, and not the medical profession, to determine the required standard of care in a given case, courts will naturally be reluctant to find that a doctor has been negligent if he or she adopted a commonly accepted medical practice.

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The patient must persuade the court that he or she suffered injury as a result of medical treatment (causation) and not the progression of an earlier medical condition. Proving this is much more difficult than a healthy person proving that they were injured by a motor vehicle or industrial accident. Given that the patient is already sick, how much of the later condition is due to the initial illness and how much, if any, to the doctor's negligent act or omission?

Some doctors have been concerned about the increase in 'informed consent' cases where doctors have been held liable for adverse outcomes, even where procedures are performed with due care and skill. This occurs because patients later say that would not have agreed to the procedure had they been properly informed of the risks. In such cases, however, a stricter test of causation has recently been approved by the High Court and such cases are likely to become more difficult for patients to win.[2]

No win – no fee

One issue of particular concern to doctors has been the 'no win – no fee' advertising by some solicitors. It must be remembered though that, even with this arrangement, a plaintiff still has to pay upfront in order to initiate litigation. The patient has to pay all disbursements, such as court costs and costs for expert witness reports. Also, if the patient loses the case, he or she will probably be ordered to pay

the defendant's costs even though the patient's own solicitors will not be paid.

Patients do not commence litigation lightly, and the 'no win – no fee' solicitors do not accept cases unless they are relatively confident that the patient has a good case. The majority of applicants are, in fact, turned away since law firms are not prepared to incur substantial expenses pursuing doubtful claims. Also, in practice, most patients whose cases reach the courts do not win.

Litigation alternatives

Patients now have many alternatives to litigation to find out what happened and to obtain compensation. All jurisdictions now have alternative dispute resolution procedures such as the Office of the Health Services Commissioner of Victoria. These provide a cheap and less stressful method of resolving disputes and have become increasingly popular.

Conclusion

I do not believe that the legal profession should be blamed for the current problems with medical indemnity insurance. The reasons are far more wide-ranging and include the increasing costs in providing long term care, the regulatory requirement that all insurers increase their capital base, the difficulty of obtaining reinsurance after the collapse of key insurers and the events of September 11. Potential litigants have difficult pathways ahead of them – alternatives to litigation should be encouraged.

Series Editor's comment

There are two elements to the current 'crisis'. The first of these is the substantial deficiency in the monies set aside by UMP as a reserve for its members' currently unreported incidents. The requirement to be imposed on medical defence organisations (MDOs) by the Australian Accounting Standards Board, probably with effect from 1 July 2002, is to take up the value of those unreported incidents as a liability into an MDO's financial statements. As UMP's Chairman told the Court on 3 May 2002 when seeking the appointment of a provisional liquidator, this means that UMP would show a very large shortfall in net assets.

The second factor is a more systemic one. Can a relatively small group in the community continue to fund its own liabilities in negligence when the sum total of those liabilities has grown in value about fivefold in the last 10 years or so?

The number of claims (i.e. demands for compensation) brought against doctors has increased substantially over the last two decades. The Australian Health Ministers' Advisory Council's principal consultant, Ms Fiona Tito, whose 1995 Report for the Commonwealth Government, *Compensation and Professional Indemnity in Health Care* predicted the current crisis, told the Medical Indemnity Summit held in Canberra on 23 April that claims had doubled in number in 15 years. However, over that time, the number of medical services claimed against Medicare increased by 66% and hospital services by 75%. While higher 'exposure' is part of the reason for the greater number of claims, it is still a relatively small group (doctors represent about 3% of the Australian community) that is funding those claims through their professional liabilities cover.

Over the same period, the average cost of a medical claim doubled, principally because of higher payouts to severely injured claimants (e.g. children with cerebral palsy). Those higher payouts arose paradoxically because of advances in health care. Many severely impaired children now have normal life expectancies due to better care of their disabilities. Thus the future care costs component of any award or settlement is now predicated commonly on 40 or 50 years of future care, rather than the 20 to 30 years assumed in judgments in the 1980s. The very small number of these high value claims has had a substantial skewing effect on total claims value. For example, UMP's 2001 Annual Review reported that the 2% of claims estimated to each have a probable value of more than $1,000,000 made up 45% of UMP's total claims' liabilities.

One problem is that the only publicly available index of claims is the number of writs lodged in the various courts around Australia. For example, there are about 250 writs per year lodged in the Medical List of the County Court of Victoria, and that figure has not changed substantially over the years. These figures, however, ignore the large and increasing number of claims that are resolved without litigation ever being commenced. In my experience, most MDOs are now proactive and will respond directly to a 'letter-before-action' and not await commencement of formal proceedings.

The other point to put into the equation is that in the past only a small percentage of patients who could sue successfully actually chose to do so.[3,4] The growth in litigation over the last 10 to 20 years is almost certainly due to an increase in that percentage, compounded by a much higher level of medical activity.

So, where do lawyers fit into the equation?

It needs to be said that a lawyer cannot create a successful action in negligence out of nothing. It takes two doctors to ensure a successful action – one to commit the negligent act, the other to say it was negligent. Advertising by plaintiff lawyers might encourage a higher percentage of injured patients to take their chance, but when that advertising is of 'no win – no fee' arrangements, the patient might find it hard to find a lawyer willing to take any case other than one with a very high probability of success.

The overall rise in total litigation costs has put increased economic pressure on doctors as their MDOs increase rates rapidly to cover these rising costs. Also, there has been the added burden of 'calls' imposed by some of the MDOs to correct historic underfunding of unreported incidents. My view is that the increasing cost of claims brought by the very small number of catastrophically injured patients is now too large to be met from the relatively small pool of doctors involved. For example, the recent award by the NSW Supreme Court to cerebral palsy sufferer Calandre Simpson, which will end up costing more than $15 million, represents more than $20,000 for each practising obstetrician in Australia. And that's for just one case.

A patient who wants to sue a doctor has an enormous hurdle to jump. In general, the process of litigation fairly sorts out, in a fault-based system, which patients should or should not succeed. Occasionally the judge gets it wrong. So, occasionally, do doctors. The current crisis is not the fault of the law and lawyers. However, the costs of legal process and awards assessed simply on the basis of restitution (restoring the patient fully to the position they would have been in financially had the damage not occurred) cannot be sustained. MT

References

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