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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Review of Professional Indemnity Arrangements
for Health Care Professionals

Compensation and Professional Indemnity in Health Care

FINAL REPORT

November 1995

Australian Government Publishing Service
Canberra

ISBN 0 644 46360 0

National Library of Australia Cataloguing-in-Publication entry

Review of Professional Indemnity Arrangements for Health Care Professionals (Australia).

Compensation and professional indemnity in health care: final report
1. Medical personnel - Malpractice - Australia.
2. Physicians - Malpractice - Australia. 3. Insurance, Physicians' liability - Australia. I. Title.

346.940332

This version of the Final Report of the Professional Indemnity Review has been prepared by Enduring Solutions Pty Ltd, from the penultimate electronic draft of the Report held by its author, Ms Fiona Tito. It has been closely checked against the published version of the Final Report, but the page numbering and position of the Endnotes is different. No electronic copies of the published version were retained by the Commonwealth Department of Health and Ageing, and no reprints of the Report are otherwise available.

Enduring Solutions Pty Ltd prepared this version as a public service for the community, following many requests for copies. Fiona Tito is Executive Director of Enduring Solutions and is contactable on +61 (0)2 6231 1640 or fiona.tito@gpo.com.au.

Thanks are also gratefully extended to the Australian Council for Quality and Safety in Health Care for making it available on its web-site.

Produced by the Australian Government Publishing Service

Foreword

The Review of Professional Indemnity Arrangements for Health Care Professionals (PIR) was established by the Commonwealth Government in April 1991 to examine the current arrangements relating to professional indemnity and current experience with compensation for medical misadventure.

Over its four and a half years, the PIR has produced a significant number of publications and funded important research and pilot activities within its terms of reference. This Final Report brings all these things together and makes recommendations for action designed to address many of the issues raised in the work of the PIR.

Any correspondence about the recommendations of the PIR should be forwarded to:

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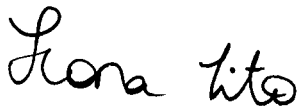
I would like to thank all those individuals and organisations who took the time to respond to the work of the PIR at its various stages. I believe that this helped guide and inform the PIR in its pursuit of reform in this important area. The final recommendations reflect many of the concerns raised through this consultative process.

I would also like to thank the various people who have participated on the various committees and research projects established under the auspices of the PIR, including: the PIR's Advisory Committee and Reference Group, which provided invaluable assistance in the preparation of the Interim Report; the many members of the Birthing Issues Sub-committee, who provided significant assistance in the work that resulted in Chapter 10 of this Report; the members of the Incident Monitoring Steering Committee, who showed great perseverance in working together on the various incident monitoring pilots; and the Steering Committee and Research Team of the Quality in Australian Health Care Study.

The members of staff of the Review have been numerous over its course, with many people coming and going over the time. All have provided invaluable assistance in the work of the PIR. In terms of completion of the Final Report, I would like to particularly thank Robin Boyce, Gabriela Taloni, Peter Harlow, and Madonna McGahan, whose continued interest in the completion of the Final Report has seen them working above and beyond any legitimate claim I had upon their time. Without these officers, the Final Report would not have been completed. Their honest and vigorous pursuit of the truth and their dedication to thoroughness are reflected in its content and scope. I would also like to thank Clare Wall, Vong Peacock, Gwen Meyer and Bill Ross, whose various efforts also helped draw the work of the PIR to a satisfactory conclusion, and the Secretary of the Department of Human Services and Health, Dr Stephen Duckett, for his assistance in finalising the Report.

I would also like to pay due regard to all the other officers of the department and the ministerial staff who have provided assistance in the work of the PIR.

Last but not least, I would like to thank the large number of health professionals who have provided significant assistance to the work of the PIR - these include Professor Bill Runciman, Dr Clive Wellington, Dr Bob Webb, Dr Ross Wilson, Dr David Watson, Dr Heather Mitchell, Dr Paul Nisselle, Dr Craig Lilienthal, Dr Peter Arnold, Dr Bill Coote and many others. Without their generous assistance and encouragement, the completion of the PIR's work would have been much more difficult.



FIONA TITO
Chair
Review of Professional Indemnity Arrangements
for Health Care Professionals
3 November 1995

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Executive summary

The Professional Indemnity Review (PIR) was asked to examine the arrangements for patients who are injured through health care negligence or misadventure, and the means of funding them, to determine any problems with these arrangements and to propose solutions. The results of four and a half years of research and policy development conducted by the PIR are summarised in this Final Report.

The PIR identified a wide range of problems in this broad area. These problems included:

- an absence of publicly available data on both health care negligence actions and adverse patient events arising from health care, which has led to the creation and perpetuation of many myths and much misinformation;

- an inadequate outcome focus and an inadequate evidentiary basis for many health care treatments;

- inadequate accessible information for both health professionals and health care consumers on risks, benefits and treatment options in health care;

- lack of access by patients to their own health care records;

- poor communication in the health care process, particularly if something does go wrong and the patient is harmed;

- the undertaking of many quality-directed activities, few of which however are data driven and few of which complete an information-action-monitoring cycle that could lead to improved health care over time;

- the unavailability of meaningful performance information for health care consumers upon which to base their choice of health care provider, and for health care institutions to grant practising rights to ensure quality care is provided to patients;

- the absence of a predetermined minimum level of government-funded assistance for those who have severe disabilities, and inadequate, uncoordinated assistance in many such cases;

- the difficulties for health care consumers in accessing the tort system where there is negligence;

- the inappropriateness of single lump sum payments for those with significant future care needs and tax impediments to the broader use of structured settlements to meet costs as they arise;

- a number of significant barriers to the development of a full partnership between health care providers and health care consumers - these barriers limited the benefits that could flow from the wider adoption of this new paradigm for health care;

- long-standing inadequate funding of liabilities by medical defence organisations (MDOs) and the unavailability of public data on their financial circumstances, even for doctor members;

- the absence of any providential scrutiny of the MDO industry, even though an important element of their business - that is, professional indemnity cover - has characteristics and social and financial goals similar to those of insurance;

- inadequate professional indemnity products for many self-employed health professionals;

- the absence of any requirement for health care businesses and institutions to hold any professional liability cover or cover for their institutional non-delegable duty of care;

- a lack of clarity in the law relating to professional indemnity for health care provider employees; and

- concerns about the workforce effects of indemnity in specific areas - the Final Report uses birthing service provision as an example of these.

In brief, the PIR's research concludes that there are very many adverse patient outcomes which arise out of health care in the Australian health care system - probably considerably in excess of 400 000, with around 230 000 being preventable with current knowledge according to the results of the PIR's Quality in Australian Health Care Study. While many of them involve only minor disabilities, 30% resulted in a disability that was likely to prevent the person returning to work or normal activities for 1-12 months, and 20% resulted in some degree of permanent disability or death.

By contrast, there appear to be fewer than 2000 tort claims commenced each year where health care negligence is alleged, and many of these never result in any payment of damages. Only a handful of cases where liability is disputed go to court each year and the majority of these appear to be won by the health professional. Most cases involve small payments, with few resulting in payments over $500 000.

However, the paucity of available 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 more promptly in future and to provide data for health professionals, MDOs and tort funders, health care consumers and governments.

The vast bulk of costs relating to preventable adverse events in health care and probably even those where negligence is a causal factor are borne by the community, the people who have the adverse events and their families. For example, lost income is met through sick leave, social security and, in some cases, simply doing without. The services required and costs relating to disability are met through a broad range of health and community services.

Both the tort system and community assistance arrangements have problems, which must be addressed if people whose disabilities arise from adverse patient events are to have their needs met efficiently and equitably. A wide range of recommendations are made to address shortcomings in both arenas. Some of the most important of these include:

- the modification of tax arrangements to encourage the use of structured settlements in larger compensation cases, so service needs and income needs can be met throughout the person's lifetime;

- wider use of court-based case management methods to overcome unnecessary delays in resolution of cases; and

- the establishment of agreed minimum levels of community assistance for those with severe disabilities.

The Report also looks at better use of alternative dispute resolution mechanisms, through the various health care complaints mechanisms, as well as ways of improving communication between health professionals and health care consumers. It also focuses on resolution of as many disputes as possible "at the coal face" and the use of health consumer advocacy and information services.

The Report looks closely at the issue of rising MDO contribution rates and concludes that these have resulted mainly from corrections to long-term underfunding of MDO liabilities, and to increased damages in the small number of cases involving people with long-term care needs. While some MDOs appear to have improved their reserves to meet their underfunding, it appears likely that others have been less provident.

The evidence for a so-called claims crisis is scant - while the reporting of incidents has increased, this has been in response to direct efforts by MDOs to get early notice of potential claims, and does not, thus far, appear to be reflected in increased legal claims. Some MDOs have been making such claims publicly without the production of data to substantiate them. However, they do not appear to be basing their premiums on such increases, as premium rates in these same organisations have remained steady.

The fostering of such a crisis mentality can serve to deflect attention from irresponsible financial management by such MDOs, and can be used to disguise later rises in contributions which have, in fact, arisen because of this financial improvidence. Such improvident strategies can also be used by an organisation to increase cash-flow at the expense of longer-term financial viability, if an organisation is short of funds. While these are all possible explanations, there is no publicly available data on the operations of MDOs against which to judge these possibilities.

There are also concerns about the adequacy of cover for other health professionals and health care institutions, as well as confusion about when health professionals are covered by their employer and when they must carry their own cover.

Adequate professional indemnity cover is crucial for health professionals, health care institutions and health care consumers. It is imperative that the cover exist at the date of treatment and that the cover be adequate to meet the rare, but potentially high, costs associated with severe disability arising from health care negligence. The only product that can provide this security is an insurance-based product, offered on a claims incurred, uncapped liability cover basis. The cover must be self-funding and loss spreading across other forms of insurance business should be prohibited. After a transitional period, it should be an offence for a health care provider to provide health care without adequate professional indemnity cover.

Existing unfunded MDO liabilities should be funded through a separate fund - managed by the industry, Government and the profession - which is to be contributed to by a levy on premiums paid by doctors. This fund should be run on a pay-as-you-go basis, to minimise the size of the levy, and to spread out the funding of the liabilities, until they are discharged.

The Final Report's 168 recommendations for action are set out below.

List of recommendations

Chapter 2

1. The PIR recommends that the Taskforce on Quality in Australian Health Care gives priority to :

   (a) identifying those adverse events which are the most frequent and preventable and cause the greatest degree of disability or death (priority adverse events); and

   (b) developing strategies to prevent priority adverse event.

2. The PIR recommends that the Taskforce ensure that priority adverse events are considered in the context of processes that could improve patient safety such as development of practice guidelines, outcomes research and Cochrane Collaboration review funding.

3. The PIR recommends that the Taskforce consider the appropriateness of health care facilities and individual health care practitioners collecting data on priority adverse events in their services and practices.

4. The PIR recommends that the Taskforce consider:

   (a) whether information on priority adverse events should be used in assessing practitioners' performance, for example in the granting or continuation of practising rights; and

   (b) which information relating to priority adverse events should be made available to patients and an appropriate format for the information.

5. The PIR recommends that study be undertaken to examine the relationship between the medical concept of preventability and the legal concept of negligence.

6. The PIR recommends that State Government departments with administrative responsibilities for court registries seek to improve processes for making judgements available quickly and cheaply.

7. The PIR strongly supports the establishment of the Australian Institute of Health, Law and Ethics, and recommends that, once established, it give priority to production of relevant publications and provision of training opportunities to provide current and accurate information in areas of law that are of interest to practising health care professionals; providing educational links in the primary training of legal and health care professionals; and promoting debate and discussion about areas of shared interest and concern, including tort law and professional ethics.

8. The PIR recommends that deans of medical, nursing and health sciences faculties, professional colleges and others with responsibility for health care professional training explore ways of providing education and training for health care professionals about the legal system, including the tort system and regulations of the health care sector.

9. The PIR recommends the establishment of a national minimum data set for health care negligence cases, which includes sufficient details to allow the data to be used to examine trends in particular specialties and diagnostic areas, and to detect areas likely to benefit from prevention strategies. The contributors to the database should be all medical defence organisations, any insurers providing health care professional indemnity cover to individual practitioners or facilities, and all State Governments and private sector self-insurers.

Chapter 3

10. The PIR recommends that the Taskforce on Quality in Australian Health Care determine whether there are any priority adverse events that could benefit from a systematic Cochrane Collaboration review.

11. The PIR further recommends that Australian Health Ministers Advisory Council (AHMAC), with the National Health and Medical Research Council (NHMRC), consider the establishment of a set of priority areas for Cochrane Collaboration Reviews, and the most appropriate manner and level of funding for these, particularly taking into account any findings of the Taskforce in relation to priority adverse events.

12. The PIR recommends that the Australasian Cochrane Centre establish formal links with consumer groups to:

    (a) promote review findings among health care consumers; and

    (b) examine appropriate ways for consumer representatives to be involved in the centre's work.

13. The PIR endorses the work of the NHMRC in relation to the participation of women in clinical trials and recommends that all bodies responsible for approving and designing randomised controlled trials and other clinical trials in Australia ensure that such trials include research subjects of both genders, unless the safety of participants would be compromised, or the treatment or drug under scrutiny is intended for application to one gender. In the latter case participants should be of the relevant gender.

14. The PIR recommends that, given the costs and difficulties associated with only using evidence from randomised controlled trials to support different health care options, governments, professional colleges and bodies such as the Australian Institute of

Health and Welfare and the Australasian Cochrane Centre examine valid ways of gathering experiential data from routine practice in appropriate health care areas and encourage their use to provide evidence of the efficacy, risks and benefits of different treatments.

15. The PIR recommends that the results of United States medical treatment effectiveness research projects be considered by the NHMRC and other appropriate bodies for their applicability and utility in Australia. These bodies should also seek ways of making the results of the studies accessible to health care consumers.

16. The PIR believes that clinical practice guidelines are an important tool for improving the quality and appropriateness of health care services, and for assisting health professionals to properly inform their patients about options, risks and benefits and recommends their continued development.

17. The PIR recommends the NHMRC consider electronic and facsimile methods of dissemination of Australian clinical guidelines, as well as the more traditional publication route, to ensure the widest possible dissemination amongst health care professionals and health care consumers.

18. The PIR recommends that the NHMRC develop ways of ensuring that health care consumers are made aware of areas where there are uncertainty and variation in clinical practice, and that they are informed about the variations that are being examined, for example, through articles in the press and appropriate journals.

19. The PIR recommends that the Commonwealth Government establish a mechanism that links findings from evidence-based medicine and outcome studies (including adverse event studies) to reviews of funding for various medical services under the Medicare Benefits Schedule, so that financial incentives can be used to influence clinicians to adopt treatment choices that are the most beneficial for patients, either because they have better outcomes or fewer adverse events, or because the preferred treatment is less costly.

20. The PIR recommends that the Taskforce consider the best ways of: detecting inappropriate breaches of guidelines that aim to prevent the occurrence of adverse events; dealing with breaches of guidelines, including deciding how the inappropriateness of any breach could be determined; and establishing benchmarks of performance that require information on such breaches by individual health care practitioners to be publicly available.

21. The PIR recommends that the Taskforce consider whether to create statutory duties in certain areas, where the danger to patients is very high if there is a failure to act in a certain manner.

22. The PIR recommends follow-up studies on the use of Australian guidelines be undertaken, once they are implemented, to determine whether they are being used, and what barriers there may be to their broader use.

23. Prior to the establishment of the broader process of funding reviews as suggested below, the PIR recommends that guidelines on the standard of proof of efficacy and cost-effectiveness be established by the Commonwealth for colleges intending to recommend funding of a treatment under the Medicare Benefits Schedule.

24. Because similar decisions need to be made in relation to treatment of public patients in public hospitals, the PIR recommends that AHMAC be involved in the development of such funding guidelines.

25. The PIR recommends that necessary ethical safeguards for consumers, such as those that govern clinical trials, be put in place where there is not a sufficient evidentiary base for current practices.

26. The PIR also recommends that the NHMRC consider the issue of whether health care treatments whose efficacy has not been scientifically demonstrated constitute human experimentation; if so, decide whether the existing NHMRC guidelines on human experimentation are appropriate in these cases; and, if the guidelines are not appropriate, develop new guidelines to cover these cases.

27. The PIR recommends that part of the information that should be provided to patients in relation to treatment options be whether or not the efficacy of particular treatment options has been scientifically tested to the degree sufficient to produce NHMRC outcome-based guidelines and, if not, to what degree of certainty the benefits, risks and efficacy can be shown.

28. The PIR recommends the development by the NHMRC of criteria to determine whether formal evaluation should take place before new treatments can be used.

29. The PIR recommends that, once such criteria are established, health care consumers should make payment for any new treatment contingent upon having its satisfied the formal evaluation requirements of these criteria. Where a new treatment does not require formal evaluation prior to introduction to practice under the proposed NHMRC criteria, funding should still be contingent upon the establishment in practice of appropriate efficacy and cost-effectiveness evaluation mechanisms.

30. The PIR recommends that any such assessment information - whether formal evaluation prior to or after introduction to practice - should be publicly available and accessible to health care consumers.

31. The PIR recommends that a timetable for consideration of all existing clinical activity that has not had its efficacy and cost-effectiveness demonstrated should be established by the Commonwealth and AHMAC, in cooperation with relevant bodies. Priority areas should be those that involve greatest human or financial cost to the community, highest usage, and those areas that are part of the National Health Goals and Targets Program for Australia.

32. The PIR recommends that as reviews of various treatments are planned and undertaken, this information must be made available to health care providers, consumers and funders.

33. The PIR recommends that the Commonwealth establish a process for reviewing funding of various health care interventions, so that when it is shown that various health care interventions are not efficacious or cost-effective, Commonwealth funding for them ceases. Equally, it is important that the inclusion of any new schedule items or variation of the description of them only occur where there is adequate evidence of their efficacy and cost-effectiveness. The same body could have responsibility for both. It's membership should include: State Governments with similar needs in relation to public hospitals and community health centres; private health insurers with similar needs in relation to their products; and health care consumers.

Chapter 4

34. The PIR recommends that the Commonwealth Government and the Australian Health Ministers' Advisory Council (AHMAC) develop a model to provide information services to consumers throughout Australia, as are provided by bodies like the Help for Health Trust in the United Kingdom and the small number of health consumer information services in Australia.

35. Effective communication between health care professionals and patients is so important that the PIR recommends that the development of skills in communicating with patients be a compulsory part of all primary health care professional education courses, and also be included as appropriate in continuing education courses.

36. The PIR recommends that all existing and future Commonwealth government-funded health programs be required, as a condition of funding, to provide scientifically accurate and consumer-friendly information to all people participating in the program on the risks and benefits of the program activity and of non-participation, as well as any limitations to its procedures.

37. The PIR recommends that the Commonwealth Government determine;

(a) whether the programs it is funding have adequate scientific evidence for the efficacy and safety of the procedures funded; and

(b) whether or not clinical practice guidelines or other strategies (for example funding variations) should be examined to ensure programs are maximising the health gains and minimising costs.

38. Where problems are revealed, the PIR recommends that the Commonwealth Government initiate appropriate processes, for example Cochrane Collaboration systematic reviews and/or development of clinical guidelines, as a priority.

39. The PIR recommends that priority areas for development of performance measurement information be determined by the Taskforce on Quality in Australian Health Care from the work of the Quality in Australian Health Care Study.

40. The PIR recommends that the development of performance measures and systems for undertaking ongoing performance monitoring form an obligatory part of clinical practice guideline development.

41. The PIR also recommends that areas of significant concern, such as those where it is alleged that defensive medicine, rather than good clinical care, is dictating practice should be other areas of high priority for standards development and monitoring, both by individual facilities and individual practitioners.

42. In all cases, the PIR recommends that performance measures and performance information be available in an appropriate format for consideration by health care consumers.

43. The PIR recommends that these draft consumer and health professional information guidelines be made available to State Governments, consumer groups and professional bodies to modify appropriately and to ensure their wide dissemination in user friendly formats.

44. Following the determination of the case of *Breen v. Williams* and the completion of the work of the Australian Law Reform Commission-Administrative Review Council Freedom of Information Review, the PIR recommends that, if necessary, the Commonwealth ensure via legislation that patients have access to their own health care records held by doctors, other health care professionals and public and private health care facilities. The minimum requirement should be right of access to all records created after the commencement of the legislation and access to matters of fact, including test results, for records created prior to the commencement of the legislation.

45. The PIR recommends that the Commonwealth Department of Human Services and Health examine the option of a patient-held record as a matter of urgency.

Chapter 5

46. The PIR recommends the continuation of the piloting of an integrated reporting form, which allows the collection of different elements of data from the same form for risk management, risk prevention and patient information, and the exploration of other ways of streamlining the data collection processes. This should result in the promotion of a final version, or range of options, through the Australian Health Ministers' Advisory Council (AHMAC) and other appropriate bodies, once the pilots are completed and evaluated.

47. The PIR recommends that for the extension of effective data collection and analysis for quality improvement, priority must be given to the development and promulgation of inexpensive, effective ways of providing feedback from quality data collection to practitioners and others involved in the health care system, such as administrators and consumers.

48. The PIR recommends that medical, nursing and health sciences faculties, as well as professional colleges, examine ways of training students and health professionals in error identification and analysis, as well as training them to seek appropriate supports when errors do occur, at undergraduate, postgraduate and continuing education levels.

49. The PIR recommends that health care institutions examine what support mechanisms exist in their facility to assist health professionals to deal with errors in a positive manner (for example an incident monitoring feedback group, peer support mechanisms, team care support groups and confidential counselling).

50. The PIR recommends that the Department of Human Services and Health examine how greater outcome accountability can co-exist positively with a greater recognition of error and positive analysis of errors to improve health care.

51. The PIR recommends that the National Health and Medical Research Council (NHMRC) examine the issue of health professional fatigue, its impact on health professionals, their families and patients, as well as its effect on quality of care. It should then establish national guidelines dealing with maximum safe working hours and minimum rest breaks for all health professionals and health care institutions.

52. The development of outcome self-monitoring mechanisms by professional colleges for their members, specifically in high-risk areas revealed by incident monitoring, the Quality in Australian Health Care Study or other initiatives, for example relating to clinical indicator development within specialties, could be a useful first step towards a greater outcome focus to health care.

53. Measurement, maintenance and improvements in quality of care must be seen as a senior management and senior clinician responsibility, and this should be reflected in the structures and policies in place in hospitals and other health care management units (for example individual practices and divisions, regions or areas). The PIR recommends that such structures and policies be encouraged, and where possible enforced, through appropriate funding measures at the State and Commonwealth levels.

54. The PIR recommends that effective health care consumer feedback mechanisms be widely implemented. Once sufficient data are available, linkages should be made between the incidence of formal complaints and litigation to see if the feedback from such mechanisms is useful as a predictor of complaints or litigation. If such a connection is demonstrated, then it is arguable that these feedback mechanisms could be one of the elements used in performance appraisal, and in the determination of clinical privileges and visiting rights.

55. The PIR recommends that health care facilities have health care consumer representation on their various quality of care committees and activities.

56. The PIR recommends that data on appropriate quality of care indicators, which are comparable between facilities and different health care professionals, be made available to users of the health care system, so that consumers can make informed choices about their individual and institutional health care provider, and about the risks and benefits of treatment options.

57. The PIR recommends that the issue of the best ways of conveying information to health care consumers on relative quality of care in different health care facilities and the quality of care provided by individual health care professionals be explored as a matter of priority by the Cochrane Review Group on Communicating Effectively with Consumers.

58. The PIR recommends that AHMAC promote development of model legislation for quality assurance confidentiality legislation. This could allow the different States to achieve consistency of coverage of activities, streamlined administration and greater openness of information in protected quality assurance activities, for example through public reporting requirements, while minimising the confusion about coverage. Such model legislation could also set out the best interrelationship with the Commonwealth legislation from the States' perspective.

59. The PIR recommends that an amendment be made to the *Health Insurance Act 1973* to allow cover of declared quality assurance activities relating to veterans' health services.

60. The PIR recommends that the Health Insurance Act 1973 be amended to allow the declaration of quality assurance activities relating to the *Therapeutic Goods Act 1989*.

61. The PIR recommends the Commonwealth begin preliminary discussions with State Governments on options to allow the coverage by the Commonwealth quality assurance confidentiality legislation of activities covered by equivalent State acts, so far as subpoena by courts exercising federal jurisdiction is concerned.

62. The PIR recommends that no amendments be made to section 124Z of the Commonwealth's quality assurance confidentiality legislation (*Health Insurance Act 1973*, Part VC). The provisions of section 124Z do not appear to be limiting the effective operation of the legislation at this time, and it is an important, but narrow safeguard for the community's interests in prosecution of criminal offences.

63. The PIR recommends that the issues arising from revelation of practices that endanger patient safety in a declared quality assurance activity be examined in the AHMAC promotion of model quality assurance confidentiality legislation recommended above, as it relates to all such legislation, and the balancing of interests that underlie it.

64. The PIR strongly supports the continued development and refinement of incident monitoring under the National Health Outcomes Program and other quality initiatives

at the State level, with its extension to a national self-funding patient safety improvement system across all disciplines being the end goal.

65. The PIR strongly supports the development of an integrated General Occurrence Classification system, which is based upon common occurrence descriptors, as is currently being developed through the Australian Patient Safety Foundation.

66. The PIR continues its support for credentialling activities as an effective quality assurance activity, but only where such credentialling is based upon evidence-based, skill-specific standards, which can be demonstrated to benefit patient care and outcomes, which can be measured and which are measured in an individual health professional's practice.

67. The PIR recommends that the holding of adequate indemnity cover be required for pathology bodies to be accredited under the Commonwealth legislation.

68. The PIR recommends that all government-funded health programs develop and put in place specific and appropriate performance standards and monitoring processes where they are not already in existence. This should include adverse event recording in these programs. Such performance data should be used by government to inform itself about the overall efficacy of the program and of different service providers. Funding should be contingent upon these measures being in place, and upon continued reporting of this information in an appropriate manner. Consumers should be able to have access to this information - both about the program overall, and about specific providers.

69. The PIR recommends that similar legislation to section 72 of the *South Australian Medical Practitioners Act 1983* (SA), which requires a doctor to provide details to the South Australian Medical Board of any finalised tort case where he or she is a defendant, be enacted in all Australian jurisdictions.

70. The PIR further recommends that similar legislation should be explored for all other registered health professionals to provide a positive quality link between the tort system and the registration system.

71. To address both the fears and uncertainty of doctors and other health professionals and the need to maintain and improve quality and appropriateness of care for patients, the PIR recommends the identification of areas where defensive health care practices are said to exist, followed by the development of clinical guidelines to indicate whether, and in which circumstances, these processes are necessary or clinically advisable.

72. The PIR recommends that proactive risk management methods be developed and implemented in all parts of Australian health care practice. The data being obtained from incident monitoring and the Quality in Australian Hospital Care Study will provide important basic information to facilitate this. These methods should be included in an integrated quality management model for Australian Hospitals to be developed as part of the National Hospital Outcomes Program. Priority should also be

given to developing proactive risk management assessment tools for general practitioners and other primary health care providers.

73. The PIR recommends the broader use in Australia of reactive risk management strategies to minimise the human costs to those who are injured by an adverse event, and to minimise the financial costs and delays arising from these, whether or not the event gives rise to litigation.

74. The PIR recommends that the need for statutory protection of reactive risk management activities, particularly where they are administered in circumstances where legal professional privilege may not apply, be considered in the context of the development by AHMAC of model quality assurance confidentiality legislation.

Chapter 6

75. The PIR considers that rehabilitation obligations on compensation payers and injured people ameliorate some of the perceived anti-rehabilitative effects of common law damages and recommends that similar obligations to those under sections 38 and 39 of the *Motor Accidents Act 1988* (NSW) be extended to all areas of common law damages for personal injury through a nationally coordinated approach by the Standing Committee of Attorneys-General.

76. The PIR strongly endorses the National Health Goals and Targets Review of Rehabilitation Assistance in Australia, and recommends it examine ways of ensuring people with severe disabilities obtain early access to rehabilitation services.

77. The PIR recommends that the evaluation of the Commonwealth-State Disability Agreement examine the key areas of difference between compensable and non-compensable people with disabilities. These include access to aids and appliances, on-going support to live in the community, assistance for carers, early and coordinated access to rehabilitation and difficulties relating to education and transport.

78. The PIR also recommends that the evaluation look at the issue of access to information for people with disabilities, to ensure they are aware of what services are available, and have the opportunity to seek to access them, if necessary with the assistance of someone as their advocate or case manager.

79. The PIR recommends that state and Commonwealth disability programs consider the possible use of existing compensation case management resources to provide case management assistance for people with disabilities more generally. The use of broader use of case managers in the Commonwealth Rehabilitation Service or in other parts of the health system should also be examined.

80. The PIR recommends that the Commonwealth Department of Human Services and Health consult with Commonwealth, State and community agencies, and people with disabilities and their carers to develop a single assessment point for disability-related needs for non-aged people with disabilities.

81. The PIR recommends that a pilot program for coordinated assistance for people with severe disabilities and their carers be developed (the pilot program) between the Commonwealth and States using a case management approach, which is consumer-centred, and where possible, uses existing disability case management resources, rather than creating new ones.

82. The PIR recommends that the pilot program focus on people with severe disabilities and trial a single eligibility assessment process. The pilot program should include people with different kinds of disabilities; people who have different levels of support from unpaid carer; those who live in rural areas, which may involve additional difficulties; those who have access to compensation; and those who have significant financial disadvantage.

83. The PIR recommends that the Commonwealth Government and State Governments, with the assistance of the Australian Institute of Health and Welfare and relevant consumer groups, establish minimum and optimal levels of government-funded assistance for people with severe disabilities as a matter of priority. The Commonwealth Department of Human Services and Health should initiate discussions with this aim in the Disability Services Subcommittee of the Standing Committee of Community Services and Income Security Administrators.

84. The PIR recommends the further analysis of the Quality in Australian Health Care Study data to better define the characteristics of those people who were categorised as having 50 per cent or more disability, as a good starting point in terms of identifying those groups of people who have severe disabilities from adverse patient outcomes and are likely to require ongoing assistance. Other groups that may be illustrative of the needs of those with severe disabilities are children with cerebral palsy, and the very small number of children who suffer neurological damage following immunisation.

85. The PIR recommends that the Commonwealth Government and State Governments, with the assistance of the Australian Institute of Health and Welfare and relevant consumer groups, establish minimum and optimum levels of government-funded assistance for the carers of people with severe disabilities as a matter of priority. The Commonwealth Department of Human Services and Health should initiate discussions with this aim in the Disability Services Subcommittee of the Standing Committee of Community Services and Income Security Administrators.

86. The PIR recommends that the evaluation of the Commonwealth-State Disability Agreement should report on the current approach of State and Commonwealth community services to assistance for those who have received compensation.

87. The PIR recommends that the Commonwealth Government and State Governments determine the most effective arrangements between compensation and other relevant programs of assistance to maximise financial transparency and coordinated care. The aim should be to clarify arrangements in a manner that does not disadvantage those who receive compensation, but that looks to minimise any opportunities for double-dipping and cost-shifting, and that aims to better mesh the systems of compensation and community assistance.

88. The PIR recommends the Government examine the potential for longer term reform of compensation arrangements by removing payments for future care from lump sum payment under the tort system, in exchange for a right to case-managed individual assistance for people with severe disabilities.

Chapter 7

89. The PIR recommends that health professional organisations, medical defence organisations, divisions of general practice and health care institutions look at the availability of counselling and other support mechanisms (including a peer mentor, who may have had experience with a similar event) for health professionals who have a negligence claim or complaint made against them.

90. The PIR does not support the further development of a separate no-fault health care injury compensation scheme at this time.

91. With the above reservations about the need to monitor whether access is actually being improved through contingency fee arrangements, the PIR supports the expansion of the kind of up-lift contingency fee arrangements proposed in the Justice Statement as one way of potentially addressing the problems faced by people seeking redress for alleged health care negligence.

92. The PIR recommends that problems experienced with contingency fee arrangements, where a plaintiff wants to cease an action or change lawyers, be considered by the Law Council of Australia and the Standing Committee of Attorneys-General, when they are making the contingency fee recommendations of the Justice Statement operational.

93. The PIR considers that the National Disbursements Fund to be established by the Commonwealth has significant potential to improve patient access to the tort system, and recommends that the establishment of standards and fair and appropriate fees for such things as medico-legal reports should form an early part of its work.

94. The PIR recommends that accreditation or experience rating of lawyers specifically for health care negligence cases be developed in Australia to ensure that injured patients get the best, most appropriate advice at an early stage in their cases.

95. The PIR considers a body to represent the interests of patients in the manner described above for the English Action for Victims of Medical Accidents (AVMA) to be an option worthy of the support of government.

96. The PIR recommends the development of a national professional standard through the Australian Medical Council and other national or State-based professional bodies to define the discrimination or other negative treatment of those who provide evidence in tort cases, disciplinary processes or any other legally sanctioned investigations (such as royal commissions and coronial inquiries) as professional misconduct, with strong sanctions in such cases. This should also cover similar offences under the different State health complaints acts, relating to discouraging complaints being made or investigated, or disadvantaging those who participate in a complaint. In all cases it should cover negative treatment against another person of the same health profession, a different health professional, a patient or anyone else.

97. The PIR recommends that similar legislative protection should also be provided for those who give evidence in tort cases, disciplinary processes or any other legally

sanctioned investigations (such as royal commissions and coronial inquiries) from discriminatory or negative acts perpetuated at an institutional level, with appropriate enforcement mechanisms for breach of this legislation, for example fines and damages for losses caused to the victim of the negative acts or discrimination.

98. The PIR recommends that AHMAC and the various colleges work together to determine ways of encouraging high quality health professionals to recognise their public responsibilities to provide expert evidence in tort cases, disciplinary procedures and other related processes, so that decision-makers have access to the best evidence available.

99. The PIR recommends the development of a model like AVMA to address the problems plaintiffs currently face in obtaining expert advice.

100. The PIR strongly supports current court-based delay reduction reform initiatives as detailed in Appendix G.

101. Given the complexity associated with many health care negligence cases, however, the PIR considers that it would be worthwhile monitoring the effects of such initiatives on these cases, to see if they are settling more quickly. The PIR recommends that the Department of Human Services and Health liaise with an appropriate body, such as the proposed Australian Institute of Health, Law and Ethics, to undertake such a study and to liaise with court registries to ensure health care negligence cases can be identified for tracking purposes. Such a study should also include liaison with the Australian Institute for Judicial Administration about any special needs there may be to streamline these cases even further.

102. The PIR accepts that a shortened statute of limitations in health care negligence cases should, at this time, be rejected. The current lack of accessibility to the tort system for health care consumers, the difficulties they face in finding out what occurred, and their difficulties in getting access to their health records are all good reasons not to attempt to shorten the period of the statute of limitations at present.

103. The PIR recommends that the Standing Committee of Attorneys-General establish a model statute of limitations which could be adopted nationally to ensure equity of access to the courts for all citizens.

104. For structured settlements to be more widely used in Australia, the PIR considers that a clear ruling about the existing law covering the tax treatment and characteristics of the structured settlement products covered by the ruling is a necessary first step to any broader use of structured settlements. The PIR recommends that the Taxation Office finalise such a ruling as soon as possible.

105. If such a ruling is not consistent with the encouragement of the use of structured settlements, the PIR recommends the Commonwealth Government take urgent action to amend the tax law to encourage the use of structured settlements.

106. The PIR recommends the Government consider an amendment to the tax law to define a period after which periodic compensation payments would be considered as provision for loss of the capital asset of capacity to earn.

107. Further, the PIR recommends that the Government consider an arrangement to allow periodic receipt of income for injury-related care costs in a tax-free manner, up to a statutory limit and subject to proof of expenditure on such costs.

108. If the Government accepts the PIR's recommendations about the desirability and practicality of encouraging the use of structured settlements, the PIR recommends the Commonwealth Government further consider whether it should be mandatory in very large damages awards (for example those over $1 million) for the future care costs component to be taken as a structured payment arrangement - whether by settlement or judgment.

109. The PIR considers that it is not appropriate to recommend the adoption of any system based upon accelerated compensable events for Australia at this time, though their continued development in the United States should be watched with interest.

110. The PIR recommends that the Taskforce on Quality in Australian Health Care, the National Health and Medical Research Council (as part of its guideline development work) and those who are developing performance measures for health professionals consider whether there are certain outcomes which should prima facie be considered likely to result from substandard care.

111. Where such circumstances can be identified, the PIR recommends that the Department of Human Services and Health should investigate the possibility of such outcomes attracting strict liability in any tort action seeking damages, either through Commonwealth or State legislation.

Chapter 8

112. The PIR strongly supports the development of a national health care consumers' charter to clarify the rights and responsibilities involved in the health care partnership.

113. The PIR recommends the establishment of consumer complaints mechanisms at the point of service throughout the health system as part of regular quality assurance processes.

114. The PIR recommends that independent complaints commissions be established as a matter of priority in all States to receive, assess, investigate, refer and conciliate consumer complaints.

115. The PIR also recommends that complaints commissions are able to initiate disciplinary proceedings as a result of investigating a complaint.

116. The PIR recommends that the Australian Health Ministers' Advisory Council (AHMAC) provide funding to the Australian Institute of Health and Welfare and the National Council of Health Complaints Commissioners to hold a workshop to determine which complaints data should be collected and collated nationally to inform quality assurance activities, and appropriate ways of disseminating the information to all relevant levels in the Australian health system. Results of the workshop should be reported to AHMAC.

117. The PIR recommends that AHMAC initiate a study of complaints data collections in each State with a view to recommending standard definitions, collection and electronic collation, based on the results of the workshop mentioned above. The study of complaints data collections should involve the Australian Institute of Health and Welfare and the National Council of Health Complaints Commissioners, with funding provided by AHMAC. The aim of the study is to produce a national data set of health care complaints information from complaints commissions in all States.

118. The PIR recommends the National Council of Health Complaints Commissioners presents an annual report on complaints data to the Australian Health Ministers' Conference, together with its conclusions and recommendations drawn from information in the report.

119. The PIR recommends that an agreed definition of sexual misconduct by a health professional be developed by the National Council of Health Complaints Commissioners to enable uniform data collection, analysis and reporting of such misconduct. Further research may also be needed to determine the nature and extent of the problem.

120. The PIR recommends that complaints involving sexual contact between a patient and a health care professional are assessed, and investigated where appropriate, by the independent health care complaints commissions.

121. In addition, to promote greater consistency and co-operation between the police, complaints commissions and health care professional registration boards, the PIR recommends an agreed protocol be developed by the three parties for receiving complaints from people who allege sexual abuse by a health care professional. The protocol should cover information given to the complainant about all avenues for complaint and support, including any health care advocacy service and the sexual assault counselling services available.

122. The PIR recommends that the National Council of Health Complaints Commissioners develop a national program for informing health care consumers of their rights, and the sanctions and prohibitions against sexual misconduct between patients and health care professionals, for example in professional codes of conduct.

123. The PIR therefore recommends that professional associations:

(a) include information and education on gender relations and sexism in their continuing education, recertification and accreditation programs;

(b) assist members to recognise common situations in which health care professionals sexually abuse patients, understand that this is always inappropriate and provide readily accessible counselling and debriefing for health care professionals; and

(c) as part of professional support to members, ensure that support and assistance are available for members who believe their personal circumstances may adversely affect their professional practice.

124. The PIR also recommends that undergraduate and postgraduate health care professional training and education include information on gender relations, sexism and ethical practice that emphasises the seriousness of sexual misconduct in professional practice, including information on the adverse impact on patients who are subject to sexual misconduct. The possible adverse impacts on health care professionals, such as shame, loss of reputation, de-registration or restrictions on practice, fines and facing litigation, should also be stressed.

125. The PIR recommends that all complaints legislation provide protection for health care professionals who report incidents where a health care professional has used the clinical setting for sexual contact. In those jurisdictions yet to enact complaints legislation, the PIR recommends that any actions taken to discourage a person from lodging or continuing a complaint of sexual abuse or providing evidence in such a case should constitute serious professional misconduct by the person taking such actions.

126. The PIR recommends that the advocacy service to be established by the New South Wales Health Care Complaints Commission, and any advocacy service model based on the United Kingdom Action for Victims of Medical Accidents established in

Australia, be closely examined by AHMAC as potential models for adoption in other States.

127. The PIR recommends that the advocacy service maintains close links with community advocates who advocate on behalf of people who are disadvantaged due to age, or physical or mental disability.

Chapter 9

128. On balance the PIR considers that there are strong public policy reasons to support government legislation requiring all health professionals to have adequate professional indemnity cover as a condition of practice.

129. Similarly, the PIR recommends that all health care businesses, including private hospitals, day surgery facilities, pathology services and health centres, have adequate professional indemnity cover or be required to demonstrate sufficient financial reserves to be able to meet any probable maximum loss arising from negligence in service provision. A combination of self-insurance and catastrophe cover could also be suitable, where financial reserves were sufficient.

130. The PIR is strongly of the view that adequate health professional indemnity must be contractually based, not discretionary, and fully funded from premiums collected for this purpose (that is there should be no cross-subsidisation by other forms of insurance business).

131. The PIR recommends that all health professional indemnity insurance contracts should be expressed as clearly as possible, using the plain English methods common in other sectors of the insurance industry.

132. The PIR recommends that the Commonwealth and States, through AHMAC, develop an agreed strategy for making professional indemnity cover (with a defined minimum set of characteristics) compulsory for all health professionals, either through their own cover, or through adequate cover by their employer in the case of vicarious liability.

133. The PIR recommends that this strategy aim primarily at developing nationally consistent legislation to be passed in all States, but that if this does not seem likely to occur, the Commonwealth should use the full scope of its constitutional powers to ensure that professional indemnity cover is a requirement for all health professionals in Australia.

134. In the interim, the PIR recommends that the Commonwealth introduce administrative requirements, for example as conditions on grants, as part of accreditation processes and through any other similar devices, that the health professionals or health care businesses provide proof of adequate professional indemnity cover.

135. The PIR recommends that compulsory professional indemnity apply not only to registered health care professionals, but also to all health care providers and those who hold themselves out as providing health care, because in all health care cases there is the potential for negligent care to result in significant harm to patients (either through treatment, omission to treat, failure to diagnose or provision of advice).

136. The PIR recommends that all health professional and health care business indemnity cover be uncapped.

137. The PIR recommends that the professional indemnity cover for all health professionals and health care businesses be required to be on a claims incurred basis.

138. The PIR recommends a transition period of two years to enable these developments in health care professional and health care business indemnity to occur in an orderly fashion.

139. The PIR recommends that legislation should be introduced to preclude a neglicence action against a rescuer or voluntary provider of first aid for services rendered in an emergency.

140. The PIR recommends that the medical defence organisations (MDOs) and health professional indemnity insurance sectors standardise definitions of basic terms and calculations and commence to use the AASB 1023 reporting standards to report to their members. This should provide sufficient information for existing and potential members and policy holders to assess the relative financial strength and products offered by the organisation in a fair and accurate way.

141. The PIR recommends that, where false or misleading claims are made by insurers or MDOs about their products, the matters should be referred to an appropriate body such as the Insurance and Superannuation Commission or Trade Practices Commission.

142. The PIR recommends that the Minister for Human Services and Health propose to the Commonwealth Attorney-General that a clarification of the law of vicarious liability in all States (in a manner similar to the *Employees Liability Act 1991* (NSW) and similar legislation in South Australia and Northern Territory) be referred to the Standing Committee of Attorneys-General for coordinated national action. The legislative amendment should be as broad as possible, and cover negligence in activities arising out of or in the course of employment.

143. If a national approach cannot be achieved through the Standing Committee of Attorneys-General, the PIR recommends that health unions seek to have similar arrangements included in industrial awards or enterprise bargains. Because the issue of vicarious liability reform is of relevance to other providers, the PIR further recommends that the Executive of the Australian Council of Trade Unions examine the need for coordinated national action.

144. The PIR recommends that all employed health professionals should have access to independent legal advice and assistance, where their actions are the subject of judicial or other inquiry for example complaints authority investigation, disciplinary processes or coronial inquiry. This could be through the negotiation of employer funding through awards or enterprise bargaining arrangements; through the combined purchasing power of their unions and professional associations to enable purchase of inexpensive legal costs insurance, self-insurance or some direct funding arrangements with the legal profession; or through the availability of specific products from insurers and MDOs that do not include a professional indemnity component in their contract.

145. The PIR recommends that employer and employee groups and AHMAC consider the model clauses and seek to have them included in health contracts of employment, to clarify their entitlements and obligations in relation to professional indemnity and related matters.

146. The PIR recommends that AHMAC and hospital managers consider the possibility of using enterprise liability arrangements in any circumstances where professional indemnity premiums appear to be causing problems in attracting or retaining appropriate health care professionals.

147. The PIR recommends that the General Practice Branch of the Department of Human Services and Health monitor the indemnity concerns of general practictioners (GPs) to determine whether it is necessary to adopt an appropriate premium setting option to ensure that professional indemnity issues are not discouraging diversification in general practice, or limiting the practice choices of rural GPs.

148. In the event of a direct link between MDO premiums and the level of Medicare rebates, the PIR recommends that a regulatory body to scrutinese the level of premiums and the justification for movements in them be established by the Commonwealth Department of Human Services and Health.

149. The PIR recommends the establishment of an MDO fund to cover the costs of claims incurred but not reported by a specified date. That date should take account of the fact that all MDOs now claim to be setting their contribution rate on a fully funded claims incurred basis. All providers of cover - whether existing or new MDOs or insurers - would be required to collect the levy from doctors holding membership or a policy with them.

150. The PIR recommends the concept of a mutual insurance mechanism to any part of the health care sector that considers commercial insurance too costly, and self-insurance too risky. Some possible areas where mutuals might be appropriate could be pathology laboratories, private hospitals and individual groups of health professionals who are otherwise unhappy with the range or cost of available commercial products.

Chapter 10

151. The PIR recommends that a National Cerebral Palsy Database and Register be developed by the Australian Institute of Health and Welfare to collect national data on the incidence and possible causes of or contributing factors to cerebral palsy.

152. The PIR recommends that funding for the National Cerebral Palsy Database and Register should come from both the State Governments and Commonwealth Government.

153. The PIR recommends that the proposed National Cerebral Palsy Database and Register seek to determine whether there are any distinguishing characteristics of cases of cerebral palsy that may have been associated with birth asphyxia, and whether the intervention of birthing service providers could have prevented the cerebral palsy occurring in any of these cases.

154. The PIR further recommends that the National Cerebral Palsy Database and Register seek to determine, as a priority, whether there are any preventable causes of cerebral palsy, whether associated with health care or not.

155. Given the widespread concern among birthing service providers, which has arisen from the rumours of a rapidly rising number of successful cerebral palsy claims, the PIR emphasises the need for sufficiently detailed national data on all health care negligence claims to ensure any similar concerns can be tested. The minimum data set must include the category of practitioner involved, a broad indicator of the nature of the claim and the outcome of a claim. The inclusion of whether its resolution involved settlement, a judge, or a judge and jury may also be useful to monitor what effect, if any, these mechanisms have on which party is successful.

156. The PIR recommends that the Relative Value Study consider the existing medical defence organisation (MDO) subscription fee differentials in determining whether Medicare Benefit Schedule fees are appropriate for different medical treatments for different specialties.

157. Given the range of factors at play, the PIR recommends that the Commonwealth Department of Human Services and Health continue to monitor the numbers of specialist obstetricians and gynaecologists involved in private birthing services, and that it seek to encourage the States to collect data on the numbers of specialist visiting medical officers, as well as general practitioners and midwives, involved in birthing services in the public sector, to ensure early detection of any developing problems.

158. The PIR recommends that the Australian Health Ministers' Advisory Council (AHMAC) establish a working group to determine what can be done to encourage the retention of skills and practices, such as obstetrics, anaesthetics and surgery, in rural general practice in addition to addressing any direct financial incentives arising from MDO subscription concerns as discussed below.

159. The PIR considers that the determination of the most appropriate means of addressing subscription disincentives for GPs from the three options of income-related

subscriptions, a single GP subscription rate and enterprise liability should be a top priority for the proposed AHMAC rural general practice working group, to avoid further reduction in the numbers of GPs providing obstetric and other services in rural areas.

160. The PIR considers that it is important that the premium for midwives be determined on the claims risks associated with midwife birthing services, rather than the claims experience of either GPs or specialist obstetricians and gynaecologists.

161. As part of the implementation strategy for its recommendations on professional indemnity cover, the PIR recommends that the Department of Human Services and Health ensure that products are available at a reasonable cost to the full range of self-employed health professionals, including midwives, to minimise any unintended workforce effects of professional indemnity arrangements.

162. The PIR recommends that all State Governments adopt a policy that the costs associated with negligence in public patient birthing services will be borne by the public sector, with no recovery from either employed health professionals or Visiting Medical Officers (VMOs) providing these services.

163. The PIR recommends that the National Health and Medical Research Council (NHMRC) determine whether there are any significant outcome differences for practitioners who undertake different numbers of deliveries each year, and whether there are any differences in relation to the incidence of claims of negligence.

164. Given the apparent concerns among specialist obstetricians about lifestyle factors described in the RACOG survey of members in 1993, and the possible impact fatigue or haste can have on quality of care, the PIR recommends that RACOG look towards encouraging different models of care, which can recognise the validity of lifestyle issues, as well as the need to ensure high quality care and minimum intervention rates.

165. The PIR recommends that professional bodies of birthing service providers and institutions where births occur be required to develop intervention guidelines and procedure audits to ensure that such procedures are only being undertaken when clinically appropriate and not because of fear of litigation. Appropriate monitoring mechanisms to look at the practices of individual birthing service providers and of institutions need to be put in place as well.

166. The PIR recommends that both the intervention guidelines and the performance monitoring information be publicly available.

167. The PIR recommends the development through the NHMRC of an information booklet for parents in Australia, which details the various outcomes associated with pregnancy, the various interventions and their risks, and the normal process of pregnancy and childbirth as well as the risks associated with childbirth, based on the best scientific information currently available through the Cochrane Collaboration and other sources. It should also set out birthing service options (that is different

providers, public versus private, different locations), as well as the costs associated with these.

168. The PIR recommends that groups with special information needs because of cultural or language differences have adequate information freely provided to them.

169. The PIR recommends the development of a set of agreed minimum data that all hospitals and birthing service professionals will collect and monitor, including number of births and outcomes, practice patterns, intervention rates of various kinds and patient satisfaction. Such data should be available to patients and health care consumers. Such data should be available free of charge to patients and health care consumers in the proposed information booklet.

List of Abbreviations

AASB	Australian Accounting Standards Board
ACE	accelerated compensable event
ADR	alternative dispute resolution
AHCPR	Agency for Health Care Policy and Research
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AIL	AIMS Industry Liaison
AIMS	Anaesthetic Incident Monitoring
ALRC	Australian Law Reform Commission
AMA	Australian Medical Association
APSF	Australian Patient Safety Foundation
ARC	Administrative Review Council
AVMA	Action for Victims of Medical Accidents
CCSESC	Cervical Cancer Screening Evaluation Steering Committee
CHF	Consumers Health Forum
CFM	cash flow management
CRS	Commonwealth Rehabilitation Service
DCM	differential case management
FOI	Freedom of Information
HIROC	Healthcare Insurance Reciprocal of Canada
HMPS	Harvard medical Practice Study
IBNR	incurred but not reported
ISC	Insurance and Superannuation Commission
JAMA	Journal of American Medical Association
MEDTEP	Medical Treatment Effectiveness Program
MPAA	Medical Protection Association of Australia
NASOG	National Association of Specialist Obstetricians and Gynaecologists
NHMRC	National Health and Medical Research Council
NPAAC	National Pathology Accreditation Advisory Council
PORT	Patient Outcome Research Team
RACGP	Royal Australian College of General Practitioners
RACOG	Royal Australian College of Obstetricians and Gynaecologists
RADGAC	Research and Development Grants and Advisory Committee
RIM	Reciprocal Insurance Management
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SCAG	Standing Committee of Attorneys-General
TGA	Therapeutic Good Administration
VMO	Visiting Medical Officer

Chapter 1: Bringing it all together

A. Introduction

1.1. This is the Final Report of the Review of Professional Indemnity Arrangements for Health Care Professionals (PIR). It brings together four years of research and policy development and proposes a comprehensive reform agenda to ensure that the problems identified by the PIR are addressed. The Report does not duplicate the work included in the PIR's other publications, although summaries of these are presented where relevant. The PIR's publications are listed below for reference and should be consulted to supplement the information presented here.[1]

1.2. This Final Report presents a strategy to fulfil the PIR's overall objective of minimising the human and financial costs of adverse patient outcomes from health care.[2] It does so in the context of current arrangements for health care, professional indemnity and provision for compensation, and in the light of what the PIR's work has revealed about the extent and consequences of adverse patient outcomes.

1.3. Even with the results of the PIR's intensive research, there are gaps in knowledge about adverse patient outcomes which still need to be filled. The completion of the PIR is not the end of reform. Much more is still required to ensure the Australian community achieves maximum benefits from the minimisation of the human and financial costs of adverse patient outcomes arising from health care. There are few areas where action is not needed to achieve this important goal. Doctors and other health care professionals, lawyers, governments and health care consumers,[3] all have important roles to play, and sometimes difficult changes to make, if the proposed reforms are to achieve their aims. Improved publicly available information will allow the refinement of reforms over time. It will also permit more informed debate on a range of topics that have been important to the work of the PIR and continue to be critical for improving the quality of health care in Australia.

1.4. The period during which the PIR has been conducted has been one where there were many changes to the health care system and many new developments in the law. There have been vigorous public debates about the health care system, about the nature and consequences of the doctor/patient relationship, about programs for the provision of assistance for people with disabilities, and about the accessibility and adequacy of the legal system. This Final Report covers all these issues and links recommendations with developments happening in these areas.

B. The early stages

1.5. The PIR commenced in April 1991. The concerns that gave rise to its establishment include:

- very few people who suffer adverse health care outcomes are actually compensated and for these people the common law system is extremely costly and involves unreasonable delays;[4]

- the operation of the current fault-based compensation system sometimes conflicts with broader public health policies such as the desirability of immunisation. For example, it may act as a deterrent to manufacturers of therapeutic goods and doctors where their activity is perceived to entail a high risk of being sued;

- the current indemnity, legal and compensation arrangements are ineffective in the prevention of adverse patient outcomes;

- the existing indemnity arrangements for health care professionals may be inadequate;

- the levels of subscriptions for indemnity for some health care professionals have been rapidly increasing; and

- the law with regard to the vicarious liability of employers is inconsistent among the States and in some respects inadequate.[5]

The PIR's Terms of Reference are set out in Appendix A.

1.6. Following a period of preliminary consultation and research, the PIR issued its first Discussion Paper in February 1992.[6] Consultations on this Discussion Paper were held with interested groups and individuals in Adelaide, Perth, Sydney and Melbourne and a separate report on these was produced.[7] Interested parties from all States were invited to attend or hold separate discussions with the PIR and submissions were received from 97 individuals and organisations.

1.7. As a result of consultation and comments on the Discussion Paper and further research work, the PIR released its Interim Report in March 1994.[8] The Interim Report contained 47 recommendations and requested views on over 20 topics. More than 10 months were allowed for the Report to be publicly considered and comments provided. Around 100 written submissions were received (see Appendix B.)

1.8. The Interim Report drew on a number of research projects and publications produced by the PIR. Together they offered a comprehensive strategy to minimise the human and financial costs of adverse patient outcomes. The following is a complete list of PIR publications:

- Compensation and professional indemnity in health care: A discussion paper, February 1992;[9]*
- Report on consultations on first discussion paper, November 1992;[10]
- Report on the feasibility study of an Australian hospitals' adverse health care incidents study, December 1992;[11]*
- The health/medical care injury case study project, February 1993;[12]*
- Australian Bureau of Statistics Survey of medical defence organisations, April 1993;[13]
- Defensive medicine and informed consent, May 1993;[14]*
- Compensation and Commonwealth health and community services programs, June 1993;[15]*

- So you want to know more about the Commonwealth Quality Assurance Legislation, July 1993;[16]
- Birthing issues: background paper, August 1993;[17]
- Birthing issues: a rural perspective, December 1993;[18]
- Compensation and professional indemnity in health care: an interim report, February 1994;[19]*
- Report on medical professional indemnity arrangements, March 1994;[20]*
- Incident monitoring & risk management in the health care sector: conference proceedings, November 1994;[21]
- Final reports of the incident monitoring pilots – these cover pilots in emergency medicine, obstetrics and gynaecology, gastroenterology, psychiatry, intensive care medicine, general practice and the hospital institutional pilot;
- Patient guidelines: consultancy for the development of information guidelines for health care professionals and patients in the event of an adverse patient outcome, March 1995;[22]*
- Provider guidelines: consultancy for the development of information guidelines for health care professionals and patients in the event of an adverse patient outcome, March 1995;[23]*
- Structured settlements as payment of compensation for personal injury, June 1995;[24]*
- Report on taxation treatment of compensation payments, June 1995;[25]* and
- Compensable and non-compensable people with disabilities: equal needs – unequal assistance, August 1995.[26]

1.9. A summary of each of these publications is provided in Appendix C. Those marked with an asterisk (*) were distributed widely, deposited in libraries throughout Australia, or made available on the Internet. The incident monitoring pilots are detailed in Chapter 5 and the patient and provider information guidelines are presented in full in Appendix D.

1.10. As part of the work of the PIR, the Government also provided funding for the Quality in Australian Health Care Study (formerly titled the Australian Hospital Care Study). There will be two separate reports on the Quality in Australian Health Care Study, as well as separate reports from a Task Force appointed in June 1995 by the Minister for Human Services and Health, Dr Carmen Lawrence. Part 1 was due in November 1995 and Part 2 in December 1995.[27]

1.11. The PIR would like to thank all individuals and organisations for their contributions to the work noted above. The submissions, consultancies and consultations provided the PIR with a range of views which have been invaluable. Many contributions to the PIR were from individuals who had relevant personal experiences of the health/medical and compensation systems, both as health care professionals and health care consumers. The PIR especially appreciates the time and efforts of individuals in assisting in its work. All contributions were greatly appreciated and informed the PIR's work and final recommendations.

C. Main themes of the PIR's work

1.12. A number of themes are apparent in the information, views and opinions presented to the PIR over the last four years. They have recurred in different contexts and are central to all the PIR's work. The following have been critical in addressing the PIR's Terms of Reference:

- the need to improve preventive strategies such as quality assurance (QA);
- implementing an effective health care partnership;
- establishing effective and accessible complaints and disciplinary processes;
- the importance of appropriate and adequate professional indemnity to protect both health care professionals and health care consumers; and
- improving equity of access to needed services.

Each of these themes is addressed comprehensively in this report. A brief overview is provided below.

Preventive strategies

1.13. The PIR found there was a need for improved data collection on which to base preventive strategies. Throughout the PIR's work, many correspondents offered differing views on:

- whether adverse patient outcomes occurred in the Australian health care system;
- the extent of adverse patient outcomes in the Australian health care system;
- whether adverse patient outcomes involved health care professional negligence;
- what constitutes medical negligence; and
- whether adverse patient outcomes were preventable.

1.14. To begin to clarify some of these issues, the PIR funded incident monitoring pilot projects and the Quality in Australian Health Care Study. Incident monitoring is a method of:

- reporting any events which could, or did, give rise to an adverse patient outcome; and
- analysing data to ensure elimination or reduction of the risk.

1.15. The Quality in Australian Health Care Study aims to identify:

- the underlying causes of adverse patient outcomes and factors contributing to them;
- strategies to reduce the incidence and severity of adverse patient outcomes; and
- mechanisms for routinely collecting data to monitor the incidence and severity of adverse patient outcomes.

1.16. These projects have been carried out with the co-operation of health care professionals, health care facilities and State Government health authorities. They reveal that:

- a substantial number of adverse patient outcomes occurs in the Australian health system;

- some have serious consequences, such as disability and death;
- many are preventable; and
- there is a need to continue to improve QA activities in the health system.

1.17. Both incident monitoring and the Quality in Australian Health Care Study depended on QA legislation, developed by the PIR, that promotes wider use of quality assurance measures by providing for the confidentiality of information collected and discussed in QA activities. The QA initiatives and legislation received increasing support from correspondents as their potential to improve patient safety became clear.

1.18. Other initiatives such as credentialling have been discussed by the PIR in the context of risk management. The PIR explored its use in health care facilities, but noted the potential for unintended and inappropriate consequences in restricting the practice of some individual health care practitioners.[28] Accreditation, or certification, was examined with respect to health care professionals and their professional associations. Credentialling and accreditation received support from correspondents to the PIR. Many professional colleges and health care facilities provided extensive details of their credentialling and accreditation procedures to ensure doctors are practising safely.

1.19. The PIR examined how to increase health care consumers' confidence in the health system. This included the recommendations of the National Health Strategy that health services and area management could review QA procedures to identify areas where consumer participation could be initiated and strengthened.[29] This possibility was addressed by several correspondents to the PIR who supported greater consumer participation. For example, one correspondent noted that consumer experiences were able to complete the information feedback loop necessary for effective QA strategies and urged consumer input at all levels into the definitions of quality, desired outcomes and adverse outcomes.[30]

1.20. The PIR concludes that the best way to minimise the human and financial costs of adverse patient outcomes is by effective QA and risk management strategies throughout the health system. Correspondents to the PIR expressed broad agreement with this conclusion.

The health care partnership

1.21. The PIR's work highlights the changing role of health care consumers, from passive recipient of services to active partner with the health care professional. For an effective partnership, health care consumers must not only be actively involved in their own health care, but they should have opportunities for participating in decisions about health service planning and delivery. The individual consumer's right to be informed of the risks and benefits of proposed treatments has been a constant theme of the PIR's work.

1.22. Health care consumers require a range of information in order to participate as full partners in decisions related to health care. Consumer expectations regarding the outcomes from health care interventions have changed over time. Many consumers lack the basic information that almost all interventions carry some risk of harm. Health professionals may be reluctant to say anything about this for fear of a patient rejecting recommended treatment options. Some patients still believe as an article of faith, that *the doctor always knows best*

and can employ modern methods and technology to achieve the desired result without any risk to them.

1.23. Throughout the PIR's work, good patient/provider communication has emerged as a critical determinant of patient satisfaction with health care treatment. Correspondingly, poor or absent communication has been identified repeatedly as a major factor in dissatisfaction with health care, closely linked to complaints and litigation..[31] The importance of information giving in the health care partnership was emphasised by the Australian High Court of Australia in *Rogers v Whitaker*,[32] where the court found a doctor had a duty to disclose risks which might be considered material by a reasonable patient.

1.24. Many correspondents commented on information and communication issues. Some correspondents endorsed the view that the community is overly optimistic about the outcomes of health care and that many health care consumers do not know the risks or side effects of the medical procedures performed. Other correspondents approached the issue in the context of the disclosure of risks about proposed treatments by health care professionals, or in the context of health consumers' rights generally. Some correspondents commented from a health care professional's perspective on the difficulties with providing complete information and consumers' difficulties with assimilating complex information, especially during the stress or anxiety of a severe illness.

1.25. On poor communication, one correspondent wrote of the "socially isolating language and technology of health care".[33] Another correspondent said the concept of customer service, "... should be inculcated at early stages in the training (and upgrading) of health care professionals. It should be observed however that shortage of staff, stress, inadequate or poor working conditions can be unproductive in this context".[34]

1.26. Some correspondents saw measures for consumer participation in the health system and the issue of consumer expectations of health care as linked to the broader question of health care consumers' rights. For example, arguing for a comprehensive package for health care consumer protection, some correspondents supported the concept of a charter of consumers' rights.

1.27. The Final Report argues that an effective health care partnership requires openness and access to information for both patients and health professionals. Currently openness and easily accessible information are often absent or are compromised. These problems adversely affect the full development of an effective health care partnership between health care consumers and health professionals. The Report makes detailed recommendations on ways to address the various information deficiencies, including:

- the lack of available information on risks, benefits and costs of treatment options (including no treatment) for health professionals and consumers;
- the lack of available information on the operation of the tort system; and
- the lack of individual professional and system-wide performance measures and performance standards.

Complaints and disciplinary processes

1.28. Effective complaints and disciplinary processes are essential if consumers are to have confidence in the health system. They also have a part to play in maintaining professional standards and improving the quality of health services.

1.29. Health care consumer correspondents to the PIR frequently expressed dissatisfaction with health care complaints and disciplinary processes. Many believe complaints processes are slow and ineffective and that disciplinary procedures, in particular, appear to operate in favour of the health care professional.

1.30. Health care professionals often informed the PIR of their concerns that the number of consumer complaints was increasing. Many doctors wrote to the PIR noting that consumers were becoming litigious, and that common law courts were defining what was acceptable medical practice without sufficient weight given to medical opinion.

1.31. The PIR documented the many costs and delays of common law negligence actions. Correspondents' views differed on the role of the common law in medical negligence.[35] Some supported it as the appropriate vehicle for achieving compensation for harm resulting from negligence, while acknowledging the importance of reducing costs and delays. Others supported greater use of alternative dispute resolution in health care complaints.

1.32. The establishment of independent health care complaints commissions in each State, with powers to investigate and conciliate on complaints was strongly supported in the Interim Report. Independent complaints commissions are an important avenue for patients to resolve many of their concerns without having to commence litigation. The PIR also noted the desirability of resolving complaints at the point of service wherever possible. To assist in this process, the PIR discussed the importance of health care facilities appointing patient liaison officers. These measures generally received support from correspondents.

1.33. The PIR concludes that:

- complaints should be seen by health care professionals as an opportunity to improve services and as a key part of QA and risk management processes;
- independent complaints commissions are appropriate bodies to boost consumer confidence in the health system and conciliation of complaints is a valid option for many consumers and professionals; and
- the common law system should be more accessible and streamlined for those health care consumers and others who choose to seek compensation for alleged negligence in this way, and damages should be paid in more appropriate forms where large financial sums and long-term care and support needs are involved.

Professional indemnity

1.34. Research and consultation highlighted several issues concerning professional indemnity, for example:

- uncertainties about which health care professionals are covered by vicarious liability;
- the accessibility and affordability of insurance/indemnity cover for some health care professionals;
- the discretionary nature of the indemnity provided to doctors and dentists by medical defence organisations (MDOs);
- the long-term financial viability of MDOs; and
- the cost of MDO indemnity subscriptions as a disincentive to practice for some groups of doctors.

1.35. Vicarious liability refers to an employer's liability for an employee's negligent actions. The PIR found some health care professionals had double indemnity cover, due to uncertainties about whether they should be considered employees or independent contractors. In these cases, health care professionals buy their own indemnity, while the facility in which they practise also has indemnity insurance which may cover the health care professional. A further factor is that, in some States, damages paid by an employer due to an employee's negligence may be recovered from the employee if the employee has indemnity cover.[36]

1.36. The PIR also investigated the situation of a health care facility's non-delegable duty of care. This refers to particular circumstances under which a facility will be held responsible for the negligent actions of independent (non-employee) doctors, for example, when they are operating in a hospital. It also examined the United States developments in relation to enterprise liability as a method of cost-sharing and risk management.

1.37. The PIR found there was a variety of arrangements and indemnity cover for non-medical health care professionals, with some concerns expressed by correspondents about the lack of choice, the high cost of the indemnity cover and the possibility that negligent actions might not be covered.

1.38. Many correspondents cited the alleged increasing rates of common law actions against doctors as the reason for increasing costs of medical indemnity. Correspondents also wrote that the cost of indemnity was likely to cause doctors to cease practising in high risk areas of medicine. While acknowledging the concerns of many doctors, the PIR has been unable to obtain unequivocal evidence of a medical malpractice crisis referred to by some correspondents and the media. The PIR concludes that the recent cost increases of medical indemnity mainly related to financial adjustments and changes in the MDO industry as it sought to fully fund its liabilities. Some increases in indemnity costs resulted from record level damages awarded where the costs of life-long care of the injured party were involved. These costs are taken into account in assessing outstanding liabilities. The degree to which increased claims, if indeed there has been an increase, have contributed to rises in indemnity costs is less clear.

1.39. The PIR argues that indemnity should be compulsory for all health care professionals, either through vicarious liability or through purchasing private indemnity/insurance cover. This will protect both health care professionals and health care consumers by ensuring that compensation is available where negligence is found. Consistent with this view, the PIR believes the discretionary nature of medical indemnity offered by MDOs must change to provide doctors and health care consumers with more certainty regarding cover and

compensation, where a doctor is found to be negligent. Compulsory indemnity for health care professionals has been supported by many correspondents to the PIR.

Equity of access to needed services

1.40. The PIR has been very concerned about the difficulties people have in accessing necessary health and community services they need. Correspondents who had common law actions pending cited difficulties in accessing on-going health care, frequently because full payment for services was demanded or because practitioners were allegedly reluctant to become involved with a patient pursuing a negligence case.

1.41. Another source of concern was that rehabilitation may be delayed while an injured person seeks compensation. Often, if rehabilitation is delayed, the person's degree of recovery from injury is permanently compromised.

1.42. The difference in being able to access needed services is striking between compensable and non-compensable people with disabilities in some areas, although not all. In general, compensable people with disabilities are able to access or buy needed services, aids and appliances, at least after receiving compensation, where they are not available from public sources. Non-compensable people with disabilities generally rely on government-subsidised services. Many government services have limited budgets which means there are sometimes not enough services to cater for all those people who require assistance.

1.43. The PIR's work also revealed that compensable people with disabilities may *double dip*, that is, receive compensation to cover health care costs but then access government-subsidised services. Sometimes this is because the compensation provided was inadequate to meet their needs, or a lump sum compensation payment was received by a person with no assistance or experience in managing a large sum of money to provide income or meet expenses over an extended period of time. In the latter case, lump sum payments that were intended to provide a lifetime's care may be spent fairly quickly and the person then has to rely on government-subsidised services for needed support.

1.44. In the Interim Report, the PIR discussed a variety of ways of improving access to needed services and removing inequities, for example:

- no-fault compensation;
- removing future care costs from common law compensation and meeting needs through government-subsidised services;
- greater use of structured compensation settlements as an alternative to the payment of lump sum compensation;
- improved co-ordination between the various compensation systems and health and community services; and
- prevention of double dipping - legislation was drafted to prevent double dipping in the Medicare and nursing home benefit programs and is discussed in Chapter 6.

1.45. Correspondents to the PIR frequently cited the difficulties people with severe disabilities have in co-ordinating a package of services to meet their needs. For example:

- information on availability of services was hard to find;
- multiple assessment procedures were conducted to elicit the same information;
- a lack of focus on individual needs meant services were frequently inappropriate;
- frequent turnover of service staff caused frustration; and
- carers' needs were ignored or not catered for adequately.

1.46. Regarding no-fault compensation, correspondents had mixed views. Some rejected it as too costly to provide for all cases of medical misadventure. Others noted that, because all compensation on systems have eligibility criteria, there would be difficulties and inequities in deciding who should receive it. For example, assuming that funds are *not* available to compensate all people who have a disability through hereditary, accident or injury, it would be necessary to determine who should be eligible, usually on the basis of how the disability arose. If the compensation were restricted to those people who suffer medical misadventure, it could be necessary to determine which interventions should be the subject of compensation where harm is suffered. Some correspondents proposed no-fault compensation should be provided for special groups of people, for example, those who suffer vaccination-related injury, or who have received false-negative results from screening programs for early detection of cancer.

1.47. Removing future care costs from the common law system was supported by some correspondents, who noted this would reduce the cost of professional indemnity. Others stated it would penalise those people who had the greatest need for assistance, that is people with severe disabilities whose future care costs are greatest, unless there was a guarantee of service through equivalent community-funded programs.

1.48. Structured compensation settlements where generally supported by correspondents. Most agreed that structured settlements offer advantages, especially for people with long-term costs to meet or who are inexperienced in managing lump sums, by providing regular payments from which expenses can be met as they arise.

1.49. There was general agreement that better co-ordination of compensation, health and community services is needed urgently. The PIR notes that other review and reform processes have recognised this need and many recommendations have been made.

1.50. The PIR does not favour the creation of any separate no-fault health care misadventure compensation system at this time. Where a person needs assistance and support, it is concluded that the most equitable basis for entitlement is their level of need, rather than how the disability arose. People with severe disabilities are most disadvantaged when they are unable to access the assistance they need.

1.51. Where community services are not perceived to be adequate, the incentives to litigate for compensation to meet these needs are much greater. This appears to be a major reason for the much greater use of the tort system in the United States. Therefore, determining the assistance needs of people with severe disabilities and ensuring the adequacy of available assistance are important elements in minimising the need to undertake tort actions. Where increased funding is necessary, the PIR explores some options, including better use of tort-

funded resources. So far as funding options are concerned, the Final Report argues that funding from a range of sources is appropriate, but that need, rather than causation and source of funds, should determine access to necessary assistance and its adequacy. The PIR has therefore recommended measures to: determine what is an acceptable level of assistance and an optimal level of assistance for people with severe disabilities and their carers; and to trial co-ordinated care arrangements for people with severe disabilities and their carers who need a package of services over an extended period of time.

1.52. These broad areas encompass almost the whole of the PIR's work. The area of professional indemnity and compensation encompasses many related issues which required the PIR to have a very broad focus. In addition to its own work being open to public comment, the PIR has maintained an interest in, and in some cases participated in, other review and development work which is briefly examined in the next section.

D. Related developments

1.53. There has been a continuing period of change and consolidation in the Australian health care system since the release of the PIR's Interim Report. The examination of health and community services programs by the Council of Australian Governments' (COAG) is an important initiative for the future of the PIR's reforms. In January 1995, the COAG Taskforce released a discussion paper which presented a program for reforms intended to:

- make people's needs, rather than the services themselves, the focus of planning and funding policy;
- improve service co-ordination and continuity of care;
- introduce greater flexibility in the provision of services at the local level;
- promote investment in prevention and early intervention for individuals and families;
- provide clearer roles for the Commonwealth and States; and
- develop funding and service incentives which support service reform, minimise gaps and get best value for money.[37]

1.54. The program for reforms was endorsed at the April 1995 COAG meeting. A range of projects has arisen from this. Those which may have relevance to the PIR are briefly referred to in Chapter 6 of this Report.

1.55. The PIR has reported on review and evaluation activity relevant to compensation and people with disabilities.[38] Common elements flowing from these reviews and evaluations include:

- the need to prevent as many injuries and disabilities as possible;
- the undetermined, but probably high level of unmet need for services and support;
- the scope to simplify arrangements for compensation and health and community services to preclude gaps, overlaps and opportunities for cost-shifting and double dipping; and
- the requirement to implement a focus on individual consumer's needs in health and community services.

1.56. An important first step in addressing some of these problems was to determine a minimum level of assistance which should be available from government-funded sources. This would allow levels of unmet need to be accurately determined, and provide a framework for evaluation of performance. It would also provide some certainly about when a person should self-provide, for example, through private insurance arrangements.

1.57. The PIR also noted that compensation systems and support from health and community services have been considered in isolation from each other. The PIR's work addressed these issues and was also informed by the Review of the Relationship between Compensation and Health and Community Services Programs (Compensation Review). The Compensation Review was responsible for a set of four bills, the *Health and Other Services (Compensation) Bill 1994* and cognate bills, which address the issue of cost-shifting by compensable people to the Medicare and nursing home benefit programs and which is currently before Parliament.

1.58. Other relevant work includes: the development of codes of rights and responsibilities by the health complaints commissions in the Australian Capital Territory and Queensland; the implementation of measures to improve the quality of care and outcome measures in health care, for example, the development of clinical practice guidelines and benchmarks in health care; and the proposed development of a national health consumers charter. The PIR has attempted to frame its recommendations with due regards to this broader reform context.

E. Outline of the Final Report

1.59. Chapter 2 outlines the information that is needed for decision-making by health care consumers, service providers, governments and indemnity providers. It looks at some of the difficulties faced in obtaining accurate information and it examines the results of the Quality in Australian Health Care Study and the need for a national data collection relating to the common law system.

1.60. Chapter 3 examines information relating to the risks and benefits of health care, and the moves towards more evidence-based decision-making. It also looks at clinical guideline development, health outcomes work and when treatments should be considered experimental.

1.61. Chapter 4 looks at issues relating to access to information, including the sources of information for consumers, communication issues and access to health care records. It also provides information on the PIR's information guidelines for health care consumers and service providers, which are at Appendix D.

1.62. Chapter 5 covers ways of minimising the costs of adverse patient outcomes, firstly by preventing their occurrence, and secondly by ensuring prompt intervention through risk management where an adverse event occurs. It looks at quality standards and ways to ensure that efforts directed at improving quality are effective.

1.63. Chapter 6 examines the problems with access to assistance for those who have an adverse patient outcome, and puts forward ways to improve this assistance. It details the importance of defining a safety net of government assistance for those with long-term care

needs. It looks at ways of funding such assistance by using existing and new funds more effectively.

1.64. Chapter 7 addresses possible changes to the common law system to reduce the administrative costs and delays, and to address other problems with this system. It also looks at the current developments in the law of negligence, and its the relatively limited role at the moment in providing for the needs of those whose adverse patient outcomes arise from negligence. It briefly examines the issue of no-fault compensation.

1.65. Chapter 8 looks at the rapid evolution of a new partnership in health care, and the rights and responsibilities of both parties to that partnership. It reviews complaints mechanisms, advocacy services and the maintenance and enforcement of adequate professional standards. It also examines the issues surrounding sexual misconduct by health professionals.

1.66. Chapter 9 considers the range of reforms necessary to ensure that health care professionals and health care consumers are adequately protected in relation to the funding of common law actions and through a clarification of the professional indemnity requirements of various health care professionals and facilities. It considers the role of government in ensuring the long-term financial soundness of these provisions.

1.67. Chapter 10 applies many of the above reforms to the contentious area of birthing services, and examines how the reforms proposed in the rest of the Final Report may address the problems faced in this important area of health care. The problems include: the availability of birthing services, especially in rural and remote areas; the cost of professional indemnity for birthing practitioners; and the effect of professional indemnity issues on the mix of health care professionals, involved in birthing, that is midwives, general practitioners and specialists.

Chapter 2: Information for decision-making

A. Myths, misinformation and getting to the truth

Why we need information

2.1 When the PIR began its work there were many views on adverse patient outcomes but very little information on them. It was impossible to state how many adverse patient outcomes there were and how many were preventable. There was also limited information available about how many patients received adequate compensation, or what happened to patients who were injured and required long-term assistance, but who were not compensable. As work progressed, further information needs were identified. Without the information, all decision-makers were making choices in the dark, and speculation and myths abounded.

Consumer information needs

2.2 Health care consumers need information to determine which treatment is appropriate to their circumstances. This includes information on relevant treatment options, including no treatment at all, and the benefits, risks and financial costs of these options. Health care consumers also need information about:

- the skills and experience of any health care professional from whom they seek assistance;
- the health care professional's practice preferences and relevant financial interests, for example in services or facilities to which a patient can be referred, where these could affect the advice being provided;
- whether a health professional whom they consult or a health care facility or service that they use, has adequate indemnity or insurance cover, whether directly or through vicarious liability, for any negligent action or omission which results in damage to them;
- what to do if something goes wrong with their health care;
- services and assistance that can help them if they have an adverse event;
- how to access confidential information about their condition and treatment in their health care records.

2.3 The PIR notes that health care consumers require direct access to some of the above information to make vital health care decisions. In other areas, for example adequacy of professional indemnity cover, a health care consumer may be adequately protected through obligatory scrutiny by a registration board or some other body. In choosing a health care professional, health care consumers will assess the professional's empathy, ability to communicate clearly and other personal skills, as well as clinical competence.

Health professional needs

2.4 Health professionals need accessible, up-to-date information on:

- the range of appropriate treatment options for various conditions;

- how to interpret this information so it is relevant to their practices;
- the level of evidence for the efficacy of various options;
- how to best convey information on options to patients to facilitate their understanding and informed choice; and
- how to asses the standard and quality of the care they provide.

2.5 Given the importance of poor communication is a factor in dissatisfaction with health care services, health care professionals must know how to provide a factual and sensitive account to patients when something goes wrong with health care.

2.6 The PIR's research on medical defence organisations, their discretionary indemnity cover and their unfunded liabilities for claims incurred but not reported, demonstrates that health care professionals should also understand the financial situation of the organisation which provides their professional indemnity cover and the nature of the cover provided – Chapter 9 addresses these issues and ways to ensure that sufficient information is available for health professionals to make informed choices.

2.7 Given the uncertainties sometimes surrounding employers' vicarious liability for the negligent actions of employees, health care professionals would be well advised to understand the nature of their relationship with a health care facility in which they practise. They should know whether are considered employees or independent contractors. Knowing this, they can determine what their professional indemnity requirements are. For example, if they are considered as employees, they generally will not need to buy personal professional indemnity. Chapter 9 also proposes solutions in these areas.

2.8 Health care professionals need accurate, basic information about cases involving negligence by health care providers. Having this information will enable health care professionals to fulfil their responsibilities regarding their duty of care to patients, for example, by providing information about possible risks and benefits of proposed treatments. This need was brought to the PIR's attention by correspondence which highlighted the different perceptions of negligence that health care professionals and lawyers may have, and doctors' views on the role of courts in determining acceptable standards of medical practice.

Information needs of others

2.9 Health care facilities such as hospitals and pathology laboratories, for example, need adequate information about the standards of performance in their services, and about the nature and frequency of negligence actions, and the size of damages awarded in cases where they or similar facilities are involved. Health care facilities require information on the skill levels or competence of those health care professionals who are either employed by them, or who provide services for them, for example as independent contractors. They also need to understand ways of reducing the costs of any claims made against them. This is basic information for effective risk management, which also increases patient safety. This need was apparent to the PIR when it failed to obtain evidence of an integrated risk management strategy in any State health system and when it could not obtain comprehensive details of medical negligence claims.

2.10 Relevant industries, such as manufacturers of health care products, including therapeutic goods and other health care equipment, also need performance information to ensure their products are safe and that they are appropriate to the purpose for which they are provided. In order to ensure they have adequate liability insurance, they must know what their potential liabilities are, such as under the strict liability regime imposed by Part V of the *Trade Practices Act 1974*. Manufacturers of therapeutic goods also need information concerning litigation taken against themselves or similar manufacturers to determine and minimise risks. The PIR has noted many examples where product liability has been an issue, for example: silicone breast implants; the re-use of therapeutic goods labelled single use; and in the human pituitary hormone program.

2.11 Governments, other policy-makers and program managers are held accountable for the achievement of desired health outcomes. To know if these outcomes are being achieved, and if the taxpayer is receiving value for public monies spent on health care, a range of information is necessary. Information about the nature and incidence of adverse patient outcomes and other benchmarks of quality of health care is required as a priority. Governments need to know that any funding provided is for treatments of demonstrated efficacy and cost-effectiveness. They need information on the costs arising from adverse patient outcomes, including the costs to other programs, which meet the on-going needs of those who have significant disabilities flowing from an adverse event.

2.12 Governments must be sure that patients are protected from the financial consequences of negligent actions of health care professionals – by the health professionals and health care facilities having adequate insurance cover or other provisions to meet these costs. They need to know about aggregate patterns of health care litigation to determine appropriate policy responses to emerging areas of concern.

Myth and misinformation : down the garden path and back

2.13 It has been the experience of the PIR that little of the information discussed in the previous section is available or accessible to any of the relevant decision-makers. Professional indemnity, negligence in health care and adverse patient outcomes are areas replete with myths and assertions and little incontrovertible data useful to the various decision-makers. In the health care field, there are certain highly organised and effective groups of health care professionals, that are able to lobby governments effectively and put forward a point of view in the public media. Other interest groups, some consumer groups for example, are under-resourced and have difficulty in accessing decision-makers and the media. In order to gather as many opinions and facts as possible, the PIR made sure it was accessible to all groups who wished to contact it.

2.14 Effective decision-making requires sufficient information upon which to base an informed choice even the fact that something is *not* known is relevant information. Recognising and acknowledging that something is not known can be the first important step towards filling information gaps. The sifting of fact from myth and identifying what is not known have been an important part of the PIR's work. This chapter and Chapters 3 and 4 set out the PIR's findings from its research and how the priority gaps in information can be filled for all decision-makers in the health care system.

B. The Quality in Australian Health Care Study

Why the study was undertaken

2.16 The study was undertaken to identify the nature and incidence of adverse events, their causes and contributing factors, the levels of disability arising from adverse events, and how preventable the adverse events were.

2.17 A preliminary question the PIR sought to answer was how many adverse patient outcomes arise from health care services in Australia. Initially, this information was considered necessary to determine the role of the common law system in meeting the needs of people who had adverse events in the health care system, for example, how many people were successful in obtaining adequate compensation. As the PIR progressed, information on adverse events became important for determining how best to minimise the human and financial costs associated with adverse patient outcomes.

2.18 Information such as the Quality in Australian Health Care Study sought is crucial for health care consumers in considering the risks and benefits of different health care options. Health care professionals need such information so they can evaluate the standard and quality of care being delivered, and determine ways to prevent those adverse events which are preventable. The information is important to administrators of health care facilities because of the likely additional costs arising from adverse patient events, for example through extra bed day and treatment costs.

2.19 The basic question of how many adverse patient outcomes arise proved to be one of the most difficult to answer. As noted in the Interim Report:

> "Comprehensive information about the incidence and causes of adverse patient outcomes and their costs in Australia is not available. No national studies have previously been undertaken and only limited information is available from standard health and other statistical collections and from claims data held by insurers, medical defence organisations (MDOs) and State Government bodies."[1]

2.20 Claims by health care professionals at the time included the assertion that there were very few adverse patient outcomes and that almost none were preventable. Other individuals made general statements about the pervasiveness of such outcomes – apparently none with any supporting data. Even in formal submissions to the PIR, figures were quoted without supporting evidence.[2] There was simply no information to inform correspondents or the PIR, so people made estimates or guesses. The difficulty for the PIR was that a lot of time was spent in trying to verify views and opinions which, ultimately, could not be verified. The PIR's task of developing policy options, and even the accurate identification of problems, was extremely difficult.

The Harvard Medical Practice Study and other overseas studies

2.21 Overseas data on adverse events in health care were also relatively scarce. A number of relevant studies were detailed in the Interim Report.[3] Further research has uncovered a

number of earlier studies which were small scale, but which nonetheless confirmed the widespread existence of adverse patient outcomes over several decades.[4] When the PIR commenced, the main overseas study was the Harvard Medical Practice Study (HMPS) in the United States. This study looked at approximately 30,000 patient records from 1984 in New York State. Its main report was issued in 1990. Its specific purpose was 'to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice'. The study focussed on negligence in adverse events. It was concluded, among other things, that 1,278 adverse events occurred in the sample and 306 were deemed negligent. Results are summarised in the Interim Report.[5]

The 1992 Australian Feasibility Study

2.22 In late 1991 the PIR commissioned the Australian Institute of Health and Welfare to explore:

- the possibility of determining the incidence of adverse patient outcomes arising from health care in Australia by using the methodology employed in the HMPS; and
- whether information collected from Australian hospitals was adequate to support such a study.

2.23 This involved an assessment of the applicability of the HMPS methodology to the Australian health care setting. The Feasibility Study, which was separately reported, concluded that the HMPS methodology and tools could be used in Australia with some modifications.[6]

2.24 The PIR rejected one part of the HMPS, a patient follow-up study. To provide a different focus, in keeping with its overall goal of minimising the human and financial cost of adverse patient outcomes, the PIR recommended that the focus of any Australian study be on the prevention of adverse patient outcomes, rather than on negligence. Funding for a full Australian study was obtained in the 1991–92 Budget.

The Quality in Australian Health Care Study

2.25 A two-stage competitive tender process was undertaken between interested medical schools in Australian universities. Funds were made available to develop the project methodology and a consortium involving the Universities of Newcastle and Adelaide was selected to carry out the study in June 1993.[7]

2.26 The consortium was required to:

- identify the underlying causes and contributing factors in adverse events;
- identify those outcomes which could be preventable;
- identify the risk factors in sustaining an adverse event;
- identify the extent of disability resulting from adverse events;
- identify and provide advice on strategies to reduce the incidence and severity of adverse events;

- determine which data items may be routinely collected to monitor the incidence and severity of adverse patient outcomes (including key indicators for use in national minimum data sets); and
- to examine the relationship between clinical concepts of adverse outcomes, preventability and the legal definition of negligence.

2.27 This last proposal for a legal component to the Study was dropped because it might have compromised the focus on preventability which, as noted above, was deemed to be consistent with the PIR's overall goal.

Methodology and progress of Quality in Australian Health Care Study

2.28 The study was conducted over the following 18 months. Thirty-one hospitals were asked to participate, 23 from New South Wales and eight from South Australia. The hospitals were acute public and private hospitals, but no psychiatric hospitals were included. The hospitals were chosen to ensure the total sample was consistent with the composition of the Australian hospital system. This meant that while the results only came from two States, they were generalisable for Australia. One hospital chose not to participate and the records of two hospitals were kept on microfiche and so were not suitable for the study, leaving 28 participating hospitals.

2.29 The study sought and obtained the support of the Ethics Committees at the participating hospitals, and of the New South Wales and South Australian Governments. All data were recorded in a de-identified form to ensure the protection of the privacy of patients and the Study's design conformed with the National Health and Medical Research Council Guidelines for the Protection of Privacy in the Conduct of Medical Research. The Study was declared under the quality assurance confidentiality provisions of the Commonwealth's *Health Insurance Act 1973*.[8] This provided protection for the study's activity, for example, none of the study's material could be subpoenaed by a court.

2.30 The preliminary preparations took some time to complete. Field work commenced in early 1994, first in New South Wales and then in South Australia. The study examined the records of people who were in hospital in 1992 and excluded records of day-only patients. Fourteen thousand six hundred and fifty-five admissions (called *index admissions*) were sampled from the 28 participating hospitals. Four hundred and forty-five of the records relating to these admissions could not be found and 31 had inadequate or incomplete information, so that 14,179 admissions were actually reviewed.

2.31 The admission was considered to involve an adverse event if either an adverse event occurred in the index admission, or the index admission was the result of an adverse event occurring previously. For the purposes of the Study, an adverse event was defined as, ‘an unintended injury to a patient which resulted in a temporary or permanent disability, prolonged length of stay or death, and which was caused by health care management and not by the patient's underlying disease.’ Adverse events ranged from events such as a patient receiving the wrong medication and being kept in hospital a day or two longer, to a health care professional failing to notice a significant test result, which led to a failure to treat the

patient correctly and the patient's death. Adverse events could include a doctor perforating a patient's bowel in abdominal surgery, where this led to peritonitis,[9] or a person suffering permanent disability when a nerve was accidentally severed in surgery.

2.32 The study involved an initial screening, the RF1 review, of all records by nurse reviewers who were looking for evidence with reference to a set of 18 explicit criteria, that might indicate an adverse event had occurred. The criteria included death, unplanned readmissions and injuries in hospitals. At the RF1 review, 44% or 6,200 records had one or more criteria present, that could have indicated the occurrence of an adverse event. Extrapolating from the results of the HMPS, it was expected that 25% of records would show evidence of an adverse event during the RF1 review. The greater than expected result at RF1 review led to considerable delays and additional costs in the field work.

2.33 The main delays and additional costs arose because those records selected by the senior nurses were then examined by two senior clinicians, RF2 review, usually a physician and a surgeon or anaesthetist, though in certain specialty areas such as obstetrics and paediatrics, a relevant specialist acted as one of the reviewers. RF2 reviewers were asked to comment on various items, including the degree of certainty of causation and preventability. Where there was dispute between the RF2 reviewers, a third senior reviewer, a discrepant reviewe*r*, reviewed the records. If agreement could not be reached, the view of the discrepant reviewer was accepted.

2.34 The consortium sought additional funding when it became clear that the numbers of adverse events identified were much greater than expected. The PIR provided additional funds to ensure a more detailed analysis as this was an important factor for the development of prevention strategies. The total cost of the Study was just over $1.3 million.

Preliminary results of the Quality in Australian Health Care Study

2.35 At the RF2 review, 16.6% or 2,353 admissions in 1992 revealed an adverse event had either occurred in that admission or the admission arose from an adverse event which had occurred earlier. The consortium has called this the prevalenc*e* figure. The incidence of adverse events which occurred in 1992 was around 11% of admissions. These figures include adverse events which may not be preventable. Causation and preventability were considered to be high in 8.2% or 1,157 admissions.

2.36 The causes of adverse events have yet to be examined in detail. During preliminary analysis, the study has shown that around 50% of all adverse events were associated with an operation, 15% related to system errors, 13% related to diagnostic errors and 2% related to anaesthesia. In the case of system errors, over 50% of these were attributed to an absence of, or failure to follow, a protocol or plan, with a further one-sixth being due to inadequate reporting or communication.

2.37 In analysing different records, reviewers graded the degree of causation and preventability on a scale of 1–6 in two separate questions, with 1 indicating virtually no evidence for preventability/causation and 6 indicating virtually certain evidence for preventability/causation. In describing adverse events as preventable in this discussion, those

events which were graded as 4 and above for both causation and preventability were considered to be preventable.

2.38 In just over 50% of the admission records where an adverse event occurred, the adverse events resulted in a patient disability lasting less than one month, and in another 30%, the disability was resolved in less than 12 months. However, the other 20% of adverse events resulted in various degrees of permanent disability or even death. In 0.8% of all admission records studied, the adverse event resulted in death, with 0.5% of the total being judged as preventable. The study showed that in 0.8% of admission records, the adverse events resulted in a permanent disability greater than 50%, for example, where a person required permanent nursing care or institutionalisation, or was significantly impaired in the capacity to perform ordinary household tasks or paid work. In another 1.5% of admission records, less than 50% of the adverse events resulted in permanent disability. In both the two latter cases, about 50% of the adverse events were judged to be preventable.

2.39 Many of the people whose records were studied were very ill and frequently quite elderly. Some people had very complex medical conditions, or were having very risky procedures. It is too early to be certain of the effect of all of these factors and further analysis is being undertaken by the consortium.

2.40 Table 2.1 provides details by patient's age of the 112 admissions where patient died because of the adverse event. There were estimated to be 268 deaths in all the admissions covered by the Study. While this indicates that approximately 40% of all deaths resulted from an adverse event, it is important to remember that just over 25% were judged to be preventable, with probably around half of these in people who were very ill and who may have had a short life expectancy due to the underlying condition. Early analysis does show that people over 60 years of age have a greater chance of experiencing an adverse event than people younger than 60 years. The significant increase of adverse events in the older age group may well be because they have more complicated conditions, and are less able to withstand the effects of the adverse event than a younger person. It may also indicate the need for some system changes to better address the needs of this group. Further analysis will determine this. The risk of an adverse event does not appear to vary according to sex, marital status, insurance status or aboriginality.

Table 2.1: Quality in Australian Health Care Study: deaths caused by an adverse event by age group and whether or not preventable

Age	All deaths from an AE	Preventable (4>)†
0–10	24	0
11–19		1
20–29		1
30–39		0
40–49		3

50–59		4
60–69	18	18
70–79	36	18
80–89	29	21
90+	5	4
Total	**112**	**70**

† In the 1–6 scale for preventability and causation, a score of 4 or greater was deemed to indicate a preventable adverse event.

2.41 These adverse events result in a number of different kinds of costs. Final analysis of the data will elucidate this. However, an obvious cost is the expense associated with an increased length of the patient's stay in hospital. Some adverse events did not prolong the hospital stay. For example, a person may have been expected to stay for a long period because of his or her underlying condition. For those that did have a lengthened time in hospital because of an adverse event, the average additional length of stay was 8.7 bed days. For preventable adverse events, it is likely that there were at least $650 million in extra bed day costs. This doesn't include the range of other social and economic costs. Where an adverse event results in a permanent severe disability, social and economic costs can be very significant.

2.42 Due to the delays in the completion of the research, the final report of the Study, in two parts, is not expected until late 1995. The publication of three articles, after peer review, on the Study is expected in November 1995, but the articles were not available in time for the preparation of this Report.

The Taskforce on Quality in Australian Health Care and beyond

2.43 Extrapolation of the results of the Quality in Australian Health Care Study with respect to adverse events in the Australian hospital population in 1992 offers striking figures. For example, it indicates around 30,000 people suffered a permanent disability of some kind and between 10,000–14,000 died because of a preventable adverse event. The total number of adverse events which were preventable was likely to be around 230,000.

2.44 The Commonwealth Minister for Human Services and Health, Dr Carmen Lawrence, was so disturbed by these figures and so determined to ensure prompt action to improve patient safety, that she released the preliminary results of the study in a Ministerial Statement to the House of Representatives on Thursday 1 June 1995. The statement and the preliminary results of the study were considered by the Australian Health Ministers' Conference in Melbourne on 2 June 1995. As a result, it was agreed to establish a high-level taskforce containing representation from the Commonwealth and State Governments, the professional colleges of doctors, nurses and health care administrators, and health care consumers, under the leadership of Dr Bruce Armstrong, the Director of the Australian Institute of Health and Welfare.[10]

2.45 Its terms of reference require the Taskforce on Quality in Australian Health Care to:

- assess and assign priorities to the leading causes of adverse events and suggest strategies able to be implemented immediately to address them;
- recommend measures to improve the management of quality of care in hospitals including ways in which patient records and other relevant data can be routinely reviewed and problems identified and acted on;
- recommend indicators to be used to monitor quality of care in Australian hospitals and suggest priorities for the development and use of protocols relating to diagnosis and treatment;
- propose changes in health care professional education and training that may reduce the incidence of adverse events;
- recommend other measures that may reduce the incidence of adverse events in the health system, both in and out of hospitals; and
- recommend further analysis or research to identify and improve control of preventable adverse events.

2.46 The Taskforce was to make an interim report to the Commonwealth Minister for Human Services and Health by 15 September 1995, on strategies that can be implemented immediately to reduce the incidence of adverse events. The interim findings of the Taskforce were to be communicated as soon as practicable to State Health Ministers, providers of health services and the general public. The Taskforce was to provide a final report by 15 December 1995, addressing all of the terms of reference.

Related measures

2.47 In the 1995–96 Budget, the Commonwealth Government announced a new National Hospitals Outcomes Program which is a $14.5 million program over three years to develop and implement national performance measures for standards of quality and outcomes of care in Australian hospitals. The program will respond to concerns about adverse patient events and quality and outcomes of care. As the Quality in Australian Health Care Study shows, performance measures on standards of quality and outcomes of care in Australian hospitals are needed urgently.

2.48 Health outcome indicators and measures were forecast in Schedule I of the Medicare Agreements 1993–1998. The National Hospitals Outcomes Program will develop and trial indicators and measures. It will establish and complete a range of practical initiatives to improve quality of care. These include incident monitoring, continued development and implementation of clinical practice guidelines, research into the relative cost-effectiveness of alternative clinical interventions, and various demonstration projects to enhance quality management. Some funds will also be used to promote the use of quality indicators and to ensure that better information on quality and outcome improvement strategies is available to clinicians, managers and consumers. Many of these matters will be discussed later in this Report.

2.49 **The PIR recommends that the Taskforce on Quality in Australian Health Care gives priority to: (a) identifying those adverse events that are the most frequent and**

preventable and cause the greatest degree of disability or death (priority adverse events); and (b) to developing strategies to prevent the priority adverse events. (Recommendation 1)

2.50 **The PIR recommends that the Taskforce ensure that the priority adverse events are considered in the context of processes which could improve patient safety such as development of practice guidelines, outcomes research and Cochrane Collaboration review funding. (Recommendation 2)** (all discussed in Chapter 3). It is also recommended that the Taskforce determine the most appropriate manner of measuring system progress in addressing adverse events, either through the development of routine reporting of appropriate data, through repetition of the study within 3 – 5 years, or a combination of both these strategies, and advise the Government on this issue.

2.51 **The PIR recommends that the Taskforce consider the appropriateness of health care facilities and individual health care practitioners collecting data on priority adverse events in their services and practices, to measure and improve their own performance. (Recommendation 3)**

2.52 **The PIR recommends that the Taskforce consider: (a) whether information on priority adverse events should be used in assessing practitioners' performance, for example in the granting or continuation of practising rights; and (b) which information relating to priority adverse events should be made available to patients and an appropriate format for the information. (Recommendation 4)**

2.53 **The PIR recommends that further study be undertaken to examine the relationship between the medical concept of preventability and the legal concept of negligence. (Recommendation 5).** This could better inform the debate between doctors and lawyers on the current role of the common law system, as well as policy-makers and the general public. The PIR has found the common law system, its role, philosophy and rules, is poorly understood. This study may provide a useful opportunity and mechanism to provide a better level of understanding.

C. Information and the tort system

Litigation, fear and information

2.54 A number of times in the PIR's search for information, concerns have been raised that:

- knowing that mistakes and adverse events occur in the health care system may lead to more litigation;[11] and
- if patients were aware of the unknowns and risks they may lose confidence in the health care system and not accept the advice of health care professionals on the preferred treatment options, which will compromise patient care.

2.55 As discussed in the Interim Report the reasons that tort actions are taken are complex, and knowledge that a mistake, even a clearly negligent one, has occurred is usually not enough to give rise to litigation.[12] When data from the Quality in Australian Health Care

Study, discussed above, are compared to the frequency of negligence actions taken against health care professionals, it is clear that few people suffering even a highly preventable adverse event with significant resultant disability ever sue their health care professional.

2.56 Some of the reasons health care consumers give for suing because of an adverse patient outcome 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.

It seems likely that some common law negligence actions could be prevented by:

- recognition and acknowledgment that adverse patient outcomes can and do occur. This would assist everyone involved to have a realistic understanding of the risks before treatment is undertaken. The legal duty to disclose risks is discussed further in Chapter 4. The PIR believes that where a patient is better informed about the risks and benefits, and is actively involved in the decision-making process about the health care, it is much more likely that, if an adverse event occurs, it will be accepted as a risk they were prepared to take when weighed against the possible benefits;

- improved communication by health care professionals in providing factual accounts to patients of what happened when an adverse event occurs. As documented in the Interim Report, the importance of this point is being increasingly recognised by health care professionals. The PIR's consultants have developed broad guidelines to assist health care professionals in this respect (see Appendix D); and

- putting in place measures to detect, report and prevent the recurrence of adverse events which compromise, or could compromise, patient safety. Most importantly, this will help prevent similar events occurring in the future, which is better for health care consumers, health care professionals and those who fund health care services. The PIR's support for incident monitoring discussed in Chapter 5 has provided proof that it is an effective technique in this respect.

2.57 Even if more common law actions occurred because health care consumers knew they had suffered negligent harm in their health care, this may not be inappropriate. It would be appropriate where common law actions are in respect of health care professionals' acts that breach the standard of care they owe to their patients. In correspondence to the PIR, those health care professionals who supported the tort system saw it as an appropriate consequence of their professional responsibilities to their patients, and as a way of maintaining professional standards.[13] Other correspondents also expressed support for the role of the common law in medical negligence.[14] It is also argued by some economists that the economic imperatives for prevention of negligence relies upon the health system bearing all the costs of negligent acts.[15] To rely on patient ignorance of the occurrence of a negligent act to control the cost of the common law system is, to the PIR, an inequitable and inappropriate means of achieving the goal of cost-containment.

2.58 The PIR's research indicates it is likely that a patient will have confidence in a health care service provider, and the health care system more broadly, if he or she has the relevant information on benefits and risks of proposed treatments provided. The health care partnership is discussed in detail in Chapter 8 below. An important component of this is a patient's right to self-determination, that is, it is the patient's choice whether to undergo any treatment and, if so, which treatment. It cannot be an informed choice if relevant information is not provided. The provision of information to patients is discussed further in Chapters 3 and 4.

A patient's right to self-determination under the common law

2.59 It is crucial to remember that a patient has a fundamental right to refuse certain treatments, even if this is likely to result in death. This was emphasised in a recent report titled *Fetal Welfare and the Law*, where it was stated that:

> When a competent properly advised pregnant woman has clearly communicated her decision to decline a particular form of treatment, there are no circumstances in which the law should seek to over-ride that decision. The principle that her wishes should be respected should prevail, regardless of the degree of risk – either to herself or the fetus – which her decision entails. In some circumstances, this will mean the woman will die in labour or that the fetus will not be born alive. The principle should also prevail, whether the recommended treatment is invasive or minor.[16]

2.60 The role of a doctor or other health professional is not to make the decision for the patient, but to provide the necessary information so the patient can make the decision. If this results in a refusal of the doctor's preferred or recommended course of treatment, the doctor can seek to terminate the doctor/patient relationship, or accept the decision of the patient. This notion of self-determination, as encapsulated in the conclusions of the report *Fetal Welfare and the Law*, is not one that is universally accepted or supported by some health care professionals.[17] However, it is an excellent summary of Australian law. A patient's right to choose his or her own health care options is also likely to be one widely supported by health care consumers. It is unclear why this should be unacceptable to some health care professionals, because so long as the patient has been fully informed, then the health professional cannot be held legally liable for an adverse outcome which arises from that choice.[18]

2.61 The concept of personal self-determination in health care has also been encapsulated in recent legislation such as the Rights of the Terminally Ill Bill 1995 in the Northern Territory,[19] and in the judgment of *Rogers v Whitaker*[20] in the High Court of Australia.

Reporting of common law cases

2.62 There has been considerable publicity of a number of important court cases involving medical negligence. While the legal issues in some of these will be examined in Chapter 7, the PIR is concerned that reporting of the judgements in these cases is frequently not accurate. Public comments on the press reports of these cases, rather than on the actual content of the judgment, often accelerate the myth-making that proceeds from the cases. This process

becomes a self-perpetuating one, which is used by those who may have a financial interest in claiming the system is in crisis and that frivolous plaintiffs 'must be stopped' at all costs, or 'health care will come to a standstill'.

2.63 Publicly available information is so scarce that counteracting what could be seen as a fear campaign among health care professionals is very difficult. When data is sought to back up the public statements, it is frequently delayed, if it can be found at all. In the case of MDOs, there have been alleged to be concerns about revealing information to competitors. The lack of availability of data on such basic things as the number of claims made and the number of claims where a plaintiff is successful have fostered an environment of crisis, when the absolute numbers of claims appears to be still very low in Australia.

2.64 The PIR has also noted the occasional re-creation of history to suit particular perspectives in relation to medical negligence litigation. A minor example of this is the public statements by doctors about the alleged connections between cerebral palsy and birth asphyxia, which is discussed later in Chapter 10.[21] This link was originally made by a doctor in the last century,[22] and was believed by doctors until very recently.[23] For many years, doctors justified their interventions in birthing and intrusive monitoring procedures as necessary preventive measures.[24] Subsequent recent epidemiological data casts considerable doubt on the proposition.[25] There have been a number of court cases, before judges and juries, in the last few years in which children with cerebral palsy were unsuccessful in demonstrating any causal link between their condition and interventions during their birth because of this research.[26] However, public statements are still being made which criticise the law for providing compensation in such cases in the past.[27] The PIR notes the implication that there many such successful cases.[28]

2.65 The PIR believes these are inappropriate statements which perpetuate two myths:

- doctors always knew that cerebral palsy was not generally related to birth asphyxia; and
- there are many of medical negligence cases involving babies with cerebral palsy in which large amounts of money are paid in damages or compensation.

2.66 On the information available to the PIR, neither of these are true. All parties accept there are a very small number of cases where there has been substandard care and this probably contributed causally to the child's disability.[29] Data show that currently only a very small number of such children receive damages through the tort system in Australia, though more seek damages.[30] Rather than using this information to argue for appropriate reform to address the problems identified by the data, it is argued that the Commonwealth Government, or other parties, should pay for the care of children with cerebral palsy – rather than the provider of the birthing care paying for care via damages for negligence.

2.67 Courts in the tort system rely on the best evidence available in reaching their decisions. In the case of medical negligence, the evidence is provided by both the doctors and the patient, and, sometimes, by other witnesses. As discussed later in this Report, there are formidable difficulties for a plaintiff in proving medical negligence.

2.68 In making decisions in the very small numbers of medical negligence cases which go to judgement, the court is sometimes obliged to consider the evidence of at least two people, the plaintiff and the defendant, and their versions of what is alleged to have occurred. Sometimes the court prefers the evidence of one party and sometimes the other, depending upon the surrounding evidence. Judgements usually set out the court's reasons for making decisions in detail. It is usually only through carefully reading of the judgement in full that the reasons for the decision are clear. Sometimes conclusions will be reached involving no modifications to the law and the court will decide the matter on the facts of the case. Sometimes the law will be modified by a court's decision.

2.69 It seems likely that few health care professionals have time to examine the judgements in medical negligence cases. Press reports designed to capture headlines and attention provide insufficient information for health care professionals to be certain of the law. However, the PIR believes that subsequent analysis and debate in health care professions are often based upon the content of the press reports rather than the judgement.

2.70 The importance of the mass media as information providers to doctors was exemplified in the PIR's defensive medicine report. When participating doctors were asked their reasons for believing there has been an increase in their risk of being involved in litigation in the last 5 years, 90% said it was based on 'publicity about litigation'.[31] This was the largest single reason. Other reasons were the perception that there had been a rise in litigation in Australia, presumably also gained from press reports, and the perception of changes in patient expectations and demands. All these reasons vastly overshadowed doctors' personal experiences, with only 12% having been sued.

2.71 There are, in some cases, formidable difficulties for the press, health care professionals and consumers in obtaining information other than through the mass media. Although some jurisdictions are very helpful and provide transcripts of judgements promptly and without charge, the PIR faced significant difficulties in other jurisdictions in obtaining copies of judgements promptly and at reasonable cost. Some court registries have quoted $2 per page for photocopying a judgment, which makes obtaining a copy of a long judgment a costly exercise. Other jurisdictions impose a significant flat fee, which can make very short judgments even more costly. Many require a written request and pre-payment by cheque. Delays of several weeks and more have been experienced in receiving these documents. **The PIR recommends that State Government departments with administrative responsibilities for court registries seek to improve processes for making judgements available quickly and cheaply (Recommendation 6).** This will help to promote an accurate knowledge of relevant law and assist in improved accuracy of reporting court judgements. The PIR considers that judgements concerning medical negligence cases should be more readily available to the public and easily accessible at low cost. Electronic and facsimile availability appear to be desirable options, as well as low cost paper versions for those without access to relevant technology.[32]

2.72 There are clearly differences between the understanding of various concepts in the fields of law, medicine and other health care professions.[33] There is a need for health care professionals to have better information about current court cases and their effects, if any, on the law and their professional practice. Lawyers need to understand the complexity of

modern health care. Doctors and other health care professionals also need to understand the evidentiary process better, so they can understand how a court weighs the evidence before determining what happened.

2.73 Many doctors have expressed concern to the PIR that courts sometimes accept the patient's views of the facts rather than those of the doctor, and so they argue that courts are partial to plaintiffs. It is frequently the cases in which plaintiffs are successful in proving medical negligence that receive the most publicity. In fact, as far as the PIR can determine, in the majority of cases the court prefers the doctor's view of events and the plaintiff is not successful.[34] The PIR believes that the media which serve doctors sometimes contribute to this misperception, perhaps for some of the reasons mentioned above.

2.74 Equally, important judgments limiting the liability of doctors and imposing obligations on patients may not be reported widely. For example, a recent Queensland case[35] reduced a patient's damages by 20% for contributory negligence in a case involving failure to diagnose bowel cancer, because she did not describe her symptoms sufficiently clearly. Health professional and consumer awareness of these cases is important to ensure that everyone has a clear understanding of the checks and balances in the legal system.

2.75 If one accepts the difficulties in readily obtaining full information in these areas, it is understandable that doctors and other health care professionals have an inaccurate or incomplete understanding of the law and of the tort system. While there are some publications available that provide information on health law, it is unlikely that these are read by many doctors and other health care professionals. The PIR considers an improved understanding between the two disciplines of law and medicine is very important.

2.76 An Australian Institute of Health, Law and Ethics was proposed last year in a meeting at the Australian National University. The PIR believes that the establishment of such a body is an important development in improving the understanding between the two disciplines. The Institute was formally launched on 16 September 1995, with the following aims:

- to increase public awareness of issues relating to health care, law and ethics;
- to provide expert advice to governments, organisations and the media on matters to do with health care, law and ethics;
- to provide a base for research into issues concerning health care, law and ethics;
- to hold conferences in areas relevant to the work of the Institute;
- to provide a resource centre for those interested in the areas of health care, law and ethics and to liaise with other Australian and overseas bodies with similar interests; and
- to provide continuing education courses and seminars.[36]

2.77 **The PIR strongly supports the establishment of the Australian Institute of Health, Law and Ethics, and recommends that, once established, it give priority to production of relevant publications and provision of training opportunities to provide current and accurate information in areas of law that are of interest to practising health care professionals; providing educational links in the primary training of legal and**

health care professionals; and promoting debate and discussion about areas of shared interest and concern, including tort law and professional ethics. (Recommendation 7)

2.78 There is also a need to promote an understanding of legal processes as part of medical training. This should begin at the undergraduate level and continue in special purpose training courses. Among other things, health professionals, particularly doctors, would benefit from improved understanding of the process of giving evidence, as they may be required to provide expert evidence in medical negligence cases. Expert evidence is further discussed in Chapter 7. **The PIR recommends that deans of medical, nursing and health sciences faculties, professional colleges, and others with responsibility for health care professional training explore ways of providing education and training for doctors and other health care professionals about the legal system, including the tort system and regulation of the health care sector. (Recommendation 8)**

Aggregated national information

2.79 The PIR found there is a lack of data available on the medical defence industry. It was necessary to commission a number of studies to get even a general idea about the financial position of the medical defence industry in Australia. Medical defence organisations (MDOs) provide, among other things, professional indemnity for doctors and dentists including legal representation and advice concerning medical negligence. The PIR's first study was outlined in the Interim Report.[37] The PIR's second report on MDOs was carried out by Coopers & Lybrand and was recently released as a separate publication. These reports are outlined in Chapter 9. The second report made it clear that there was insufficient available information to determine with certainty the degree of inadequacy of funding of the medical defence industry to meet its incurred liabilities.

2.80 With respect to the medical defence industry, it is impossible to determine from information available to the public: whether there are more claims being made now than in the recent past; what the pattern of claims is; how many claims result in payment of damages or compensation; and the financial amounts involved. A similar situation exists for public and private sector health care negligence claims. This is an unsatisfactory situation, and results in many of the myths and much of the misinformation generated in this area.

2.81 The National Health Ministers' Benchmarking Working Group, established in June 1994, comprises representatives of Commonwealth, State and Territory health departments, the AIHW, and the Australian and Victorian Hospitals Associations. Its terms of reference include the establishment of appropriate national indicators of performance in the health sector under the following categories: quality; production efficiency; outcomes; investment utilisation; access; human resource management; and business operations. The Working Group has agreed on a set of key indicators covering efficiency, productivity, quality and access measures. The Working Group will publish data on the performance indicators to enable an assessment of the relative efficiency and effectiveness of service delivery across jurisdictions. It is working closely with the Hospitals Working Group of the Council of Australian Government's Review of Commonwealth and State Government Service Provision, which is addressing the issue of benchmarking across the broad range of government services.

2.82 One of the indicator areas being developed under the broad area of quality relates to the tort system, and adverse patient outcomes. The PIR provided a detailed and staged proposal to improve the existing data on the tort system in the context of this benchmark development.

2.83 Stage 1 involves the development of national State-wide measures on health care negligence cases commenced and finalised against State Government health agencies. Collection of legal claims commenced and claims paid in health care negligence cases is important management information for State health departments and both Commonwealth and regional health authorities, as unmonitored costs in these areas can soon amount to a significant unplanned on-cost to the system. Early identification of problems and potential problems can assist in the development of strategies to correct and prevent system deficiencies which may be costly in both human and financial terms. The first benchmarking measures to be proposed would be:

- the total number of new claims each year and the total estimated liability flowing from these claims; and
- the total number of claims paid out each year and the amount paid in the year.

2.84 These are very broad indicators, but it is useful to identify overall costs and trends. If claims data were recorded on a de-identified unit record basis, which connected the date of the incident, the date of the claim and the date of payment or finalisation of the claim, the data could also be used to provide aggregated information on differences between States so far as time taken to resolve cases is concerned; the impact, if any, of statutes of limitation, which vary between States; and set time limits for tort cases to be lodged.

2.85 Stage 2 covers the collection of more detailed national claims data. The PIR's discussions with the MDOs on a national claims data set for collection by them will provide a basis for more detailed development of these broad measures for State health system collection. Some elements which could form part of this are:

- specialty of the practitioner against whom a claim is made, for example obstetrician, surgeon, general practitioner;
- type of health care treatment from which the claim arose, for example laparoscopic procedure, anaesthetic, emergency surgery; and
- details about the clinical circumstances of the adverse event, for example nosocomial infection, wrong drug, failed sterilisation.

Data would also be required on Diagnosis Related Groups or other diagnosis classification in non-hospital treatment, and it is likely that the national benchmarking data would also include some additional details, such as location and whether it relates to a public or private hospital treatment. Some patient characteristics may also need to be included in both MDO and benchmarking data sets.

2.86 The relatively small number of health care negligence actions cases in Australia currently means the collection of such data is feasible. Collecting data on small as well as

large claims is important. In terms of costs associated with litigation, there appear to be two main groups of cases: the high-incidence-low-cost cases, which collectively give rise to significant costs, for example failed sterilisation; and the low-incidence-high-cost cases, for example brain-damaged/neurologically impaired infants, each of which is high cost. Available data are too scant to say anything definitive about the relative costs of these two groups but, anecdotally, MDOs believe their total financial liabilities are divided about equally between the two groups of cases. There are, therefore, strong arguments that sufficiently detailed data should be collected on all cases. The frequently occurring, low-cost cases may often be amenable to inexpensive preventive action. If there is resistance to collecting information on all cases, its importance in the low-incidence-high-cost cases must be stressed. This is because a small increase in the frequency of these claims can have a very large overall financial impact.

2.87 Stage 3 in this component of the benchmarking strategy was the development of data sets on the incidence of adverse patient outcomes. One of the requirements of the consultancy for the Quality in Australian Health Care Study was to determine which measures could be included in regular hospital data collections to monitor the frequency of adverse patient outcomes. Preliminary results indicated an alternative process may be to repeat the study within a relatively short period (say 3-5 years). One of the earlier recommendations in this Report suggests that the Taskforce on Quality in Australian Health Care should provide advice on the best method for such data collection and monitoring, and the conclusions of this will feed into the benchmarking exercise.

2.88 The final proposed stage of the benchmarking strategy is the development of hospital, regional and practice-specific measures, that build on each of the above stages. At an institutional level, these could become important as performance measures for differential funding and for accreditation purposes.

2.89 Improved data on the payment throughput of the tort system will also be available from the new data, which is to be collected by the Health Insurance Commission under the new double-dipping legislation, discussed in Chapter 6.

2.90 The availability of data of the kind outlined in Stage two of the above proposal from both MDOs and the public sector is crucial if the Australian community is really ever to know what is happening in the tort system, both at any single point and over time. The PIR had considerable difficulty in obtaining relatively simple information, such as the pattern of claims against obstetricians and gynaecologists, which is discussed in Chapter 10. We are only wiser now, because of the open assistance provided by certain medical defence organisations.

2.91 While the basic financial data, incidence of claims, cost of payments and frequency of incidents being reported are important necessary first steps, real patterns and possible areas of concern really only emerge when the factual circumstances of cases are available, as set out in Stage two. This does not, for aggregated purposes, need to be very detailed, but it is necessary to have sufficient details of the clinical situations and alleged negligent acts, as well as some doctor and patient details, to enable patterns of claims to be examined. The General

Occurrence Classification system being developed as part of the Incident Monitoring work discussed in Chapter 5 may be of significant assistance in achieving this.

2.92 The absence of publicly available information of this kind contributes to broad misunderstanding of existing problems. For example, given the press coverage and professional activity on brain-damaged babies, few specialist obstetricians and gynaecologists would be aware that around 80% of the claims made against them relate to the gynaecological part of their practice, and that around half of those claims relating to obstetric cases relate to alleged damage to the mother. This is important information, because while the brain-damaged baby cases are much more costly individually, the collective costs of the damages to women patients may well be quite high, and that these cases may be more amenable to preventive interventions.

2.93 **The PIR recommends the establishment of a national minimum data set for health care negligence cases that includes sufficient details to allow the data to be used to examine trends in particular specialties and diagnostic areas, and to detect areas likely to be able to benefit from active prevention strategies. The contributors to the database should be all MDOs, any insurers providing health care professional indemnity cover either to individual practitioners or facilities, and all State governments and private sector self-insurers. (Recommendation 9)** This data set should be developed in conjunction with the complaints database, discussed in Chapter 8, as well as the related parts of the National Benchmarking exercise and the Taskforce on Quality in Australian Health Care. Such data could be collected and maintained by the Australian Institute of Health and Welfare, with appropriate funding contributions from data users.

State-based tort data

2.94 Data from State courts did not prove very accessible[38], though it may be possible to request State courts to keep separate data on health care negligence claims. One unexpectedly useful source of data was that collected under section 72 of the South Australian *Medical Practitioners Act 1983*. This section requires a medical practitioner to notify the South Australian Medical Board of specified details of any settlement or judgement relating to their performance as medical practitioners. The PIR investigated this system because it was considered to be a possible model for linking tort information with quality investigations (see Chapter 5). After examining the system, the PIR considered it might also be able to provide some useful information on the size and nature of settlements and judgments made in South Australia, involving medical practitioners.

2.95 A study was commissioned by the PIR with the Medical Board of South Australia in December 1994 to provide de-identified information from a review of the section 72 submissions made by medical practitioners to the Medical Board. To ensure the confidentiality of the data, the returns were scrutinised 'in-house', with the PIR sighting only the aggregated, de-identified data. It is possible that even richer information for prevention could be obtained from such records, if sufficient relevant details of the cases were required to be lodged and were able to be analysed fully.

2.96 There were 228 section 72 submissions under the Act in the six years from 1989 to 1994. Twelve practice types or specialties were listed, with the top five practice types accounting for 82% of the settlements, as can be seen in Table 2.2 below. Those specialties with significant lag times between the date the incident occurred and its settlement were obstetrics and gynaecology, general surgery and orthopaedic surgery, in that order. By contrast, over half the settlements in general practice had been made within 4 years of the occurrence and over 80% were settled in less than 6. In almost 60% of the cases eventually settled in obstetrics and gynaecology, settlement took place more than 4 years after the incident had occurred.

2.97 The full pattern of payments over the six years are set out in table 2.3 below. Over 60% of claims were settled for less than $50,000, and over 83% were settled for less than $100,000. While the overall number of claims paid over the period has risen over the 6 years, there is not a pattern at the moment of continuing growth. Similarly, the pattern of the size of claims does not seem to indicate any dramatic rise in the numbers of large claims against doctors. There are only 4 claims in the period over $500,000, and when the specialties of the larger claims are examined, it is particularly interesting that none of these are in the specialty generally believed to have the largest claims - obstetrics and gynaecology. Rather, two involved anaesthesia, one general surgery and the last involved a general practitioner.

Table 2.2: Incidence of settlements and judgments notified under Medical Practitioner Act 1983 (SA) 1989-1994

Specialty	All Settlements	Settlements <$100,000	Settlements >$500,000
General practice	55	45	1
Surgery - general	49	36	1
Obstetrics and Gynaecology	47	37	
Orthopaedic Surgery	23	21	
Diagnostic Radiology	13	13	
Other	41	38	2
Total	**228**	**190**	**4**

Table 2.3: Amounts of settlements and judgments notified under Medical Practitioner Act 1983 (SA) 1989-1994

$'000	1989	1990	1991	1992	1993	1994
0-9.9	12	8	17	13	13	10
10-24.9	3	16	11	12	13	10
25-49.9	3	7	3	7	7	4

50-74.9			1	2	5	4
75-99.9		1	1	1	4	2
100-249.9	2	7	7	3	2	2
250-499.9	1			5	4	1
500-749.9						1
750-999.9				1		
1M-2M						
over 2M				2		
TOTAL	**21**	**39**	**40**	**46**	**48**	**34**

2.98 The data show the somewhat random nature of big claims compared to all claims - the 2 cases over $2 million occurred in the one specialty in the one year, and yet over that whole six-year period anaesthesia only accounted for 10 settlements (around 4% of all settlements). In fact 6 of these 10 settlements occurred in the same year as the large settlements, which also illustrates the year by year variability that seems to characterise these claims and settlements. The pattern is different at the $250,000-$499,999 level, with 6 of the 11 being in obstetrics/gynaecology, 2 in general surgery, 2 in general practice and 1 in orthopaedic surgery. At the $100,000-$249,999 level, 9 involve general practice, 8 general surgery, 4 obstetrics and gynaecology, 1 orthopaedic and 1 plastic surgery.

2.99 While only for one State, these data show the relative richness of information on closed claims which can be obtained from such a source. A recommendation in Chapter 5 suggests the development of similar reporting mechanisms in all other States, and were this to be accepted, de-identified extracts from could provide an alternative data source for closed claims. It cannot provide any information on emerging claim trends.

2.100 Some data also became available from the NSW public hospital system in August 1995. The legal liabilities of the NSW Health Department and other government bodies are managed by the Government Insurance Office (GIO), under a separate Treasury-managed fund. It is a system of self-insurance, which commenced in 1989 and is administered by the GIO. Of that fund 38% relates to hospitals, but until recently, no breakdown was available between workers' compensation, public liability and medical negligence cases.

2.101 The recent analysis showed that the entire NSW public hospital system has only incurred 950 claims over the past 6 years, which worked out at less than two cases per hospital covered over the whole period. However, the claims are not evenly spread - 740 come from the 7 major teaching hospitals. This works out at around 17 claims per major teaching hospital per year. There are an additional 200 cases being managed from the period prior to 1989. Of these 1,150 cases, the GIO has 23 claims valued over $1 million, with 5-6 of these likely to cost over $3 million. Of the 23 claims, the GIO expects to make no payment in 10, because of insufficient evidence of negligence. The two main areas of claims

of concern to the GIO are failure to inform or warn cases, and cases involving devices and product liability.[39]

2.102 The importance of having such information recorded separately can be seen from this analysis. Until the analysis was done, it was not possible to judge whether or not there were any problems emerging. It was also not possible to put the incidence of claims into perspective, until the data was separately available. Even if the incidence of claims is rising and this was not discussed in the analysis of the available data, twhat emerges is the very low frequency of claims.

2.103 It seems likely from the information thus far available to the PIR that all levels of government, health professionals, medical defence organisations (MDOs) and health care consumers will benefit from the public availability of data on the incidence and costs of tort claims involving health care negligence.

Chapter 3: Risks, benefits and treatment options

A. Decision-making in the health care environment

3.1 Decision-making in heath care may be informed by examining the adverse events that are the focus of the Quality in Australian Health Care Study. Informed decision-making also involves looking at the potential benefits of the possible treatment options. This information on risks and benefits is important for a health care professional, who have a common law duty to disclose any relevant information to a patient.

3.2 The difficulty for health care professionals is ensuring that they know what the risks, benefits and treatment options are, and that they provide appropriate up-to-date advice to patients. This can be an important practical issue for a general practitioner (GP) who is consulted by patients with very diverse health problems. It is difficult to keep up-to-date across the broad fields of medicine.[1] Many GPs are consulted by a large number of people with common, often minor, complaints. The comment has been made to the PIR a number of times that in general practice it is generally expedient to focus initially on the most obvious diagnosis, rather than investigate the possibility of rare conditions.[2]

3.3 One skill required of GPs is to be able to detect the rare or atypical cases early enough to ensure prompt treatment and cure, if possible, without subjecting all patients to expensive or potentially harmful tests that might be appropriate to more serious cases. Many doctors expressed the view that the fear of litigation encourages the broader use of such tests, that is so-called defensive medicine, which is discussed in more depth in Chapter 7.[3]

3.4 The PIR acknowledges the difficulty GPs face. However, up-to-date knowledge is important for cost-effective high quality patient care and to assist patients in making informed decisions. Primary generalist health professionals have special needs so far as information is concerned. The PIR believes it is unrealistic to expect them to be able to keep across all developments by reading all relevant scientific journals. If these health care professionals are to convey the necessary information to patients, much of it needs to be in a readily accessible format, such as the various United States patient and desk-top guideline publications discussed below.

3.5 Another difficulty for health care professionals is the lack of accessible analysis of the overall effects of health care options. Medical journals are filled with studies of various kinds. However many studies are inconclusive, or the results are difficult for a GP to apply to his or her patients. The work of the Cochrane Collaboration will address some of these problems, and the development of clinical practice guidelines is providing another useful tool for health professionals. The wider use of randomised controlled trials, feedback from incident monitoring, and outcome and benchmarking initiatives discussed below are also potentially important sources of information for health professionals and health care consumers. However, there remains the problem of accessing the information as it becomes available.

3.6 In addition, much of health care has not been subject to the rigour of scientific testing. While randomised controlled trials, (sometimes called *double blind* trials), where neither the

participants nor the researchers are aware of which participants are taking the drug under test, are now generally required of drugs, for new procedures there are far fewer requirements. Many established practices and tests, too, have also not been analysed for their efficacy. Patients and health care professionals need to know what the evidence is for the efficacy of treatment options. The efficacy, benefits and risks of various tests and procedures may only be known after the procedures have been used for a considerable time. Prior to proof of efficacy, such procedures are seldom carried out under the strict guidelines which should cover human experimentation. The National Health and Medical Research Council (NHMRC) has recognised that the guidelines on human experimentation should be followed in all cases where the health care intervention and desired outcomes have not been scientifically tested and proved.[4]

3.7 Similarly patients, and often the facilities where a health professional works, may not know or be able to find out easily how skilled a practitioner is at particular procedures, or even whether she or he has successfully carried out many of the procedures. These are all relevant factors for health care consumers in making decisions about their health care and their health care provider.

3.8 Health consumers have underlined this lack of information for decision-making as a priority area for action. For example, the Consumers' Health Forum's project on Casemix[5] and the Newcastle proposal for a health consumers' charter[6] both highlight the importance to consumers of timely and accurate information as a basis for making decisions.

3.9 The increasing role of the courts in determining the standard of care required of a health professional (discussed in Chapter 7) also puts increasing emphasis upon ensuring that health care treatment is soundly based upon evidence of efficacy, rather than tradition.

B. Evidence-based health care

Background

3.10 Evidence for the efficacy of a treatment has always been important in medicine and health care. A practitioner studied his or her patients and practised in what appeared to be beneficial way. He or she learnt from other practitioners' experiences and from experts. However, such evidence alone is no longer considered satisfactory supporting evidence. The beneficial effects observed in single cases may well have little to do with the particular treatment, though such observation is still often an important starting point for establishing better evidence and propositions to test. Proof of efficacy and cost-effectiveness requires more evidence.

3.11 A recent editorial in *Annals of Internal Medicine* said of the move to evidence- based medicine:

> What *has* changed in clinical medicine in recent decades is the very nature of clinical evidence itself in three important ways: the standards for gathering it, the tools for analysing it, and the social context in which it is used. Time was, not so long ago,

> when the standard unit of clinical information was the individual patient, captured in the detail of the case report ... case reports have yielded to population-derived studies of which the randomised controlled trial is the prototype or "gold standard" of therapeutic evidence.
>
> Time was, not so long ago, when the tool kit for assembling and interpreting clinical evidence consisted largely of some rather basic biostatistics. The array of tools in the kit is now greatly expanded ... Particularly important among these is the concept that a single study, although it may prove the truth, is often not enough. The whole truth may require a synthesis of the evidence from all the best studies, optimally through the use of meta-analysis.
>
> And time was when expert opinion – authority – carried as much weight as the clinical scientific record, and often much more. ... practising physicians increasingly expect, and are expected, to base their decisions on *the evidence* rather than on authority; at the same time, the wide availability of strong clinical evidence supports the increasing democratisation of medical decision-making power. *Authoritarian medicine* may thus be gradually yielding ground to *authoritative medicine*.[7]

3.12 As well as assisting health professionals to make decisions, this change of focus has the potential to empower health care consumers, so long as relevant information is made available in an appropriate manner to them as well. This would be consistent with the democratisation of the doctor/patient relationship into a real decision-making partnership, as discussed later in Chapter 8.

The Cochrane Collaboration

3.13 A.L. Cochrane was one of the first to draw attention to the lack of information about the effects of health care. He wrote, "[i]t is surely a great criticism of our profession that we have not organised a critical summary, by specialty or sub-specialty, adapted periodically, of all relevant randomised controlled trials".[8] According to Cochrane, resources for health care are limited. They should, therefore, be used equitably to provide health care that has been shown, in valid evaluations, to be effective. Cochrane emphasised randomised controlled trials as likely to provide more reliable information on the effectiveness of health care interventions.[9]

3.14 A randomised controlled trial has been defined as a "study where `participants are allocated at random to receive one of two or more alternative forms of care' with the aim of creating unbiased treatment groups for comparison".[10] Randomised controlled trials are not uniform in design and quality. When a hypothesis is first tested, a trial may have a small number of patients or subjects and may be carried out in a single facility. Later trials may encompass dozens of investigators and thousands of patients at facilities throughout the world. The relative value of research that uses several small trials or a single large trial is unresolved. Small trials can have uniform standards for patient selection and data collection and may provide rapid conclusions. However, a small sample can limit confidence in the results. Large multi-facility trials are less likely to employ uniform practices, but they enable smaller, less frequent effects to be discerned more easily. When a large trial is carried out

first, there may be no need for other trials. For the results of a trial to inspire confidence, trial designs should avoid or allow for potential bias. Bias can be avoided by, for example: selection of the population for study that is uniform in terms of disease stage, severity and co-existing conditions; random assignment of treatment regime; effective double-blinded documentation of outcomes; measures that ensure compliance with the treatment regimes; and the use of formal statistical analyses.[11]

3.15 Implementation of Cochrane's ideas has been slow. Evidence about the relative effectiveness of different health care options may threaten a variety of vested interests and valid evidence is not readily accessible to those who need it to make decisions, even when such evidence has been published. Health professionals, health care consumers and policy-makers may find it difficult to gather all the evidence from original reports, which may be extensive and found in many different places. Most people rely on reviews of original research, but the quality of the reviews may be poor. One reason for this is that reviewers do not approach the task systematically, for example in respect of the control of biases and random errors.[12]

3.16 In the 1980s, those responsible for trials collaborated in preparing systematic reviews of the results of randomised controlled trials in cancer treatment, anti-platelet drugs for cardiovascular disease, and antibiotics for decontamination of the digestive tract of patients receiving intensive care. Reviews of randomised controlled trials relevant to the care of women during pregnancy and childbirth and of newborn infants have also been prepared.[13] These efforts were undertaken world-wide and resulted in information for guiding future research and treatment, and they provided benchmarks for measuring the quality of other systematic reviews.

3.17 Reviews or meta-analyses of randomised controlled trials are "studies of studies".[14] They synthesise the results of many trials. Standards for meta-analyses are as critical as the standards for clinical trials. For example unbiased criteria for inclusion and exclusion of trials must be identified, including whether the characteristics of patients, therapies and outcomes are comparable. Methods for extracting data from the studies and expressing the results of multiple trials consistently must be determined. Appropriate statistical techniques must be used to assess the data. Meta-analyses can help determine when further clinical trials are not necessary. Difficulties with meta-analyses include: the possibility that trial or study designs, patients, treatments and outcomes are different from one trial to another; ensuring all relevant trials have been included; the validity of unpublished trials; whether to weight studies according to a measure of their quality; and which statistical techniques to use.[15]

3.18 The Cochrane Collaboration developed in response to Cochrane's call for systematic, up-to-date reviews of all relevant randomised controlled trials. A centre named after Cochrane was established in 1992 as part of a research and development program in the United Kingdom. Following the centre's opening, there was strong support for its aims world-wide and other centres were established.[16] The Cochrane Collaboration aims "[t]o prepare, maintain and disseminate systematic, up-to-date reviews of randomised controlled trials of health care, and when randomised controlled trials are not available, reviews of the most reliable evidence from other sources".[17]

3.19 Cochrane Centres share responsibility for maintaining registers of systematic reviews by contributors and establishing randomised controlled trials. They also help to establish collaborative review groups and support field co-ordination, prepare and develop protocols and software, determine policies, set standards and promote research to improve reviews. All this also provide input to the development of the Cochrane Collaboration.[18] Its organisation and development is guided by annual colloquiums.

3.20 A systematic review of randomised controlled trials involves the following steps:

- determining the objectives and eligibility criteria for including trials;
- identifying studies that are likely to meet the eligibility criteria;
- tabulating the characteristics, and assessing the methodological quality, of each study identified;
- excluding studies that do not meet the eligibility criteria;
- compiling the most complete set of data feasible, involving the investigators if possible;
- analysing the results of eligible studies, using a meta-analysis or statistical synthesis of data if appropriate and possible;
- performing sensitivity analyses if appropriate and possible; and
- preparing a structured report of the review that states the aims of the review, describes the materials and methods used and reports the results.[19]

3.21 Each reviewer works as part of collaborative review group comprising individuals interested in the topic. Each collaborative review group is co-ordinated by an editorial team. The editorial team compiles an edited module of the reviews prepared by members of the review group for incorporation in, and dissemination through, the Cochrane Data Base of Systematic Reviews. The editorial team selects reviews contained in the main Data Base for compilation in one or more specialised databases.[20]

3.22 For example, the Cochrane Pregnancy and Childbirth Group comprises 30 reviewers and an editorial team of six. The group is responsible for maintaining about 600 systematic reviews of randomised controlled trials and for handling 200–300 new reports each year. Group members are located in Australia, Canada, Ireland, the Netherlands, South Africa, the United Kingdom and Zimbabwe. The editorial team comprises four editors, an administrator and an administrative secretary. The team is responsible for the edited module (the Pregnancy and Childbirth Module) and for its incorporation and dissemination as part of the Cochrane Data Base of Systematic Reviews. The group also selects reviews to be contained in the Cochrane Pregnancy and Childbirth Data Base.[21]

3.23 The field coordination component of the Cochrane Collaboration caters for other interests (including non-medical groups) such as certain categories of health service users, groups of health professionals, settings for health care, or classes of intervention. Field co-ordination identifies studies relevant to the field, promotes the field's perspectives and priorities within and across collaborative groups, and compiles specialised data bases of reviews. Collaborators coordinate their activities in a field by searching specialist sources for relevant studies. They convene meetings within a broad field with a view to establishing

focused, problem-based collaborative review groups. They also help to ensure that priorities and perspectives in the field of interest are reflected in the work of collaborative review groups. Specialised databases are compiled to serve the needs of people in the field concerned, for example by using all relevant reviews from modules of edited reviews contributed to the Cochrane Data Base of Systematic Reviews.[22]

3.24 A review incorporated in the Cochrane Data Base of Systematic Reviews consists of:

- a cover sheet;
- a structured report of the review;
- full citations of the reports of incorporated studies;
- tabulation of the characteristics of the trials in these studies;
- tabulation of the results of the review;
- reports of potentially eligible studies which were excluded, noting why they were excluded; and
- contact details for further information about unpublished and on-going trials.[23]

3.25 Cochrane emphasised the importance of keeping reviews up-to-date, and arrangements for updating exist in several areas.[24] The Cochrane Data Base of Systematic Reviews is updated and amended as new evidence becomes available. The Data Base is distributed on-line and on CD-ROM. Smaller, specialised databases are published on disks. The Cochrane Collaboration hopes to develop an iterative system to ensure successive versions of each review will reflect the emergence of new data and valid criticisms.[25] A new journal of evidence-based medicine was expected to be published in late 1995, and this may reach a broader health professional audience.

3.26 In summary, the Cochrane Data Base of Systematic Reviews will focus on a number of diseases and form conclusions about which treatments are effective, and which are not, by looking at all available results from randomised controlled clinical trials. These trials can overcome the biases of doctors whose clinical judgement is based largely on day-to-day experiences of treating patients. Individual randomised controlled trials based on small numbers of patients are often inadequate for drawing conclusions about benefits and side-effects of treatments. Recommendations in the Cochrane Data Base of Systematic Reviews will draw on reviews of all trials world-wide and it will be regularly updated in the light of new evidence and feedback from doctors.

The Australasian Cochrane Centre

3.27 In Australia, funding has been provided by the Health Advisory Committee of the National Health and Medical Research Council's (NHMRC's) to establish an Australasian Cochrane Centre.[26] The Australasian Centre is expected to draw on the methodology and findings of the Cochrane Collaboration to promote evidence-based medicine in Australia, especially through development of best practice guidelines. The Australasian Centre has been established by a consortium of the University of Adelaide and Flinders University.

3.28 The Australasian Centre will, among other things:

- facilitate the work of current collaborative review groups in Australia and internationally;
- act as a contact point for review work in Australia and New Zealand;
- facilitate the distribution of the Data Base of Systematic Reviews within Australasia;
- promote research into the science of systematic reviews; and
- organise workshops, seminars and other meetings to help guide the further development of collaborative review activity.

3.29 An important barrier to the expansion of the use of the Cochrane methodology by Australian health professionals is the lack of any systematic funding base for reviews. New reviews currently depend on ad hoc availability of funds from various sources. It is estimated that, on average, it would cost about $100,000 per year to conduct a review, and most reviews will take several years. This absence of a funding plan for the initiation and conduct of reviews in Australia is a direct impediment to broader use of evidence-based medicine. **The PIR recommends that the Task force on Quality in Australian Health Care determines whether there are any priority adverse events that could benefit from a systematic Cochrane Collaboration review. (Recommendation 10) The PIR further recommends that AHMAC with the NHMRC, considers the establishment of a set of priority areas for Cochrane Collaboration Reviews, and the most appropriate manner and level of funding for these, particularly taking into account any findings of the Taskforce on Quality in Australian Health Care in relation to priority adverse events. (Recommendation 11)**

3.30 The importance of encouraging health care professionals to use information from such sources in recommending appropriate care for patients is fundamental. It is also important that doctors can convey this information to patients who are making treatment choices. Establishing guidelines for clinical care is one way making information accessible to health professionals and patients. The need for health care consumers to access this information more broadly is also an important issue, subject itself to a new Cochrane Collaboration, currently being funded by the Victorian Government (discussed in more detail in Chapter 4.) In addition to its specific Review Group on consumer communication. **The PIR recommends that the Australasian Cochrane Centre establish formal links with consumer groups to (a) promote review findings among health care consumers and (b) examine appropriate ways for consumer representatives to be involved in the Centre's work. (Recommendation 12)** This will assist in ensuring that health care consumers, as well as professionals, are informed about evidence-based health care.

Problems associated with randomised controlled trials

3.31 Randomised controlled trials are the cornerstone of the Cochrane Collaboration's work. However, randomised controlled trials are not the only form of scientific evidence available. Such trials, while considered the gold standard by many, do have limitations, which have been acknowledged in the literature.[27] For example, they use a very costly methodology, the design and conduct of which requires considerably more additional training than is received by most health professionals. In addition, the populations upon which they are conducted are almost always different to the groups for which the treatment was intended because of the need to control variables. This need to control variables often means that the

circumstances of the trials are very different from the real world of day-to-day medicine.[28] The cost of randomised controlled trials and the practical difficulties means that they are often not repeated in the same area, even though procedures can change significantly over time. Such studies often also use the experts in a field as their practitioners, rather than the average clinician, which can give an overly optimistic view of the success or ease of a treatment option.[29]

3.32 Such research requires a tightly focused hypothesis, and the more variables that are introduced, the less certain are the results. Results that are applicable to one patient population may be very different for a patient population with other characteristics, such as increased age or other co-morbidities. Equally, such trials must almost by definition focus on one facet of what may well be a multi-faceted phenomenon.[30] The quest for certainty and control has from time to time led to absurd practices in some randomised controlled trials, particularly so far as the participation of women is concerned. Researchers view women as poor research subjects, on the basis that they are intrinsically too variable. For example, the changes in a woman's menstrual cycle and potential harm to a fetus if pregnancy occurs, are said to impact on the scientific control and/or safety of the study participants. There is an assumption that the norm is someone who does not have a menstrual cycle, rather than a recognition that the norm for women for around 40 years of their lives is that they have such cycles.

3.33 A recent book on this subject gave an example of the absurd lengths such standardisation can reach. It described a research study that explored the impact of obesity on the tendency for women to develop breast or endometrial cancer, in which only men participated as research subjects.[31] The practice of excluding women who have menstrual cycles from drug trials is apparently also very wide spread both in Australia and overseas. The PIR hopes that Cochrane Collaboration studies will identify such methodological weaknesses as part of its work in ensuring the appropriate quality of randomised controlled trials.

3.34 The PIR notes that such issues have already been raised in Australia through the NHMRC's Women's Health Strategy and Implementation Plan.[32] Among its recommendations was a proposal that the Australian Health Ethics Committee develop a discussion paper on the involvement of women in clinical trials[33]. This paper is currently in preparation. In addition NHMRC research application forms have been re-designed to monitor the numbers of men and women used as participants in research[34]. **The PIR endorses the work of the NHMRC in relation to the participation of women in clinical trials and recommends that all bodies responsible for approving and designing randomised controlled trials and other clinical trials in Australia ensure that such trials include research subjects of both genders, unless the safety of participants would be compromised, or the treatment or drug under scrutiny is intended for application to one gender. In the latter case participants should be of the relevant gender. (Recommendation 13)**

3.35 Another serious concern is that, in some cases, conducting randomised controlled trials to demonstrate efficacy would not be considered ethical. Such a trial requires all participants to be fully informed and randomly streamed to different interventions or

strategies as they risk the possibility that they will receive placebo treatment or no treatment, and be unaware of this. It is unlikely that in cases of serious disease a population would be willing to participate on this basis. To leave some people with a diagnosed disease untreated in order to observe the differences between those who are treated and those who are not (without informing them) would be considered unethical and even criminal, were any of them harmed.

3.36 An example of this occurred at the National Women's Hospital in Auckland, New Zealand. In 1966, a proposal was put in place to monitor the condition of women with positive Papanicolaou (Pap) smears who were not suspected clinically or colposcopically of having invasive disease. No treatment was to be offered to these women unless symptoms or examination later disclosed the possibility of invasive carcinoma-in-situ of the cervix. The proposal was based on a doctor's personal belief that carcinoma-in-situ was rarely, if ever, a cancer precursor. The doctor, and his colleagues, were aware of the world-wide view that carcinoma-in-situ was a pre-cancerous condition.[35]

3.37 A Committee of Enquiry was established in 1987 to enquire into the treatment of cervical cancer at the National Women's Hospital. The Committee of Enquiry noted that an analysis of data from the trial as it began to emerge would have clearly shown that the belief that carcinoma-in-situ rarely if ever progressed to invasive disease was quite wrong.[36] The Committee of Enquiry stated "[i]t is obvious that in human terms, a sizeable group of women who were included in the 1966 Proposal paid the cost of innumerable visits to the Hospital, frequent procedures, deteriorating health and great inconvenience to themselves and their families".[37] Some of the women developed invasive cancer[38] and some died.

3.38 The Committee of Enquiry found that the proposal was a research project even though it lacked important design characteristics. The Committee determined that a flawed research protocol had been put in place and allowed to continue without intervention or provision for termination. The 1966 Proposal was an attempt to prove a theory that lacked scientific validity and little consideration was given to ethical considerations. The women did not know they were in a trial, were not informed their treatment was not conventional and received few details about their condition. The Committee of Enquiry noted responsibility for these omissions extended to all those who approved the trial, knew or ought to have known of its consequences and design faults, and allowed it to continue.[39]

3.39 A commission was established in the United States in 1994 to investigate reports that, experiments to study the effects of radiation were carried out during the Cold War without the public or the subjects knowing about them. The commission also examined how well patients' rights are respected today. The commission reports that what constitutes consent to experimental medical treatment remains muddled in the medical profession. Patients appear to have faith in their doctors and they are dependent on the form of words doctors use. *Research* and *experiment* may be thought of as interchangeable, even though patients may agree to participate in research but not to be the subject of experimentation. The commission surveyed 1,882 patients in waiting rooms of health care facilities throughout the United States. Their names were then compared with lists of people taking part in research projects. About a quarter of those who had been taking part in research said they had never been research subjects, and 12% claimed to have been part of a research project when they had not.

The survey also indicated that many people consent because they trust individual doctors. Others agree because they have "absolute faith in medical research".[40]

3.40 The PIR notes that there are practical, ethical and cost problems where randomised controlled trials are the only acceptable evidence of efficacy or cost-effectiveness. This notion often leads to nothing at all being done, because of the practical difficulties in conducting these trials. Instead, untested practices and procedures continue to be used without evaluation. The PIR notes that the use of practices and procedures whose efficacy and safety have never been demonstrated is, in essence, large scale uncontrolled human experimentation. Where it is done without the full knowledge and informed consent of the person being so treated, it is unethical and also breaches the patient's legal rights.

3.41 There are other options for scientific assessment of various health care treatments. Carefully designed clinical trials without randomisation, cohort or case control, as well as broad scale clinical observation recording may provide the only possible scientific evidence in some areas[41]. As meta-analysis is used to determine the validity of an issue by examining a large number of studies, so the observations of many practitioners, recorded appropriately, provide evidence based on day-to-day medical practice, which can be collected and analysed. These observations form an excellent adjunct to randomised controlled trials and, where ethical issues are a problem, may be the only form of evidence possible. They are often relatively inexpensive. They involve practitioners of all kinds and enable comparisons to be made between different methods across a wide range of practitioners. Experiential research covers a wide range of methodologies, such as incident monitoring. Some of these are broadly labelled *qualitative* research, and can be particularly useful where problems are "complex, contextual and influenced by the interaction of physical, psychological and social factors".[42]

3.42 The PIR's pilot projects trialling incident monitoring within specialties and across institutions are described fully in Chapter 5 (5.122 – 5.155). These pilot projects have used such methodologies to find out more information about when things occur to reduce the margin of patient safety. The results of such studies can provide important information as well, even though there is no control of the denominator in the studies, that is, one cannot be certain how many incidents of the type recorded in the pilot projects occur throughout the health system. Incident monitoring provides a relatively low-cost method, which recognises the complexity of the factors leading to adverse patient outcomes. Systems need to be put in place that facilitate the collection of this important information and ensure its proper analysis and the dissemination of the information, in much the same way discussed for other evidence-based studies.

3.43 The PIR recommends that, given the costs and difficulties associated with only using evidence from randomised controlled trials to support different health care options, that governments, professional colleges and bodies such as the Australian Institute of Health and Welfare and the Australasian Cochrane Centre, examine valid ways of gathering experiential data from routine practice in appropriate health care areas and encourage their use to provide evidence of the efficacy, risks and benefits of different treatments. (Recommendation 14)

United States developments in medical treatment effectiveness research

3.44 One such development, which aims to provide import evidence using experiential data has occurred recently in the United States. The US Public Health Service's Agency for Health Care Policy and Research (AHCPR) has a strong focus in its work on medical effectiveness research. This grew out of awareness of significant unexplained variations in clinical – medical, nursing and allied health – practice and the inadequacy of scientific evidence to support many practices and procedures. The Medical Treatment Effectiveness Program (MEDTEP) projects assess the relative effectiveness, cost-effectiveness and appropriateness of available strategies for the prevention, diagnosis, treatment and management of illness, in terms of patient outcomes.

3.45 The design of these projects addresses some of the criticisms that are made of randomised controlled trials, because they are based on actual practice with a range of patients. MEDTEP projects are all expected to be:

- generalisable: that is they must be concerned with the outcomes that can be expected in typical patients receiving care in typical clinical situations, rather than selected patients in ideal or controlled situations;
- pragmatic: they must address questions of high clinical cost or other policy significance and must be designed with implementation of the findings in mind, for example through improved patient decision-making, clinical guideline development or refinement;
- patient-centred: outcomes must emphasise the patient's experience and perspectives. Not only survival, morbidity and complications are to be looked at, but also patient-reported symptom relief, functional capacity, quality of life, satisfaction with care, and economic burden, together with demographic, social and cultural characteristics and personal preferences, are also all considered important independent variables; and
- multi-disciplinary: studies typically involve a range of clinicians and social scientists, as well as patients, providers and policy makers.[43]

3.46 Three main types of studies are included in the program: those that determine which clinical interventions are most effective, cost-effective and appropriate; those that determine which methods and data are necessary to advance effectiveness research; and those that focus on the dissemination and evaluation of the impact of research findings on clinical practice and outcomes. Between 1989 and 1992, 14 special MEDTEP clinical projects were commenced that are known as Patient Outcomes Research Teams (PORTs). These projects are broad-based, five-year, multi-method studies, that look at the following areas:

- assessing therapies for benign prostatic hypertrophy and localised prostate cancer;
- variations in cataract management, both patient and economic outcomes;
- back pain outcome assessment;
- the consequences of variation in treatment for acute myocardial infarction;
- assessing and improving outcomes of total knee replacement;
- outcome assessment program in ischaemic heart disease;

- outcome assessment of patients with biliary tract disease;
- analysis of practices in hip fracture repair and osteoarthritis;
- variations in the management and outcomes of diabetes;
- assessment of the variation and outcomes of pneumonia;
- variation in management of childbirth and patient outcomes;
- secondary and tertiary prevention of stroke;
- an evaluation of practices intended to prevent low birth weight and its sequelae in minority and high-risk women; and
- schizophrenia patient outcome research.

3.47 A second generation of similar research, known as PORT-II. was commissioned in 1993. These projects do not have common research plans, like PORTs, but are directed at similar questions. In 1994 the following PORT-II areas commenced:

- prostatic diseases;
- care, costs and outcomes of local breast cancer;
- cardiac arrhythmia;
- homemade cereal-based oral re-hydration therapy;
- dialysis care/choices, outcomes, costs and trade-offs; and
- value of medical testing prior to cataract surgery.

Further projects will be funded in 1995 and 1996.

3.48 The result of these projects should be of direct relevance to the Australian health care system. **The PIR recommends that the results of United States medical treatment effectiveness research projects be considered by the NHMRC and other appropriate bodies for their applicability and utility in Australia. These bodies should also seek ways of making the results of the studies accessible to health care consumers. (Recommendation 15)**

C. Clinical practice guidelines: information tools for health professionals and patients

3.49 Clinical practice guidelines are, " ... systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances".[44] In its Interim Report, the PIR noted that clinical practice guidelines have the potential to improve the quality of services and set standards.[45] The establishment of a national guidelines development program was previously proposed by the National Health Strategy, as one of five major activities for a national focus on quality and effectiveness.[46] This followed an earlier survey of health professional organisations in Australia by the National Health Strategy to determine whether guidelines were being developed and, if so, for which purposes.[47]

3.50 In 1992, the Australian Health Ministers' Advisory Council agreed to work with the NHMRC to develop a process for promoting best practice linked to outcomes and effective cost management, including clinical practice guidelines. In the 1995-96 Budget, funding for

clinical practice guideline development was built into the National Hospitals Outcomes Program.

3.51 The PIR received little information in submissions relating to clinical practice guidelines. One submission did note that any work done on accelerated compensation events or designated compensation events could be linked to the development of clinical guidelines.[48] Compensation events and clinical practice guidelines both require documentation of known adverse outcomes and their links to specific treatments.

NHMRC Guidelines on development and implementation of clinical practice guidelines

3.52 The Quality of Health Care Committee of the NHMRC formulated its draft guidelines for development of clinical practice guidelines in the context of world-wide concerns about:

- documented and unjustifiable variations in practice for similar conditions;
- increasing availability of new treatments and technology;
- lack of knowledge about effectiveness of interventions in terms of patient health outcomes; and
- the rising cost of health care.[49]

3.53 The guidelines are based upon the view that the health system should focus on the outcomes of patient care.[50] They envisage a staged process, starting with a determination of the need for guidelines, thought their development and implementation, and concluding with evaluation and revision. The final version of the guidelines was to be released in late October 1995.

3.54 The NHMRC states that guidelines should be based on the best available evidence of the link between the intervention and the outcome under scrutiny. Evidence-based guidelines are those based on a systematic review of all relevant randomised controlled trials. This is considered the strongest scientific evidence. Where clinical practice guidelines are developed on the basis of less strong evidence, but where there is consensus among clinicians as to outcomes, they are called consensus guidelines. Where there is no scientific evidence or consensus of clinical opinions, it may be necessary to issues non-consensus practice statements. The extent to which an action can be recommended will depend on the strength of the evidence and the strength of the method used to synthesise the evidence.[51]

3.55 In outlining the nature of clinical practice guidelines, the NHMRC states that they should be outcome focused. Quoting the Australian Health Ministers' Advisory Council's definition of a health outcome, that is, "a change in the health of an individual, group of people or population which is attributable to an intervention or a series of interventions", the NHMRC notes that health outcomes can be positive or negative and range from survival rates to measure to improve quality of life.[52]

3.56 The NHMRC recommends that clinical practice guidelines be developed through a multi-disciplinary approach, that includes contributions from all relevant clinicians and representatives of consumers and other key groups and disciplines. Guidelines should

provide information on the best investment for the best health outcomes and include an economic appraisal. They should identify known exceptions or risks and identify the specific patient population to which they apply. They must be comprehensive and flexible enough to apply to diverse settings and circumstances.

3.57 The multi-disciplinary development process should define and recommend processes to encourage adoption of the guidelines. Implementation strategies could use the education and communication links of appropriate colleges, professional organisations and consumer groups and seek incorporation in quality assurance processes. They should include consideration of confidentiality and privacy, which may inhibit implementation, identify other barriers to implementation and ensure that incentives and support for dissemination and implementation are linked to accountability.

3.58 Regular evaluation should take place to ensure guidelines are updated and take account of evaluation, new research and technological advances. Clinical and outcomes data are required. A minimum set of core data items relating to patient profiles must be collected. Evaluation should test the validity, reliability and reproducability of the guidelines and assess the guidelines' applicability and acceptability. It should also assess whether they are flexible enough for use in local and regional practice.

3.59 In summary, the development of clinical practice guidelines is based on involving all stakeholders and focusing on appropriate patient outcomes, and evaluation of the best available scientific evidence of their effectiveness in achieving the patient outcomes sought.[53]

3.60 Two working groups were established by the NHMRC's Quality of Health Care Committee to trial the guidelines process in the fields of surgical and procedural management of coronary heart disease and the treatment of diagnosed breast cancer. The working groups are developing, testing and evaluating guidelines as part of the long-term aim to have the methodology used routinely by medical colleges and other groups. Membership of the working group comprises a full range of specialist groups, consumer representatives, a nursing representative, a general practitioner, a health economist, an epidemiologist and a medical education specialist. The guidelines for the management of early breast cancer were released for public comment in June 1995.[54] The coronary heart disease guidelines had not been released at the time of writing this Report.

3.61 In determining the need for clinical practice guidelines, the NHMRC states guidelines are only appropriate if the problem or objective is related to clinical decision-making. Guidelines may be a response to variations in treatment among practitioners for the same condition. Should the variation be due to a lack of knowledge or information among clinicians, then development of evidence-based guidelines is appropriate. Variations in treatment may also be due to patient needs and sound evidence. In these cases the variation does not indicate a need for clinical practice guidelines.[55]

3.62 Other Australian clinical practice guidelines which are being developed at the moment relate to depression, managing women at risk of pre-term birth (the need for this became apparent through the Cochrane Collaboration's work on birthing), acute pain management,

carotid artery stenosis and prevention of stroke, unstable angina and voiding dysfunction in men.

3.63 An important issue in relation to clinical practice guideline development and the work of the Cochrane Collaboration is the need to complete the initial work in a reasonable period of time, and then to have in place a review and amendment processes. Long delays in completion of the work or failures to update may mean the guidelines are out-of-date almost before they are completed. This would simply lead to them falling into disuse and being ignored. It is important that this work be adequately funded to ensure delays are minimised.

3.64 The PIR believes that clinical practice guidelines are an important tool for improving the quality and appropriateness of health care services, and for assisting health professionals to properly inform patients about options, risks and benefits and recommends their continued development. (Recommendation 16)
The process of development can, like the Cochrane Collaboration work, identify where there is little evidence available about efficacy. This can inform patients and health professionals, as well as providing fruitful areas for future research. It can also indicate areas where data collection on outcomes is a high priority. The Cochrane Collaboration work could help inform this process, and clinical guidelines could be one way of disseminating that work to health professionals and consumers.

Guideline development in the United States

3.65 In the United States, clinical practice guidelines are developed under the AHCPR. Most of its guideline development processes are very similar to the Australian processes, though it has been working on them for longer. In the United States guidelines are seen as important elements of a focus on quality improvement and health outcomes.

3.66 AHCPR–sponsored guidelines are a central part of a four-stage process to determine how specific conditions can most effectively and appropriately be prevented, diagnosed, treated and managed. The four parts to the process are:

- Clinical Practice Guidelines: these are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.
- Medical Review Criteria: these are systematically developed statements that can be used to assess the appropriateness of specific health care decisions, services and outcomes;
- Standards of Quality: these are authoritative statements of (1) minimum levels of acceptable performance or results, (2) excellent levels of performance or results, or (3) the range of acceptable performance or results.
- Performance Measures: these are methods or instruments to estimate or monitor the extent to which the actions of a health care provider conform to practice guidelines, medical review criteria or standards of quality.[56]

3.67 United States guidelines that have been developed already include: acute pain management, otitis media with effusion, urinary incontinence in adults, heart failure, acute

low back problems in adults, pressure ulcers in adults, pressure ulcer treatment, cataracts in adults, depression in primary care, sickle cell disease, quality mammography, early HIV infection, benign prostatic hyperplasia, post-stroke rehabilitation, management of cancer pain, and unstable angina.[57] Other areas where guidelines are under development include cardiac rehabilitation, Alzheimer's disease, anxiety and panic disorders and smoking cessation.[58]

3.68 United States guidelines are produced in several versions for their various audiences. These are:

- the Guideline Report: which is the technical version containing the guideline and all supporting materials, including algorithms (visual displays of the conceptual organisations, procedural flow, decisions points, and preferred management path presented in the guideline), methodology, literature review, summary of scientific evidence tables, references, and a comprehensive bibliography, for us by health care practitioners, researchers, educators, professional organisations and others.
- Clinical Practice Guideline: which contains the specific statements and recommendations, algorithms, summary of evidence tables, and pertinent references, for use by health care practitioners as a reference for clinical decision-making;
- Quick Reference Guide for Clinicians: which is an abbreviated form of the guideline, including summary points of prevention, diagnosis and treatment, intended for health care practitioners as a desk reference on a day-to-day basis; and
- A Patient's Guide: which is for patients and the parents of young patients, and describes the condition and treatment options with benefits and risks in easy-to-understand terms and suggests questions to ask health care practitioners. It is produced in English and Spanish.

In June 1994, all these became available on-line (including through the Internet). The quick reference and patient versions are also available through an instant fax service. **The PIR recommends the NHMRC consider electronic and facsimile methods of dissemination of Australian clinical guidelines, as well as the more traditional publication route, to ensure the widest possible dissemination amongst health care professionals and health care consumers. (Recommendation 17)**

3.69 As mentioned above, United States guidelines are developed in a similar fashion to that to be used in Australia, and in fact, where a United States guideline already exists, they are examined by Australian guideline developers as a starting point. In some areas, it appears they can be readily adapted for Australia, but in other areas, very different treatment methods are used.

3.70 For example, Australian clinicians were not satisfied with the United States depression guidelines, which relied almost solely on drug treatment, with little or no attention to social support, counselling and other therapies widely used in Australia. From a health care consumers perspective, the question must by asked whether there is evidence to support this wide variation of medical views between jurisdictions – are there satisfactory outcome studies of both methods, and what do they show? For example, if studies showed that drugs were more effective, or faster, or cost less than alternative therapies, then consumers may be willing to go with any risks of side effects. However, if there was no difference between the

outcomes for drugs and other different therapies, and the other therapies were demonstrated to have less risk of side effect, or to be of lower cost, then a consumer also needs to know this, as would all health professionals and government. If there is that level of international disagreement, it would seem to be an ideal, priority area for a Cochrane Collaboration review.

3.71 If consumers know that these levels of international variation of practice exist, they will have a better understanding of the fact that much of is still being scientifically evaluated. They need to understand this in order to make their own decisions about health care treatment options. **The PIR recommends that the NHMRC develop ways of ensuring that health care consumers are made aware of areas where there are uncertainty and variation in clinical practice, and that they are informed about the variations that are being examined, for example, articles in the press and appropriate journals. (Recommendation 18)** Similar information should be provided to health care professionals, so that they may properly satisfy their information-giving obligations to their patients.

Compliance with clinical practice guidelines

3.72 There are various different ways that clinical practice guidelines could be used to modify health professional behaviour. They could be voluntary and educative, they could be made mandatory, either by statute or by administrative requirements within an institution, or they can be used in such a way as to encourage their use, without requiring it. The use of guidelines in various ways in negligence actions could fall into this last category and is discussed further in Chapter 7 (7.140 – 7.147).

3.73 The question of compliance is an important one, because there is evidence from earlier studies that health professionals take a long time to change their practice habits, even once there is compelling scientific evidence to justify the change. Most recently this was remarked upon in the context of the management and treatment of breast cancer.[59]

3.74 In Australia, some groups of doctors have also dismissed guidelines as cook book medicine and, therefore, somehow second class compared to individual clinical judgement applied to each patient. It is worth noting that cook books and clinical practice guidelines were probably invented for similar sensible reasons - to increase the certainty that the end product was of a high quality each time it was made. Many culinary and clinical disasters have no doubt occurred where tried and proven recipes have not been followed, or some ingredient has been accidentally omitted.

3.75 While the availability of broad clinical guidelines is relatively new, many specialties have used specific algorithms and memory joggers, particularly for crisis situations. There have also been informal clinical and administrative guidelines within specific institutions. Some studies have looked at doctors' voluntary compliance with guidelines in these circumstances. For example, Ellrodt and others report on a study of doctors' compliance with a length-of-hospital stay guideline.[60] The guideline aimed at reducing the length of hospital stay for patients with chest pain, who could be classified as low risk. The guideline suggested these patients be discharged by day three. The study was a retrospective analysis of a prospective, controlled interventional trial. Briefly, 79 patients (out of a total of 230 patients)

with chest pain classified as low risk by the retrospective review were not discharged by day three.

3.76 Researchers hypothesised that failure to comply with the guidelines could be due to multiple factors, such as:

- doctors' attitudes towards the guideline leading to rejection of the guideline or its implementation strategy;
- limitations of the guideline or its implementation strategy;
- inefficiencies in the hospital or health system; and
- differences in the patients' clinical status.[61]

3.77 The researchers noted that there were six methods of changing doctors' clinical practice:

- education;
- feedback;
- participation by doctors in efforts to bring about change;
- administrative rules;
- financial incentives; and
- financial disincentives or penalties.

In the controlled interventional trial, there were no financial incentives, although doctors had the disincentive of fewer patients to charge if patients were discharged within three days. Administrative rules were not used. Education, doctors' participation in guideline development and concurrent written and verbal feedback were used.

3.78 In the trial, 69% of doctors complied with the guideline, whereas in the review 64% were classified as having complied. The difference was due to those patients who were misclassified in the trial as low risk, but who were truly high risk.[62] Of the 79 patients not discharged by day three, the review found:

- forty-six patients (58%) were correctly classified as low risk;
- seven patients (9%) were not discharged because of a change in their clinical situations between classification at 24 hours and potential discharge at 48 hours. All these patients were reclassified as high risk and were inappropriate for discharge;
- eleven patients (14%) were judged by doctors to be suitable for discharge, but they were not discharged due to hospital or health system inefficiency; test scheduling problems, unavailability of test results or a nursing home bed, or refusal by the patient to be discharged;
- thirteen patients (16%) were not discharged due to the doctors' refusal to discharge. No single doctor was responsible for more than one patient. Although there was a documented doctor refusal to discharge, no medically appropriate reason according to the guideline was evident on review of the patients' records for the greater than two-day hospital stay in seven cases. For five patients there was a medically appropriate reason and for one patient it was not possible to determine medical appropriateness;

- fifteen patients (19%) were accurately classified as low risk but there was no obvious reason for the doctors' non-compliance or failure to discharge in the records. The review determined, however, these patients had greater co-morbidity and severity of illness scores than low-risk patients discharged according to the guideline.

3.79 Analysis showed 42% of apparent non-compliance with the guideline was due to the guideline's classification (implementation) errors, that is, patients were classified according to the guideline as low risk, whereas they were high risk. Doctors were, therefore, required to override the guideline. Seven per cent of non-compliance related to changes in the patients' clinical status, and this underlines the responsibility doctors' have to review the guideline's recommendations in the light of patient changes during hospitalisation.

3.80 The authors drew the following conclusions from the review:[63]

- there are circumstances where doctors are required to override guidelines;
- there must be on-going review of the guideline by doctors, so that the guideline complements rather than replaces their professional judgements;
- inefficient hospitals and health care systems must be addressed. If doctor compliance with a guideline is used for analysis, the system that is measuring and attempting to encourage improved efficiency may be the cause of the problem;
- no one doctor was shown to be persistently non-compliant with the guideline, although it would have been difficult to detect a pattern of non-compliance in an individual given the nature of the study. However, the finding is consistent with the total quality management principle that most persistent problems are system-related, rather than related to an individual;
- there were complicated and challenging decisions to be made, indicating that non-compliance may be due to a "struggle with complex issues", rather than a rejection of the concept of clinical practice guidelines; and
- attempts to improve guideline performance must address implementation systems and the clinical limitations of guidelines, as well as doctors' non-compliance.

3.81 While this study showed that there were good reasons in some cases not to comply with the guidelines,[64] the PIR notes that some variations from a clinical practice guideline will not be for good clinical reasons, but because of habit or ignorance. It is important that such variations be avoided. This is particularly so where the guideline development process shows that some widely used procedures lack efficacy, are much more risky or costly than others, and perhaps most importantly, if the guideline is not followed there is a significant risk of the patient suffering an adverse event and injury or a bad outcome. The preliminary analysis of the Quality in Australian Health Care Study shows that there will be some adverse events which could be prevented if certain procedures were followed, and so these may well be amenable to the establishment of clinical practice guidelines.

3.82 The question arises of the fastest way to ensure that all health care professionals adopt practice changes that accord with guidelines, where to do otherwise will result often in damage to patients and create a potential legal liability for health care professionals and the facility in which they work. How can inappropriate breaches be detected and how should

they be dealt with? How, and by whom, should such appropriateness be determined? Reliance on the tort system as a first course is very slow, arbitrary and time-consuming. It requires that someone suffer damage before any action can occur. Equally, the only real system-wide learning from the tort system comes from the publicity surrounding a case. A case where the care was clearly beneath a satisfactory standard will rarely reach a court. It is likely to be quietly and quickly settled without any publicity.

3.83 In some cases, where it is clear that certain activities are harmful and non-beneficial, the Commonwealth may be in a position to exert financial incentives to change behaviour, for example by removing items from the Medicare Benefits Schedule. State Governments could provide similar incentives in the case of public patients in public hospitals, where the remuneration of practitioners is by State Governments. **The PIR recommends that the Commonwealth Government establish a mechanism that links findings from evidence-based medicine and outcome studies (including adverse event studies) to reviews of funding for various medical services under the Medicare Benefits Schedule, so that financial incentives can be used to influence clinician's to adopt treatment choices which are most beneficial for patients, either because they have better outcomes or fewer adverse events, or because the preferred treatment is less costly. (Recommendation 19)**

3.84 The PIR recommends that the Taskforce consider the best ways of: detecting inappropriate breaches of guidelines which aim to prevent the occurrence of adverse events; dealing with breaches of guidelines, including deciding how the inappropriateness of any breach could be determined; and establishing benchmarks of performance that require information on such breaches by individual health care practitioners to be publicly available. (Recommendation 20)

3.85 The PIR sought preliminary legal advice on the possibility of making compliance with certain clinical practice guidelines compulsory, that is, non-compliance would render a doctor liable to disciplinary action. The advice indicated that, while there is no single constitutional power, a number of heads of power would support the introduction of legislation imposing a duty to comply with guidelines. In this case it is noted that the term *guidelines* would no longer be applicable. They would be more akin to statutory duties to which penalties for non-compliance are attached and would dictate how a particular professional service is to be carried out.

3.86 The relevant heads of power which could support such legislation are:

- s51 (xx) the corporations power, which enables regulation of public and private hospitals and incorporated bodies operating private doctors' practices;
- s51 (xxiiiA) the health and social welfare power, which could allow conditions to be attached to payments of Medicare benefits;
- s96 the States grants power, which could be used to impose conditions on payment of grants regarding public hospitals; and
- s122 the Territories power, which provides for regulation of matters in relation to services within a Territory.

3.87 The PIR recommends that the Taskforce consider whether to create statutory duties in certain areas, where the danger to patients is very high if there is a failure to act in a certain manner. (Recommendation 21)

3.88 The PIR recommends follow-up studies on the use of Australian guidelines be undertaken, once they are implemented, to determine whether and how they are being used, and what barriers there may be to their broader use. (Recommendation 22)

D. Australian health outcomes work

National Health Goals and Targets

3.89 There has also been an increasing focus on health outcomes in Australia. The 1993–98 Medicare Agreements included agreement that the Commonwealth and States put in place a process for determining national health goals and targets, and that the goals and targets and priority areas for implementation would be endorsed by the Australian Health Ministers' Advisory Council in June 1994. The Sunshine statement of February 1993 from the Australian Health Ministers' Advisory Council set out a commitment "to achieve optimal individual and population health within available resources through a focus on improving health outcomes". A health outcome was, as noted above, defined as a change in the health of an individual, a group of people or population, which is attributable to an intervention or series of interventions.[65]

3.90 The following principles within which the commitment is to be fulfilled were agreed between Australian Health Ministers:

- all Australians should have access to a comprehensive range of health care services regardless of financial status and place of residence;
- health services should be of a consistent high quality across Australia;
- there should be continuity of care across the health system, with appropriate referral to appropriate higher level services; and
- major causes of ill health and premature death including environmental and life style factors should be identified and addressed, and cooperative strategies to reduce them developed and implemented.

3.91 A process to identify priority goals and targets was then put in place, through a joint AHMAC/NHMRC working group established to select initial focus areas for national agreement and action. These initial focus areas include cardiovascular health, cancer, injury and mental health. Separate working groups were established in these areas, and the results of their work were published in 1994 in a report entitled *Better Health Outcomes for Australians.*[66] This report sets out goals, targets and strategies in each of these areas. The process of consultation and development of these strategies identified a number of common challenges if health outcomes are to be improved. Many of these have also been identified in the work of the PIR as barriers to reduced incidence of adverse patient outcomes, as problems in meeting the needs of those who have such outcomes, and as challenges if we are to deal

creatively with the problems arising from adverse patient outcomes and health care professional indemnity.

3.92 Some of the common challenges are set out below:

- there is a complex interaction of government departments and agencies, non-government bodies and industry groups involved in the provision of health care and activities that impact on health;
- health services are provided in a range of community-based and facility-based settings without always maximising the opportunities for multi-disciplinary care, co-ordinated referral and follow-up protocols and procedures;
- widespread variation in treatment practice is a feature of health services in Australia. Little is known about why variations exist in rates of hospitalisation, surgical intervention, diagnostic procedures or pharmaceutical usage, or their contribution to health outcomes;
- the development of a health outcomes approach requires renewed efforts to involve patients and the community in decision-making about priorities and directions in health care and to encourage patients to take responsibility for their own health; and
- efforts need to be increased in the provision of information to health professionals about the links between treatments and outcomes, and in the promotion of appropriate care guidelines.[67]

Other Commonwealth outcome-related activities

3.93 The Commonwealth Government's work in relation to outcome performance measures received extra funding in the 1995–96 Budget. The National Hospital Outcomes Program is a $14.5 million three-year program to develop and implement performance measures for standards of quality and outcomes of care in Australian hospitals. It builds on the earlier work of the National Hospital Quality Management Program which ended on 30 June 1995. An incentive program under the 1993–98 Medicare Agreements, the Quality management program has promoted a national approach to the improvement of quality of care and health outcomes of hospital services over the past two years. The program has also addressed priority areas such as the development and use of national clinical and non-clinical indicators of quality and outcomes of care, medical record reform, integrated discharge planning and promoting a stronger consumer focus. A number of projects addressing these themes were approaching completion during the period June to December 1995 and their outcomes were to be included in an evaluation report for the program in December 1995.

3.94 The new outcomes program will develop measures that hospitals can use to improve their performance over time, and enable them to compare their performance with others. It will promote public availability of hospital performance information, and lead to quality and outcome performance measures which can be linked to funding agreements between the Commonwealth and States (for example Medicare Agreements) and between States and individual hospitals. The program includes:

- indicator development work;
- demonstration activities on enhanced quality management;

- the development and implementation of an integrated quality management model for acute care hospitals in Australia;
- research into the relative cost-effectiveness of alternative clinical interventions;
- incident monitoring to reduce adverse patient outcomes (discussed in chapter 5); and
- development and implementation of clinical practice guidelines (discussed earlier in this chapter).

3.95 So far as indicator development is concerned, work is already underway on developing nationally consistent clinical quality indicators.

- Tenders have been invited and proposals are being assessed for the testing of the reliability and validity of four national quality of care indicators and for risk-adjusting the results so comparisons can be made among different hospitals: unplanned returns to hospital; unplanned returns to the operating theatre; rate of post operative wound infection; and rate of hospital acquired bacteraemia.
- These indicators are also part of the set of performance indicators required by the Australian Health Ministers Benchmarking Working Group (discussed in Chapter 2) and the COAG Review of Commonwealth and State Government Service Provision.

- **Further work has been contracted to produce some core questions to assist in the development of consumer satisfaction indicators for benchmarking.**
- Tenders have been invited for a project to research and critically review developments in Australia and overseas relating to broad outcome measures for acute health services, and to make recommendations on key areas for the development of measures in the Australian context. This project is the first stage in the development of a core set of national measures of quality and outcomes of acute care. It will complement other work presently underway on the development of health outcome and quality of care indicators for specific clinical specialties, mental health and consumer feedback.

3.96 The quality management component of the project supports demonstration activities that assist hospitals to review their management practices and respond with quality and outcome improvements, including ways in which patient records and other relevant data can be routinely reviewed and problems identified and acted on. A public tender process has commenced for a consultancy to develop and implement a comprehensive integrated quality management program at one or more acute care hospitals in Australia, which can be adopted as a model for the hospital industry. The program must have a strong focus on developing and implementing a structured mechanism for reviewing patient medical records, including a mechanism for identifying quality problems and implementing corrective strategies to improve patient safety.

3.97 The program will be linked to the National Health and Medical Research Council's Research and Development Grants Advisory Committee (RADGAC) to fund studies into the relative cost-effectiveness of health interventions. This will enable a more co-ordinated approach to quality and outcome-related activities. The Hospitals Outcomes Program will recommend priorities for relative cost-effectiveness research to RADGAC for its consideration. Research proposals to undertake relative cost-effectiveness research in the

identified priority areas would then be sought and assessed as part of the usual RADGAC funding process.

State outcome initiatives

3.98 The increased focus on health outcomes at State level is evidenced by programs such as the New South Wales Health Outcomes Program, which aims to re-orient the planning, implementation and evaluation of health services towards health outcomes. This program aims to ensure that all health services and programs delivered in New South Wales have a consumer focus; involve co-operation between clinical, public health and management sectors; encourage innovation; put monitoring into the hands of service providers; and ensure the dissemination of information on risks, benefits and costs. It gives priority to communication, building the health outcomes orientation into the daily life of the health system and developing a strong information base. This includes the development of standard health outcome indicators and proper feedback systems for this information.[68]

3.99 Draft health outcome development plans have been prepared for: asthma, injury and critical care services, perinatal outcomes, cardiovascular disease (stroke and coronary heart disease), diabetes, the lead problem, HIV/AIDS, tuberculosis and immunisation and vaccine-preventable diseases. It is envisaged that Health Outcome Councils will be established in health areas and districts in New South Wales to:

- decide what health outcomes the local services and programs should be achieving;
- review existing services and their outcomes;
- decide what health outcome indicators could be used to measure outcomes;
- ensure that information on these indicators is made available to consumers and to people who are in a position to maintain or improve outcome;
- estimate how much is spent on current services and programs; and
- decide whether existing resources could be used differently to achieve the desired health outcomes, and if so, how.[69]

3.100 The central importance to the program of communicating is evidenced in various ways. For example, a state-wide Health Outcomes Conference, attended by over 800 people was held in August 1994 and a discussion paper on Health Outcomes was released.[70] To promote better community understanding of health statistics, a publication called *Normaltown NSW* was produced.[71] It provides a variety of epidemiological, economic and social information for a community of 100,000 people somewhere in New South Wales. Health outcomes data are also published on an on-going basis.

3.101 A practical example of the work in New South Wales is the health outcomes approach to diabetes. A need was identified for a simple clear set of guidelines that document current accepted standards of care for people with diabetes, promote uniformity of clinical practice, aid clinical decision-making and have the potential to change practice. An expert panel was convened as part of the health outcomes approach and a working party of the panel has developed 7 consensus guidelines.

3.102 Three guidelines have been identified as priorities for implementation. They are blood glucose control, diabetic eye disease, and foot problems. Each guideline has the same format: a background statement which justifies the guideline; an aim; a procedure for achieving the aim; how often the procedure should be performed; how the result should be interpreted; a broad outline of what should be done depending on the result; and a method for process and outcome evaluation of the procedure contained in the guideline. The guidelines will be produced in various formats to facilitate use in clinical practice. In the simplest form, the guidelines will be condensed into seven key points. The key points are likely to be in the form of a pad with tear off sheets to be placed in the patient's notes, or attached to the patient's record card, and are intended to prompt the general practitioner.[72]

3.103 The New South Wales Health Department's Outcomes work and other similar initiatives are important steps towards ensuring that consumers and health care providers all have better information on risks, benefits, costs and performance in the health care system.

Outcomes work and comparisons : some issues

3.104 An important issue in relation to health care outcomes research is the need to ensure that it not only focuses on different clinical treatments, but also considers the relative efficacy of prevention strategies for these same conditions. Most health professionals are trained to intervene when someone is ill, with disease prevention and health maintenance forming a minor part of their training. This training focus could lead to intervention when it may not be in a patient's best interests. In the case of cervical changes detected by Pap smears discussed below, and in other areas of health care such as prostate disease, watchful waiting or observation is not a common strategy used by many Australian health care professionals, yet it may be more appropriate for a health care consumer than other more interventionist options. The payment for health care in Australia and the training of many health professionals tend to reinforce the need for action and intervention when someone is unwell or injured, rather than either an observation-based or prevention-based strategy. In many cases, intervention may not be the best option for the consumer or the taxpayer who is funding the services.

3.105 Outcomes research and measures must avoid the temptation to focus only on interventions by health care professionals, and only on certain types of health care professionals. It may often be necessary to include evaluation of watchful waiting or observation, as well as examination of interventions by various disciplines. For example, in the case of back pain, outcomes research may have to include the treatments offered by different doctors, by physiotherapists and chiropractors, as well as examination of patients who have no treatment, but who rest or who perform self-directed exercises.

3.106 Outcomes research and measures must also include evaluation of measures that avoid the need for any intervention at all by maintaining health. Sometimes these are preventive health care measures, such as immunisation. However, often the maintenance of health has less to do with the treatments of health care professionals than with various social, environmental and economic factors. Many of these elements are included in the National Health Goals, Targets and Strategies.[73] In its first research paper, the National Health

Strategy emphasised the importance of the following non-health system areas in the reducing health inequalities:

- the distribution of economic resources
- education
- living standards
- access to and conditions of work
- social support[74]

3.107 Sometimes a re-direction of resources into these areas may reduce the need for health care expenditure, and eliminate the risks which are associated to varying degrees with most forms of intervention. While these issues extend beyond the realm of the work of the PIR, they are significant issues when designing and conducting outcomes research. Often these factors are seen as difficulties in carrying out randomised controlled trials. Yet they may be the very factors which both affect health status and the efficacy of various treatments. Health care professionals must bear this in mind when carrying out outcomes research.

E. Experimental treatment?

3.108 As noted earlier in this Report, any intervention that has not had its efficacy demonstrated should be seen as experimental. When a treatment, drug, device or procedure is experimental, specific ethical guidelines, exist that impose a high duty of disclosure of information to patients and an obligation for its use to be carried out under the auspices of a clinical trial approved by an ethics committee.

3.109 The NHMRC set out relevant guidelines in its 1992 Statement on Human Experimentation. Supplementary note 3 defines a clinical trial as:

> a study done in humans to find out if a treatment or diagnostic procedure, which it is believed may benefit a patient, actually does so. A clinical trial can involve testing a drug, a surgical or other procedure, or a therapeutic or diagnostic device.[75]

3.110 The use of the guidelines in cases of clinical treatments and procedures appears to have been limited. The guidelines clearly envisage their application to treatments or interventions whose efficacy has not been demonstrated. Harvey notes that there is growing acceptance that many, if not most, health care interventions have not been demonstrated to produce health benefits to patients.[76] He states the traditional gold standard for attributing a health outcome to an intervention has been the randomised controlled trial. Most interventions are not subject to such trials and in many cases the trial population is nothing like the population exposed to the intervention. Interventions that work well in trials may not provide the same level of benefit, or may have higher associated risks, in routine practice.[77]

3.111 Detailed processes are in place requiring proof of efficacy and cost-effectiveness in therapeutic products and health technology developments. The PIR notes that new therapeutic products are subject to pre-market registration, manufacturer licensing, post-market product monitoring and related areas of regulatory control under the *Therapeutic*

Goods Act 1989. In respect of health technologies, the Australian Health Technology Advisory Committee co-ordinates health technology assessment in Australia. The Advisory Committee carries evaluation of health technologies including safety, efficacy, effectiveness, cost, equity, access and social impact. Technology for early detection, diagnosis and treatment may be poorly understood, and where this leads to inappropriate use, heavy costs result for the health system. The Advisory Committee provides reviews of new and established technologies by recognised experts. This helps establish the effectiveness of the technology and can limit the inappropriate use of expensive technologies, while ensuring technology is used in a way likely to lead to a high quality of care. In 1995, the Advisory Committee's program included the following areas: beam and isotope radiotherapy; diagnostic ultrasound; minimal access surgery; sleep disorders; molecular biology; magnetic resonance imaging; and prostate cancer screening.

3.112 And yet these same safeguards do not exist for other treatment methods and procedures. Ideally, all treatments should be subject to proof of efficacy and examination of cost-effectiveness, or be discarded. The National Health Strategy Background Paper titled *Making it Better* recommended that all new interventions undergo formal evaluation before being introduced, and stated that doctors had an ethical duty to their patients to ensure that any treatments being used have been shown to be safe and effective.[78] It would also seem advisable that the funders of services have efficacy and cost-effectiveness advice in determining whether particular interventions should be funded.

3.113 There is no ongoing mechanism under the Medicare Benefits Schedule for this to occur, though practices which have been demonstrated not to be efficacious can be reviewed in an ad hoc manner. In the case of new inclusions in the Schedule, the recommendations for inclusion currently must come via the professional medical colleges and the Australian Medical Association, and it is the responsibility of the colleges to have assured themselves of the efficacy of the treatment prior to seeking its inclusion on the Schedule. Sometimes the responsible area of the Commonwealth Department of Human Services and Health carries out independent literature searches, but usually the advice of the medical colleges is relied upon. There are no guidelines covering how a college should satisfy itself regarding efficacy of a treatment before recommending its inclusion in the Schedule. **Prior to the establishment of the broader process of funding reviews as suggested below, the PIR recommends that guidelines on the standard of proof of efficacy and cost effectiveness be established by the Commonwealth for colleges intending to recommend funding of a treatment under the Medicare Benefits Schedule. (Recommendation 23) Because similar decisions need to be made in relation to treatment of public patients in public hospitals, the PIR recommends that AHMAC be involved in the development of such funding guidelines. (Recommendation 24)** AHMAC and the Commonwealth need also to consider whether private health insurance funders should be involved in this development, given their role in funding as well. Such guidelines could also be a useful assessment tool for the funding reviews suggested below.

3.114 The PIR concludes that where the efficacy of a treatment has not been proven, there is an argument that the patient is participating in human experimentation. In these circumstances, a health care professional is well advised to comply with the terms of the NHMRC statement on human experimentation. For many established procedures and

interventions, establishing efficacy will be a long-term prospect. For these cases, there is an immediate need for patients to be fully informed about the level of evidence available for the benefits and risks of specific treatment options, so they are aware of whether or not they are involved in experimental health care. **The PIR recommends that necessary ethical safeguards for consumers, such as those that govern clinical trials, be put in place where there is not a sufficient evidentiary base for current practices. (Recommendation 25) The PIR also recommends that the NHMRC consider the issue of whether health care treatments, whose efficacy has not been scientifically demonstrate constitute human experimentation; if so, whether the existing NHMRC guidelines on human experimentation are appropriate in these cases; and, if the guidelines are not appropriate, develop new guidelines to cover these cases. (Recommendation 26)**

3.115 The importance of patients knowing how strong the evidence is to support various treatments, was recently emphasised by the NHMRC in its clinical practice guideline development work. The NHMRC states that clinical practice guidelines should contain a statement concerning the strength of recommendations. The strength of the recommendations is based on the strength of the evidence and methods used in the synthesis of evidence. Guidelines should also include a best assessment of the positive and negative outcomes and likely risks of an intervention, since assessment of the benefits and risks may influence consumer decisions.[79]

3.116 The PIR believes that the importance to consumers of understanding the benefits and risks of treatments cannot be over-estimated. The importance of consumers understanding the relative strength of evidence for the efficacy and safety of a treatment is especially strong where no evidentiary examination has yet been undertaken, as is required to develop evidence-based and consensus-based guidelines, or non-consensus practice statements. **The PIR recommends that part of the information that should be provided to patients in relation to treatment options, be whether or not the efficacy of particular treatment options have been scientifically tested to the degree sufficient to produce NHMRC outcome-based guidelines and, if not, to what degree of certainty can the benefits, risks and efficacy can be shown. (Recommendation 27)**

3.117 Further the PIR considers that whenever any new treatments are introduced they must only be introduced after appropriate proof of efficacy and cost-effectiveness. This of course needs to be balance against the potential benefits being made available as soon as possible, once efficacy and cost-effectiveness are proven. The need for adequately demonstrated efficacy and cost-effectiveness in new treatments was identified in the work of the National Health Strategy[80]. In recognition of the practical difficulties in creating clinical trials for all new treatments, the National Health Strategy recommended as follows:

> A balance may be achieved if criteria can be established to identify those new interventions for which there is a high probability that risks to patients are small and those for which risks may be higher. For the second case formal evaluations should take place in clearly identified clinical trials. For the first category, a process similar to that being adopted by the Royal Australasian College of Surgeons for Percutaneous Laparoscopic Cholecystectomy could be appropriate. For this category of treatments, guidelines for use and evaluation could be developed by an appropriate body

(probably the clinical colleges and societies) and evaluated while still being used as a usual treatment.[81]

3.118 The NHMRC's draft guideline on guideline development discussed above, gave a description of the Royal Australasian College of Surgeons initiative relating to percutaneous laparoscopic cholecystectomy. The College is said to have "highlighted the fact that no definitive clinical trials have been carried out on the procedure, but that there was a body of evidence suggesting that, in the hands of properly trained surgeons, the procedure was safe and effective."[82] It then set out a protocol for information collection, which could feed into a database to analyse the efficacy of the procedure.

3.119 The National Health Strategy went on to suggest that the NHMRC would be an appropriate body to decide which category new interventions should be placed into. The PIR supports the National Health Strategy recommendations in relation to the assessment of efficacy of new and existing health care interventions as set out in *Making it Better*[83]. **The PIR recommends the development by the NHMRC of criteria to determine whether formal evaluation should take place before new treatments can be used. (Recommendation 28)** These should be based principally on the risk to patient safety inherent in any new treatments, but may also include criteria relating to relative cost and other factors as well**. The PIR recommends that, once such criteria are established, health care payers should make payment for any new treatment contingent upon its having satisfied the formal evaluation requirements of these criteria. Where a new treatment does not require formal evaluation prior to introduction to practice under the proposed NHMRC criteria, funding should still be contingent upon the establishment in practice of appropriate efficacy and cost-effectiveness evaluation mechanisms. (Recommendation 29) The PIR recommends that any such assessment information - whether formal evaluation prior to or after introduction to practice - should be publicly available and accessible to health care consumers. (Recommendation 30)**

3.120 As noted above, the lack of adequate evidence of efficacy and cost-effectiveness also relates to many existing treatments. **The PIR recommends that a timetable for consideration of all existing clinical activity that has not had its efficacy and cost-effectiveness demonstrated should be established by the Commonwealth and AHMAC, in cooperation with relevant bodies. Priority areas should be those that involve greatest human or financial cost to the community, highest usage, and those areas that are part of the National Health Goals and Targets Program for Australia. (Recommendation 31)** Such a strategy must include the Cochrane Collaboration work, the various overseas clinical effectiveness studies referred to in this Chapter, the findings of the Taskforce on Quality in Australian Health Care, State outcome directed work, clinical guideline development, and other relevant activities such as those of professional bodies, as these are all strands of the same fabric of evidence-based information for decision-making. **The PIR recommends that as reviews of various treatments are planned and undertaken, this information must be made available to health care providers, consumers and funders. (Recommendation 32)**

3.121 **The PIR recommends that the Commonwealth establish a process for reviewing funding of various health care interventions, so that when it is shown that various**

health care interventions are not efficacious or cost-effective, Commonwealth funding for them ceases. Equally, it is important that the inclusion of any new schedule items or variation of the description of them only occur where there is adequate evidence of their efficacy and cost-effectiveness. The same body could have responsibility for both. Membership of such a group should also include: State governments, that have similar needs in relation to public hospitals and community health centres; private health insurers, that have similar needs in relation to their products; and health care consumers. (Recommendation 33)

Chapter 4: Access to information

A. Sources of information for health care consumers

Health professionals

4.1 Traditionally, information for patients has come from health care professionals during the consultation process. If a patient is not satisfied with the advice given, or if the patient wants to "double check" it, then he or she could generally seek a second opinion. In the case of specialists, this would require a second referral. For many patients the cost of seeking second or further opinions is significant. In the case of specialist doctors and others who do not bulk bill and charge above the Medicare Benefits Schedule fee, or other health care professionals such as dentists and physiotherapists whose fees are met by private insurance or from patients' resources, seeking second and further opinions can be very expensive and is unaffordable for some consumers. Where the first advice offered is inadequate or wrong, a second opinion can be of real benefit to a patient, but the impetus to seek a second opinion relies on the patient recognising the inadequacy of the information he or she first received. For public patients in a public hospital, Public Patients Hospital Charters include the entitlement to seek a second opinion. The PIR notes, however, that there may be difficulties in some cases in seeking a second opinion, including availability of a second health care professional and possibly staff attitudes that interpret the seeking of a second opinion as slight on their competence or a vote of no confidence.

4.2 In relation to provision of information to health care consumers, there are concerns about the level of appropriate understanding of appropriate practice among some health care professionals. An example of this was reported in a recently published study[1] of the management by gynaecologists of women with abnormal Pap smears. While showing consensus on management of high-grade lesions, the study also demonstrated there was considerable variation in the management of minor lesions, provision of patient information and follow-up after treatment. Of respondent gynaecologists 41% indicated an apparent misunderstanding of important colposcopic principles, when they indicated they would proceed to actively intervene, for example through cervical ablation on an abnormal Pap smear without cytobiological confirmation of that abnormality.

4.3 This last action was not considered appropriate practice at the time of the survey. It should be noted that the study related to behaviour in 1993, before NHMRC national guidelines were published in 1994, so the situation may well have changed since then. In particular, the Guidelines require cytobiological confirmation of abnormality before further intervention occurs. In addition, in August 1995, the National Cervical Screening Program released an information package for consumers and health professionals on the management of women with screen-detected abnormalities, which should provide significantly improved guidance to clinicians and women about treatment options and proper procedures.[2]

4.4 Similarly, the report of the House of Representatives Standing Committee on Community Affairs found doctors have significant deficiencies in their knowledge of current best practice about breast cancer.[3] The report notes that although GPs usually refer people

with diagnosed breast cancer to specialists, GPs have limited information about the special interests and skills of surgeons in their area, and may refer patients to the surgeon they normally refer patients to, regardless of whether the surgeon has a particular interest/expertise in management of breast cancer. The report highlights concern that some surgeons continue to perform radical mastectomy rather than lumpectomy despite evidence there is little difference in survival rates. Further, management of women with breast cancer has changed dramatically in the last 20 years and surgery is only one element in the management of breast cancer. The report, therefore, calls for accredited, specialist multidisciplinary teams to be established throughout Australia. Such teams would be able to take into account the medical, surgical, emotional and psycho-social needs of women with breast cancer in providing appropriate treatment.

4.5 The report notes there is no system of accreditation for specialists with respect to breast cancer, observing that there are 1,400 surgeons qualified to operate on women with breast cancer, although many do so infrequently. The report examined the information provided to women about breast cancer and recommended that practitioners provide women with written information about breast cancer, with a range of approaches from purely supportive to medically sophisticated, so that women can refer repeatedly to the information. It was recommended that appropriate Colleges address the need for medical practitioners to be aware of the requirement to actively involve their patients in the decision-making process about the management and treatment of the disease. The need for Colleges to ensure that medical practitioners give adequate time and counselling to a woman in order to make an informed choice of treatment was also addressed.

Health consumer information centres

4.6 In Australia, there are few sources apart from health care professionals where consumers can seek additional health information. These include the Health Issues Centre and Healthsharing Women Health Resource Service in Victoria. Sometimes information will be available through community health centres, but they are not really set up to provide detailed information of the kind discussed above. There are also self-help and community organisations, with special knowledge and expertise in various conditions, but it can be difficult for consumers to locate them. It is possible that if patient advocacy services became widely available that they could fulfil such a role. Health care complaints commissions might also assist in an information-giving role. In both cases, providing health information would be an additional function, requiring additional funding.

4.7 In England, the Help for Health Trust was established to meet some of these information needs. The PIR believes it provides an exciting and innovative model, although the Help for Health Trust itself has noted that the potential for consumer health information systems has hardly been realised.[4] Sometimes, according to the Trust:

- we are complacent and are satisfied that services are provided, not that they are quality services;
- we are content for consumers to come to us, and we do not exploit new technologies;
- our information services do not develop rapidly to meet current concerns and they are not based on current best evidence; and

- we provide generalist information which does not answer the questions people really want know, or give them real power in decision-making.

4.8 The Trust notes that it is a sign of maturity in any discipline to be concerned with standards and quality. There must be a rigorous quality framework for consumer health information, building on current best practice. Work is beginning to identify the nature and extent of unmet need for health information in the United Kingdom. Helplines are being promoted through talking newspapers for the visually handicapped. Minicom lines are being installed for people with hearing difficulties. In areas with large ethnic groups, outreach workers with relevant language skills are being employed.

4.9 With respect to information technologies, the development of interactive technologies is involving patients in shared decision-making. An American system has been adapted to pilot the availability of interactive videodisc technology. The aim is to review published research on the outcomes of different treatment options and to present such information in a way that is tailored to the individual patient's history and priorities. This helps patients to be active in decisions about treatment.

4.10 The Trust notes, in respect of United States developments, that every day, thousands of Americans participate in electronic self-help groups without leaving their homes. Teleconferences, computer networks and bulletin boards provide opportunities for housebound people, or those with rare disorders, or those in remote areas, to gain access to mutual support and information.

4.11 Recent studies show that patients are still not always provided with information on how a particular treatment is carried out or what to expect in hospital. Even where information is provided, it does not always reflect the most up-to-date evidence on clinical practice. There is, according to the Trust, scope for the self-help groups, the media and others to channel information on the effectiveness and outcomes of treatment to the public. Such information is now being provided in the United Kingdom by centres such as the Cochrane Centre and the National Health Service Centre for Reviews and Dissemination.

4.12 The Help for Health Trust makes several criticisms about the provision of information to patients. Systematic reviews of treatments have cast doubts on some treatments. Patients are still being asked to consent to treatments without accurate, understandable information on their effectiveness. Similarly, funding of health care initiatives may be decided without such information. The information provided to consumers is often process-based rather than outcome-based – that is, while patient information literature tells patients what happens in a particular process, it rarely mentions the likely effects, or the pros and cons of having the treatment done.

4.13 The Trust cites research showing the positive effects of providing consumers with information:

- improved patient satisfaction;
- reduction in pain and anxiety;
- increased compliance with medical instructions;

- fewer postoperative complications;
- shorter hospital stays;
- reduction in blood pressure; and
- improved self-management of conditions such as diabetes and kidney disease.

4.14 The Help for Health Trust provides the Regional Health Information Services for the county of Wessex. A free telephone service is provided, handling queries about:

- local and national support groups;
- information about health conditions;
- local waiting times;
- charter rights and how to make complaints, comments and suggestions; and
- healthy life-styles information.

The Trust is responsible for several databases, for example:

- Helpbox is a data base of self-help groups and publications;
- a benchmarking data base being developed in conjunction with IBM and the University of Manchester to store and present the results of the National Health Service's Patients Charter Benchmarking projects; and
- Waitline is a database for GPs on waiting lists.

There is also a drop in centre, Healthpoint, for the public and health care professionals.

4.15 The Council of Australian Government's reform agenda for health and community services includes the objective of helping consumers to self-manage their care needs, as far as possible. This can really only happen if consumers have adequate information about their condition and the available services and options for assistance.

4.16 **The PIR recommends that the Commonwealth Government and the Australian Health Ministers' Advisory Council (AHMAC) develop a model to provide similar information services to consumers throughout Australia, as are provided by bodies like the Help for Health Trust in the United Kingdom and the small number of health consumer information services in Australia. (Recommendation 34)**

4.17 The PIR believes the Health Communications Network may also be an appropriate venue to explore a consumer-driven information network, that is, an information network that meets consumer needs for consolidated information across public and private services in a manner convenient to health consumers. The information provision role of health complaints bodies or proposed advocacy services, existing community organisations, public hospital outpatient areas, Commonwealth Rehabilitation Services' centres, libraries and community health services should also be considered. The PIR's view is that an appropriate health consumer information model should recognise the important role of health professionals in providing information, but at the same time, should recognise that more information is needed. An appropriate model would also cater for some of the information needs of health care professionals, as readily accessible, consumer-friendly information could be of

significant use to them. In developing the model, the needs of all segments of the Australian population for health information should be recognised and accommodated.

B. Improving communication and the training of health professionals

4.18 Several correspondents gave support to the PIR's recommendation in the Interim Report that improved communication between health care professionals and their patients be pursued in all relevant contexts.[5] For example, one correspondent said the concept of customer service, "... should be inculcated at early stages in the training (and upgrading) of Health Care Professionals. It should be observed however that shortage of staff, stress, inadequate or poor working conditions can be unproductive in this context."[6] Another wrote, "[i]f medical undergraduates had a more focused training on the medico/legal consequences of inadequate doctor/patient communications which account for a significant amount of this litigation, the incidents of this litigation could well be significantly lower".[7]

4.19 The recommendation was also endorsed from the perspective of pharmacists:

> ... improved communications between pharmacists and their patients is constantly being pursued in all relevant contexts. For example, at undergraduate level in pharmacy colleges throughout Australia, increasing emphasis is being placed on the importance of effective communication between pharmacists and their patients. This emphasis is reinforced during pharmacists' practical training in their pre-registration year.[8]

4.20 From a consumer perspective the issue was also seen as important:

> Improving communication between practitioners and their patients is vital and training of practitioners in these skills is supported. Consumers and their organisations should be involved in the formulation of areas for training, the delivery of training and in monitoring progress and appropriateness.[9]

4.21 Several medical and other faculties, together with other bodies responsible for the training of health care professionals, gave details of their training initiatives to the PIR. While it is clear that considerable efforts are being devoted in some health care facilities and professional colleges to the important issue of communication between health care professionals and patients, it is equally clear that more needs to be done to enhance communication skills in primary training, on-the-job training, continuing education, and at health care facilities.

4.22 **Effective communication between health care professionals and patients is so important that the PIR recommends that the development of skills in communicating with patients be a compulsory part of all primary health care professional education courses, and also be included in continuing education courses. (Recommendation 35)**

C. The duty to disclose risk

4.23 The High Court decision of *Rogers v. Whitaker* made it clear that there was a legal duty on a doctor to disclose risks that a reasonable patient would consider material.[10] The case also identified circumstances where a particular patient required a higher standard of disclosure. For example, where the patient repeatedly questions the doctor or asks for specific information, the doctor should disclose information to the standard required to satisfy the patient's questions. Many press headlines and articles foretold the disasters that would befall health care in Australia because of this allegedly unreasonable impost. These fears have not been realised. There have been a number of more recent cases where courts have indicated that there was no failure to disclose, and these have assisted in delineating the scope of the decision in *Rogers v. Whitaker*[11]. In a health system that is consumer-focused, it is difficult to imagine that any test would be appropriate other than the one set out in *Rogers v. Whitaker*. The NHMRC general guidelines for medical practitioners on providing information to patients have also assisted doctors to put this duty into practice.[12]

Government programs and the duty to disclose information

4.24 The duty to disclose information that a health care consumer would consider material is also an issue for government health programs. This is particularly relevant in circumstances where governments encourage citizens to participate, for example in screening programs or immunisation programs. The result of being consumer-focused, and of common law obligations to disclose information about risks, would be to ensure that all such programs have accurate and accessible consumer information about the risks and benefits of participation and non-participation, including any known limitations of the procedure being offered.

4.25 As it is no longer considered appropriate in most circumstances for a health care professional to withhold information about treatment options because it is for the patient's own good, so a similar paternalistic attitude has no place in government programs. Health care consumers have a right to know necessary information about and make informed choices in relation to health programs, even where the greater community good may be served by their participation. This is acknowledged in the NHMRC statement on human experimentation in relation to potentially beneficial experimentation, and as a moral and legal principle, it applies more broadly.[13] The current fulfilment of this goal in Commonwealth Government health programs is far from universal. The Commonwealth Government also requires information on the benefits, risks and limitations of procedures to evaluate the effectiveness and efficiency of its programs. Similar duties and information needs apply to State government health programs.

4.26 The PIR looked closely at the National Cervical Screening Program as an example of the kinds of information that women need to understand their condition and that governments know about programs they are funding. This program was chosen for examination because the PIR had been examining various issues in relation to the program following the Rhonda O'Shea case in 1994.[14] Until the recent release of the information booklet for women on Pap smear test results[15], there was a scarcity of readily accessible information for health care consumers who wanted information about cervical cancer, Pap smears and appropriate steps

to be taken in the event of an abnormal smear. This information booklet is a good first step in providing information to health care consumers. It provides some information on the limitations of the test, as well as providing a useful summary of what different abnormal results mean and which interventions may be appropriate.

4.27 As a base performance measure of the cervical screening program, it would seem necessary to see whether it is reducing the incidence of invasive cervical cancer. Like many other health-related programs, this basic requirement is compromised because the incidence of cervical cancer in Australia, was not measured prior to the commencement of Pap smears.

4.28 Estimates of the numbers of cancers prevented each year vary. Some estimates suggest that, were there no screening program in Australia, 1,710 cervical cancers (of all types) would occur each year. Of the estimated 1,710, just over 70% or 1,230 cervical cancers should be prevented by optimal screening. Cancers would still occur in some women because of the type of cancer (rapid onset or in a location which is difficult to detect).[16] It is also estimated by the NHMRC that the screening program currently prevents about 700 cancers per year.[17] The number of deaths in Australia due to cervical cancer has remained constant over the period 1980–92, averaging 343 deaths per annum.[18]

4.29 Most of the 1000 or so women who develop invasive cervical cancer each year in Australia currently have never had a Pap smear. This is why significant effort is put in by the Government's National Cervical Screening Program to increase the participation rate in screening. However, there are around 80 cases each year where the woman has regularly had Pap smears, but still develops cervical cancer.[19] Sometimes these women develop rapid onset disease, and sometimes there is a failure in the screening pathway.

4.30 These failures can occur at different places along the pathway. Smear takers can incorrectly sample cells from the cervix, so no abnormal cells are shown as present; the examination and subsequent reporting of correctly taken slides can be inaccurate, resulting in false-positive and false-negative reports; and there is limited knowledge of the sensitivity and specificity of the test.[20]

4.31 The issue of poor smear taking is one that has been recognised both in the Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix and by the Royal Australian College of General Practitioners. Doctors take around 80% of Pap smears. There are significant differences between and within general practices in terms of managing cervical screening. Some doctors take few, if any, smears, whereas some female doctors take very high numbers. Many practices do not operate a routine recall or follow-up system.[21] The Royal Australian College of General Practitioners has internal training and support material on screening practices and practice-based recall and follow-up systems. The Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix stated that there was potential for incorporating specific screening performance measures into practice accreditation and vocational registration criteria.[22]

4.32 Both the Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix and the NHMRC examined the question of improving feedback from laboratories to smear takers. The Interim Evaluation recommended that current smear taking education and

training initiatives be evaluated and initiatives developed to, among other things, improve feedback from laboratories to smear takers.[23] The NHMRC has recommended that laboratories provide written feedback to smear takers on the proportion of smears where endocervical cells were present. This is to improve the ability to detect endocervical adenocarcinoma.[24] The PIR notes that information from laboratories which could enable doctors to monitor the quality of their smear taking appears scant and varies between laboratories. As is the case in other areas of health care, there are few opportunities for patients to be informed about the skill of their chosen practitioner in this area. Recommendations in Chapters 2 and 3 deal more generally with the need for publicly available performance information.

4.33 The issue of false-positive results can lead to anxiety for a woman and unnecessary procedures. However, false-negative results can mean disease is not detected at an early enough stage for cancer to be prevented. As far as the PIR was able to ascertain, there are few procedures in place in laboratories to detect false-negative Pap smear results prospectively, in respect of CIN 1 (considered a low grade abnormality), CIN 2 (considered a high grade abnormality) and even CIN 3 (carcinoma-in-situ). It is estimated that for CIN 3, even laboratories operating at current best practice standards will miss 10% of cases, where, on review, there is some evidence of pre-malignant abnormalities on the slide.

4.34 The error standards between different laboratories appear to be quite variable. The reported occurrence of false-negative results with the Pap smear ranges from 15–55% and depends on the severity of the lesion. For CIN 3, the lesion that routine screening most aims to recognise, a range of 15–20% is expected. These errors can lead to women being falsely reassured about their health status. Data were supplied to the PIR which indicated that 50–60% of smears reported as negative during the preceding two-year period in women with confirmed invasive cervical cancer will, on review, be considered to show missed abnormalities.[25]

4.35 Once an abnormality has been reported from a Pap smear, the appropriate path for the woman is far from clear. The differing practices are recognised in the guidelines, as discussed earlier, and studies of individual practitioners' practices show that they vary considerably within and outside the guidelines.[26] While the greatest variation exists in those cases of minor abnormalities, the NHMRC guidelines also indicate treatment variations in the case of high-grade disease. The guidelines state that "an important factor in determining which modality is recommended will be the skill and preference of the individual gynaecologist".[27] While the NHMRC guidelines suggest that it is important for the woman also to be involved in the treatment choice, it is difficult to escape the view that, in a practical sense, the major determinant will be the practitioner's preference.

4.36 From a health care consumer's perspective, the relevant issues about practitioner skill must logically come second to the choice about the most appropriate treatment. Once consumers have decided on a choice of treatment, they should then be able to choose a practitioner who is skilled in administering their chosen treatment – rather than having the diagnosing practitioner's particular skills and preference determine the treatment. It should be noted that this is a broad concern with health care generally, and one of the reasons the PIR considers there should be information available publicly about the treatment preferences and

performance standards of particular practitioners. In relation to options for women with abnormal smear results, the recent publication by the National Cervical Screening Program of the *Guide for Women with an Abnormal Pap Smear Test*[28] discussed earlier should go some way to address the previous information imbalance, as it sets out a full range of treatment options about which a women may wish to seek advice.

4.37 The NHMRC guidelines indicate that the need for better evaluation information and evidence about the relative effectiveness of the different options, particularly new technologies:

> In view of the ever-increasing awareness among women about the existence of treatment options, data are required to provide women with information about relative gains and risks, costs, complication rates and adverse effects, including the psycho-sexual sequelae of different treatment options. Controlled trials are needed to establish the immediate effectiveness of these new technologies and, equally importantly, to monitor the long-term sequelae on women's health ... Such trials have yet to be conducted in Australia.[29]

As discussed in Chapter 3, the PIR believes a patient has a right to know the degree of scientific proof of efficacy that exists for any health care treatment. Much of this information is not currently available to either consumers or health professionals.

4.38 There has traditionally been a very high rate of active management of low-level abnormalities in Australia. For example, the NHMRC report states that:

> Even with the limited screening program in existence at present, over 100,000 colposcopies and 75,000 biopsies or ablative treatments are performed annually in the private sector. These interventions cost approximately $64 million in 1990, which represents approximately 52% of the total expenditure dedicated to cervical cancer prevention in Australia.[30]

4.39 As discussed earlier (paragraph 4.2), a recent study of gynaecological practices following detection of an abnormal Pap smear result showed 41% of the respondents were prepared to intervene with active ablative therapy, even without histological diagnosis of disease. Such premature action can result in the treatment of a woman who has no disease and, equally, it can be inappropriate where the woman has invasive disease.[31] Such variation and inconsistency appear likely to lead to considerable additional costs to the health care system, with no benefit to the health of Australian women. It is hoped that the recently released National Cervical Screening Program information package for doctors will address some of these problems.[32]

4.40 So far as the National Cervical Screening Program is concerned, it is arguable that the Commonwealth Government has a responsibility to:

- determine that evidence for the efficacy and safety of the screening program, and any interventions flowing from it, is scientifically-based;
- ensure that consumers are informed of the risks, benefits and limitations; and

- put in place mechanisms to ensure that consumers can make informed choices.

4.41 The NHMRC recognised the limited nature of information available to women who have Pap smears, and suggested the content of a pamphlet for women who had an abnormal smear[33]. The Interim Evaluation of the Organised Approach to Preventing Cancer of the Cervix recommended that "program communication strategies should provide accurate information to women and health professionals about the limitations of the Pap test".[34] These have resulted in the information booklet for women and the information kit for health professionals discussed earlier.[35]

4.42 It is also interesting to note that the recent tragic case of *O'Shea v. Sullivan & Macquarie Pathology Services Pty Ltd*[36] has led to the production of health professional guidelines[37] for referral for investigation of intermenstrual and postcoital bleeding by a Working Party established by the Royal Australian College of Obstetricians and Gynaecologists (RACOG). The guidelines were issued jointly by the RACOG, the Royal Australian College of General Practitioners, the Australian Society for Colposcopy and Cervical Pathology and the Commonwealth Department of Human Services and Health. These should provide guidance for health professionals, and should also be able to be produced in any future cases, as evidence of the current appropriate standard of care.

4.43 The PIR has used the National Cervical Screening Program to illustrate several issues that are pertinent to other health programs and, as noted above, does not wish to imply that this program is very different from others.[38] Nor does it believe that the program could address all of the issues raised here on its own. The cooperation and participation of all those in the different parts of the screening program and in the follow-up processes arising from the screening program would be necessary to address many of the concerns raised. However, there is a screening program in place, which the Government substantially funds. The PIR would argue that the Government then has a responsibility to examine what the consequences, good and bad, are of the program, and to evaluate it in this light. This will enable the determination of whether or not there is a net gain to the health of Australian people from the Government's funding of particular health programs.

4.44 It also allows programs to address shortcomings. The PIR notes the 1995–96 Budget provided for measures to enhance communication and to increase women's participation in cervical screening, and measures to strengthen quality assurance throughout the screening pathway. A quality management plan for the program has been drafted. Among the plan's high priorities are:

- ensuring accurate and up-to-date information and educational materials are readily available to health care professionals and women;
- ensuring appropriate materials are available to women and health care professionals on management options for screening-detected abnormalities;
- development of feedback systems on performance to Pap smear takers; and
- implementation of performance standards for cervical cytology.[39]

The PIR endorses these priorities. Some are being addressed through the recently released information package, though further action is necessary to fulfil its goal of a measurably high-

quality screening program. The National Cervical Screening Program is already acting to try and address the information and evaluation short-comings, of which they have become aware. The investigation of such shortcomings is a high priority for all Government-funded programs.

4.45 **The PIR recommends that all existing and future Commonwealth Government-funded health programs be required, as a condition of funding, to provide scientifically accurate and consumer-friendly information to all people participating in the program on the risks and benefits of the program activity and of non-participation, as well as any limitations to the procedures. (Recommendation 36)**

4.46 **The PIR recommends that the Commonwealth Government determines (a) whether the programs it is funding have adequate scientific evidence for the efficacy and safety of the procedures funded; and (b) whether or not clinical practice guidelines or other strategies (for example funding variations) should be examined to ensure programs are maximising the health gains and minimising costs. (Recommendation 37) Where problems are revealed, the PIR recommends that the Commonwealth Government initiate appropriate processes, for example Cochrane Collaboration systematic reviews and/or development of clinical guidelines, as a priority. (Recommendation 38)**

Performance information on providers and institutions

4.47 As noted above, it is very difficult for health care consumers to make informed choices about particular health care providers, particular treatment options or particular institutions, without adequate information upon which to base these choices. Patients may need to know, for example, how much experience a health care professional has had in certain procedures and what the practitioner's complication rate from that particular procedure is. The PIR believes a patient is unlikely to receive useful information in response to an inquiry for such information. Some health care professionals could view the inquiry as a slight on their professional competence. Others will not know the details themselves. Based on the PIR's work, it seems likely that neither patients nor health care professionals will know the common parameters for adverse events for particular procedures, nor will they be able to make a comparison with the performance of other potential health care providers.

4.48 This is not a new idea, though it appears to have had little impact thus far on health professionals. In his recent report on Australia's surgical workforce, Professor Baume recommended the development of continuing quality performance assessment programs in public hospitals. This development was to be undertaken by the Royal Australian College of Surgeons in co-operation with state and territory governments by December 1995, with implementation to occur within six months of their finalisation.[40]

4.49 While it is recognised that the development of such performance information will take some time the PIR believes that the development and implementation of experience measures and outcome assessment mechanisms are central to a consumer-focussed health care system, and to informed consumer choice in the health care partnership. Given the amount of tax-

payer funding that goes into the health care system, it is also an important requirement for governments, as well as non-government funders, such as private health insurers.

4.50 **The PIR recommends that priority areas for development of performance measurement information be determined by the Taskforce on Quality in Australian Health Care from the work of the Quality in Australian Health Care Study. (Recommendation 39) The PIR recommends further that the development of performance measures and systems for undertaking ongoing performance monitoring form an obligatory part of clinical practice guideline development. (Recommendation 40) The PIR also recommends that areas of significant concern, such as those where it is alleged that defensive medicine, rather than good clinical care, is dictating practice should be other areas of high priority for standards development and monitoring, both by individual facilities and individual practitioners. (Recommendation 41) In all cases, the PIR recommends that performance measures and performance information be available in an appropriate format for consideration by health care consumers. (Recommendation 42)**

When things go wrong

4.51 Frequent concerns were raised with the PIR about what patients should do if they are concerned about something which occurred during their health care. Similarly, health care providers indicated that they were also unclear about what to do – what to tell patients or their families, and whether they could apologise, without admitting liability for negligence. The PIR saw these communication difficulties as different sides of the same communication barrier. From the patient's perspective they needed to know when something had gone wrong, and what they could do about it, or what was being done to assist them. From a health professional's perspective they had to face a patient, who may well be confused, angry, disappointed or upset, and treat them in a respectful, dignified manner, as well as convey sometimes distressing information to them.

4.52 The PIR sought the assistance of a consultant to develop information guidelines for consumers and providers, based around the concept of the health care partnership, which is detailed in Chapter 8. The guidelines are included in Appendix D. The consultants and the PIR recognise that these guidelines will not suit all health care consumers, for example, special versions may be required for people from non-English speaking backgrounds, some Aboriginal and Torres Strait Islander people and some people with disabilities. Equally, it was difficult to make the health professional guidelines suitable for all health care professionals. However, the PIR decided that the best way of addressing these needs was to ensure that the information was available on computer disk for modification to suit the needs of others. **The PIR recommends that these draft consumer and health professional information guidelines be made available to State Governments, consumer groups and professional bodies to modify appropriately and to ensure their wide dissemination in user-friendly formats. (Recommendation 43)**

D. Health care consumers' access to their health records

Views in submissions to the PIR

4.53 Patients currently do not have a clear common law right of access to their own health care records. While it is clear that the record is owned by the person who creates it, the scope of the duty to disclose the content to the patient has been the subject of considerable court activity since the publication of the Interim Report. The statutory position for health care consumers who are seeking access to their health care record where it is held in the public sector is set out in the Interim Report.[41] Only New South Wales provides for statutory access to records held in various private health care facilities, under the regulations covering private hospitals, day procedure centres and nursing homes.[42] The PIR recommended that more open patient access to records be explored in a variety of settings and through a range of mechanisms, from guidelines to statute.[43]

4.54 The Interim Report and other PIR research documented widespread difficulties for health care consumers in accessing their medical records, where those records were kept outside areas covered by freedom of information (FOI) legislation.[44] In many instances, refusal of access to their medical records is the motivating factor for a health care consumer to pursue a complaint, or bring a tort action, against a health care professional. Combined with the evidence from jurisdictions where there is greater access that there has not been an increase in complaints or litigation from providing this access, the PIR determined that improved access was important, both for patient information and autonomy and as a way of minimising the need to resort to legal process to find out what has happened. The PIR received a number of comments discussing the relevant recommendations in the Interim Report which sought to explore options for improving patient access to their health/medical records through either the development of agreed codes of conduct or a legislative approach.

4.55 One correspondent noted that private hospitals have always considered the medical record to be the property of the hospital and that although private hospitals have encouraged doctors to be more diligent in their completion of the hospital record, doctors using private hospitals have tended to use their own medical notes rather than the hospital medical record.[45]

4.56 This correspondent discussed the impact patients' access to their medical records would have on the quality and extent of information recorded by doctors on the medical record and said it would discourage some doctors from completing hospital notes. Also discussed were a number of limitations or exceptions that the correspondent would seek to have included in any proposed legislation providing access to medical records held in private hospitals. This included the provision that original records should not be taken from the hospital, even temporarily, and the stipulation there should be no right of retrospective access. The correspondent felt there was a strong need to clarify what constitutes a medical record, for example, whether it would include test results.[46] The correspondent's practice was to limit the provision of any information from a patient's medical record to that information agreed to by the patient's doctor.

4.57 Another correspondent supported development of legislation to facilitate consumer access to medical records, noting that codes of conduct or protocols were not sufficient,

although they could assist in detailing the means by which a statutory right of access might be enforced.[47] This correspondent believed that legislation should be nationally consistent and proactive in promoting access to records and that access to the personal information maintained in a person's medical record should be recognised in legislative form as a fundamental human right. The correspondent also raised a number of issues, which, although mentioned only briefly here, are included elsewhere in this Report in the discussion on improving patient access to their medical records. The correspondent discussed the role of legislation with regard to the right of patients to amend or correct details maintained on the record and the inappropriateness of access being linked to accreditation.

4.58 Many correspondents referred to the concern among medical practitioners that the more they write down, the more that can be used against them. It was felt that this fear governs the use of the medical record by many doctors. One correspondent noted that because some doctors write very little in medical records, the quality of information on the medical record suffers.[48] Another correspondent commented on the amount of information that is not made available to either the individual, for example their medical record, or the public at large.[49]

4.59 There was a view that standards for better record-keeping for all health care professionals can only serve to assist the decision-making power of the consumer and improve doctor/patient communication. For example, a correspondent commented that a patient's understanding of the content of medical records "... can go a long way to increasing satisfaction within the practitioner-consumer relationship and should reduce litigation which results from misunderstanding and misinformation".[50] Most correspondents felt there should be statutory clarification of the issues of access and ownership of all health and medical-related records.[51] From the perspective of a medical defence organisation, one correspondent noted that with the development of legislation that provided patients with unrestricted access to medical records there would need to be clarification of the basis on which the records are being created, that is, whether the concept of a confidential record as an *aide-memoir* for the doctor is discarded in favour of an open record.[52]

4.60 A correspondent representing plaintiff lawyers, endorsed the comments from another correspondent that "[e]asy access to the patient's medical records is critical to a speedier and less costly process of dispute resolution as it should enable an aggrieved patient to much more quickly and easily decide whether or not there is any cause to take the matter further".[53]

4.61 A professional medical college wrote about the specific differences of the issue of patient access to medical records between psychiatry and other branches of medicine. This correspondent highlighted circumstances, which are not common but which are encountered in practice, where there are good reasons to limit patients' access to their medical records. The correspondent noted instances in which psychiatrists have legitimate concerns about information being provided to paranoid psychotic patients. Such disclosure could put fragile patients who have often not come to terms with their illness, at risk of harm, and the correspondent claimed psychiatrists could also be exposed to claims of professional negligence. The correspondent supported the development of guidelines that would limit access in specific circumstances or that would provide psychiatrists with a right of appeal in such cases.[54]

4.62 A number of issues raised by another correspondent in earlier correspondence to the PIR are relevant to consideration of the issue of improving patient access to their health/medical records. In correspondence of 1992, the Medical Records Association of Australia (MRAA) noted the indirect role that its members could have in patient care which could result in injury to a patient. For example, a medical record administrator could be negligent if failure to produce a medical record and the result of this failure is injury to a patient.[55] The MRAA noted that this could apply to other professional groups as well. The MRAA also addressed the role of the medical record in the establishment of fault and causation. The MRAA supported the development of clear legislative guidelines that would allow information to be made available without breaching confidentiality requirements.[56]

4.63 In addition to these comments, there have been many developments in the period surrounding and after the preparation of the PIR's Interim Report, which are summarised below.

Australian Medical Association guidelines

4.64 At the time of completion of the Interim Report, the Australian Medical Association (AMA) passed a resolution about guidelines concerning patient access to their own medical records.[57] They stated that: "unrestricted access to records concerning their medical treatment may not always be in the patients' best interests and that access to records concerning their medical treatment by patients is a matter for individual negotiation between patients and their attending medical practitioners."

4.65 The AMA guidelines on patient's access to their health records state that a doctor should generally provide a patient with factual information on their records, but that any opinions and conclusions recorded should only be released at the discretion of the doctor concerned. Even the scope of the factual material, which the AMA suggests should be released, is considered to be at the discretion of the treating doctor.

4.66The AMA guidelines refer to reports from other specialists and say that a patient has no right of access to these "reports by specialists are prepared for the purpose of communication between doctors. Consequently, patients wishing to obtain a copy of the
report from a specialist should either approach the specialist concerned directly, or obtain his/her permission for any other doctor holding such a report to release it".

4.67The publication of the AMA guidelines precluded the option of an agreed code of conduct to facilitate patients' access to medical records, which was one possibility suggested in the Interim Report.

The Allars Report and patient access to records

4.68 On 11 May 1993, Associate Professor Margaret Allars was requested to examine the operation of the Australian Human Pituitary Hormone Program and to report on issues arising from that examination. The inquiry arose when several deaths from a rare and fatal brain disease called Creutzfeldt-Jakob Disease were reported among women who had received

hormones derived from human pituitary glands obtained from cadavers. The program also provided growth hormones, which had been given to young children with specific growth problems. There had been deaths from the same condition associated with such programs overseas. Associate Professor Allars' report was published in June 1994.

4.69 The report documented significant problems for patients who were participants in the program in relation to obtaining their medical records. Because some of the records were 20–30 years old, there were problems with: missing records; accessing records from doctors who had died; hospitals which had closed; and separation of records into small areas of facilities. These problems created huge difficulties for women who were trying to track down their treatment records.[58]

4.70 Recommendation 4 of the report directed the Commonwealth Department of Human Services and Health to:

- initiate and co-ordinate the development of a uniform federal/State approach to access to medical records and their disposal, which:

  (a) applies not only to records held in public hospitals but also to records held by private hospitals and private medical providers; and

  (b) creates legally enforceable rights of patients with regard to access and disposal of such records, either through the extension of freedom of information legislation in each jurisdiction or through the application of conditions to providers under the Medicare scheme.[59]

4.71 The report was particularly concerned with the poor access patients had to records held by private hospitals and doctors in the private sector and with the lack of uniform policies in Australia on the storage and disposal of medical records.

The case of *Breen v. Williams*

4.72 In September 1994, the case of *Breen v. Williams* was heard by Justice John Bryson of the New South Wales Supreme Court, Equity Division.[60] Ms Julie Breen took action against one of her plastic surgeons, Dr Cholmondeley Williams, after she had spent five years attempting to obtain her medical records to support her participation in a class action in the United States over breast implants. Ms Breen claimed that she had a proprietary right and interest in the information contained in her medical records, or was otherwise entitled to the information, and sought orders giving her access to medical records to examine them and obtain copies.

4.73 Dr Williams agreed to provide a report of what he considered to be relevant information, but refused to allow Ms Breen access to her medical records unless she indemnified him from any claim that might arise in relation to his treatment of her. Dr Williams claimed that records maintained by doctors concerning their patients belonged to the doctor, and that the extent and manner of disclosure to a patient of information contained

in such records, depended upon an exercise of each provider's discretion. In support of this claim Dr Williams cited the AMA guidelines referred to above.

4.74 In his judgement of 10 October 1994, Justice Bryson held there was no ground on which the defendant's ownership of the documents should not be recognised as entitling him to control access to them and to impose conditions for release, such as furnishing indemnity or paying fees. Justice Bryson distinguished the relationship of the plaintiff and defendant to other relationships, such as those existing between lawyers and their clients. Justice Bryson took the view that:

> the defendant was not made the plaintiff's medical adviser for the purpose of making him a collector or repository of information for the plaintiff to have available to her for whatever purpose she chooses. Collecting and retaining information was ... a subsidiary purpose, to lead only to medical advice and treatment to be administered by him or on his referral. [61]

4.75 On this basis, Justice Bryson found that the fact that the doctor had collected and retained information was an economic advantage of his in relation to his further being consulted by his patient and it was legitimate for him to have this advantage and keep it to himself. Justice Bryson argued that the extent and manner of disclosure to a patient of information contained in such records depended upon an exercise of each provider's discretion. He held that the existing legal process for compelling production of documents through subpoena was "not inadequate".

4.76 Perhaps most importantly, Justice Bryson chose not to follow a number of overseas decisions recognising that patients had an equitable right of access to the content of the medical record. Justice Bryson stated that a doctor had an economic interest in retaining the record to oblige the patient to return to for treatment.[62] Justice Bryson concluded that he was not persuaded by overseas precedents and that he was not prepared to enunciate a significant development or change in the common law rights of the parties or to recognise an extension of equitable remedies based on those decisions.[63] Ms Breen appealed the decision.

4.77 While Justice Bryson's judgement supports the AMA's view that because medical records are the property of doctors they should decide issues of access by patients, it has drawn widespread criticism from other quarters. For example, on 12 October 1994, the Minister for Justice, Mr Duncan Kerr, issued a press release in response to the decision in *Breen v. Williams* saying "it is hard to think of information which is more inherently personal or from which the decisions which flow are more crucial to a person than medical records".

4.78 The Federal Privacy Commissioner, Mr Kevin O'Connor, outlined on radio his belief that people should be entitled to obtain any personal medical records from doctors.[64] He suggested it was only a matter of time until there was a general right of access to personal information held by the whole community, and noting that the decision in *Breen v. Williams* might be appealed, he expressed hope that a court of appeal would take a broader view. Mr O'Connor indicated that some independent legal machinery is needed and it should not be left entirely to doctors or AMA codes of ethics to provide a solution.

4.79 At the International Bar Association Conference in Melbourne in October 1994, legal and privacy experts from New Zealand, England and India expressed concern at the decision. The New Zealand Privacy Commissioner, Mr Bruce Slane, is reported to have said:

> …in New Zealand it would be considered ludicrous to suggest that the commercial interests of the doctor in trying to ensure the patient comes back should outweigh the interests of the patient in knowing the information held about them and enabling them to seek treatment elsewhere.[65]

The consumer response to the judgement in the *Breen v. Williams* case has been universally negative.

4.80 Ms Breen appealed to the New South Wales Court of Appeal, which, in a complicated set of judgements, upheld by majority the decision of Justice Bryson that a patient is not entitled to access to the medical files held by his or her doctor.[66] Justice Mahoney, who delivered the principal majority judgement, stated that while the provision of a right of access to medical records may be socially desirable, it is not the function of the courts to legislate for the change of law, but to apply the law as it is. Justice Mahoney acknowledged the role the courts have in developing the common law.[67] However, Justice Mahoney argued that in the *Breen v. Williams* decision there was a question of competing social claims:

> Ms Breen desires to establish a principle: she seeks to establish, as it has been put, the right to control what is done to her body. Dr Williams desires to ensure that he may carry on his practice in the way he thinks best: he seeks this because, it is said, that will conduce to the proper practice of medicine and the good of the community. The choice between their competing claims involves the making of a general social judgement.[68]

4.81 Justice Mahoney argued that social judgements should be made by the legislature because it is accountable to the community for such decisions in a way the judiciary is not. He concluded that there was no contractual right of access through an implied term in the doctor-patient relationship.[69] He also argued that the New South Wales law provided an enforceable obligation that "requires a doctor to act with utmost good faith and loyalty to his patient and to hold information given to him by the patient in confidence." However, he said that this did not constitute a fiduciary relationship between doctor and patient.[70] While there might be circumstances where fiduciary duties are owed by a doctor to a patient in relation to items of property, he did not see a patient's medical record as satisfying this.[71] Justice Meagher agreed with the judgement of Justice Kirby in relation to there being no common law right of access, but denied the existence of any fiduciary duty in the manner described in Justice Kirby's judgment.

4.82 The President of the Court of Appeal, Justice Kirby, found that Dr Williams was in breach of his obligations arising from the fiduciary relationship he had with Ms Breen in respect of her medical information on his files. He found that in declining to provide Ms Breen with access to information and in making it clear he would only provide access if she would release him from any claim that might arise from the access and his treatment of her, he "fell short of the high duty which ... he owed to his patient, Ms Breen, as a fiduciary".[72]

4.83 In his judgement Justice Kirby stated that:

> the fulfilment of a right asserted by a patient ought not to be frustrated by requiring cumbersome, dilatory and expensive court proceedings to be issued. It ought not to be withheld in a purported bargain to provide it only if the patient, who is vulnerable, provides the medical practitioner with a release from all possible claims, whatever they may be.[73]

4.84 In May 1995, Ms Breen was granted leave to appeal from the New South Wales Court of Appeal to the High Court of Australia. The case was not expected to be heard until late in 1995. Given the diverse reasoning between the three judges in the New South Wales Court of Appeal, it is expected that this case will decide a number of important questions about the common law and fiduciary relationships between doctors and patients.

Freedom of Information Review

4.85 In July 1994, the Commonwealth Attorney-General asked the Australian Law Reform Commission (ALRC) and the Administrative Review Council (ARC) to review the Commonwealth's freedom of information legislation (the FOI Review). The terms of reference require consideration of whether the application of the *Freedom of Information Act 1982* (Cwlth), should be extended to private sector organisations. Currently, the FOI Act applies only to documents in the possession of government or Commonwealth agencies and contract case managers under the *Employment Services Act 1994* (Cwlth). This includes documents originating in the private sector which are in the possession of a government department or body.

4.86 However, individuals do not have a legally enforceable right of access to documents held by private sector bodies even where the documents contain personal information. One example of such records is a patient's medical records where the records are in the possession of a private health care professional or a private hospital.

4.87 In an Issues Paper released in October 1994, the ALRC and the ARC noted people were increasingly seeking access to their own or their families' medical records and referred to consumers frequently experiencing difficulty in accessing their own medical records. The Issues Paper referred to a number of overseas precedents for providing access to private sector health and medical records and called for comment on whether such records should be the subject of information access legislation in Australia (Issue 132). One hundred and twenty submissions were made in response to the Issues Paper. A number of these submissions commented specifically on Issue 132 relating to access to private sector health and medical records.[74]

4.88 In the 1995 Discussion Paper, the ALRC and the ARC are clearly of the view that patients ought to be given a right of access to their medical records. While the Discussion Paper rejects the concept of extending the FOI legislation to the private sector, it considered the power of the FOI Act to provide access to, and correction of, a person's own personal information and the person's ability to protect their privacy through these processes.[75] The Discussion Paper draws attention to the international obligations which exist in relation to

privacy.[76] The Discussion Paper endorses the extension of the *Privacy Act 1988* (Cwlth) (Privacy Act) to the private sector, with the development of enforceable codes of conduct for particular industries.[77] The issue of enforceability is a problematic one since the recent decision in *Brandy v. Human Rights and Equal Opportunity Commission and Ors*.[78] The Discussion Paper recognises this and notes the establishment of a Committee by the Attorney-General into how to rectify the situation, which was due to report in June 1995.[79]

4.89 The discussion paper goes on to say that the:

> "private health and medical industry should be dealt with as a priority. There is a strong level of public and official support for this due in part to changing perceptions about the relationship between doctor and patient. ... The personal information held by that industry is particularly sensitive and warrants immediate protection".[80]

The discussion paper continues: "[t]he Review does not consider that extending the Privacy Act to the private sector will place undue hardship on private medical practitioners. It will, however, enhance patient privacy considerably". It goes on to state that the code for the health and medical industry should incorporate all 11 information privacy principles of the Privacy Act.[81] These principles are set out in Appendix E to this Report. A final report to the Minister for Justice on the FOI Review is due by 31 December 1995. The report was to include draft model Privacy Act amendments to create the suggested framework, but was not include any draft industry codes.

Medical records project of the NSW Medical Board

4.90 In late 1994, the New South Wales Medical Board engaged a consortium from the School of Community Medicine of the University of New South Wales to develop the principles underlying regulations regarding the creation, content, storage and disposal of medical records, which are envisaged under S.126 of the *Medical Practice Act 1992* (NSW), but have yet to be drafted. The legislation includes power to impose penalties for failure to comply with the regulations.

4.91 The consortium released a discussion paper on these issues in May 1995. The paper outlines a range of problems with medical records and suggests achievable goals and guidelines to improve their quality. Among other things, it discusses issues related to medical malpractice litigation[82] and access to medical records.[83] The discussion paper examines a broad range of other important issues, such as computerised medical records, the period for retention of records, and the storage and disposal of records.

Where to from here?

4.92 The determination of the issues in the case of *Breen v. Williams* by the High Court of Australia later this year will provide guidance to governments about the necessary scope of any subsequent legislation to extend or modify the common law relating to patients' access to their medical records. The High Court's determination is also likely to affect a number of issues in relation to the doctor-patient relationship. It may well have wider implications for the health care sector. The final report of the FOI Review provides the Commonwealth

Government with an ideal opportunity to enact legislation beyond the scope of the common law, once the case of *Breen v. Williams* has been decided.

4.93 The PIR believes that patients should, in principle, have access to their own health care records, whether they are held by doctors, other health care professionals or public and private health care facilities, and have a right to correct records where they are factually incorrect.

4.94 **Following the determination of the case of *Breen v. Williams* and the completion of the work of the Australian Law Reform Commission-Administrative Review Council Freedom of Information Review, the PIR recommends that, if necessary, the Commonwealth ensure via legislation that patients have access to their own health care records held by doctors, other health care professionals and public and private health care facilities. The minimum requirement should be right of access to all records created after the commencement of the legislation and access to matters of fact, including test results, for records created prior to the commencement of the legislation. (Recommendation 44)**

4.95 **The PIR recommends that the Commonwealth Department of Human Services and Health examine the option of a patient-held record as a matter of urgency. (Recommendation 45)** The needs of both health care professionals and patients could be satisfied, for example, by the provision of a copy of the notes taken at the time of their consultation and copies of all test results. Patient-held records can overcome problems where continuity of care is not possible. Patients often consult many doctors and other health professionals. While this may not be desirable so far as continuity of care is concerned, it is a fact. Patients may wish to seek second or further opinions. Patients may be admitted to hospitals or not be able to contact their normal health care professional. The health care professional may have disposed of the practice, including health care records, or he or she may have retired or died. Patients often change home and work locations, which can also result in change of health care provider.

4.96 Patient-held records are used in some States for children, for example where parents are provided with a book in which details of health care can be recorded. Such records also operate in certain shared care antenatal situations.[84] Patient-held health care records can:

- reduce the need for duplication of tests when a patient visits a new doctor;
- enable a long-term comparison of care/results for the patient from several health care professionals;
- provide more opportunity for a patient to be actively involved in health care;
- give patients immediate access to information at very low costs; and
- in all likelihood, lead to improved contemporaneous record keeping.

Chapter 5: Minimising the human & financial costs of adverse patient outcomes

A. Introduction

5.1 One of the main reasons for obtaining detailed information on adverse patient outcomes is to determine the best ways of preventing them happening again. When such an outcome occurs, it is also important in individual cases to initiate remedial action and, where appropriate, rehabilitation as soon as possible to minimise the level and duration of disability. Both of these strategies will help reduce the human and financial costs of both negligent and non-negligent adverse patient outcomes.

5.2 There was broad agreement in submissions with the PIR's conclusion that the best way to minimise the human and financial costs of adverse patient outcomes is to implement effective quality assurance and risk management strategies at all levels of care in the health system. Recommendations in the Interim Report covered: improved data collection on which to base preventive strategies,[1] piloting an integrated risk management strategy; use of credentialling; and legislative protection for those who report breaches in the standards of patient care.[2]

5.3 This chapter looks at those elements of the PIR's work that aim to minimise the human and financial cost of adverse patient outcomes. Firstly, it looks at the systemic barriers to effective quality assurance, mainly the participants' fear that information they provide will be used against them in litigation. Secondly, it outlines some practical ways to reduce the incidence of adverse patient outcomes, principally by looking at the PIR's work on incident monitoring within specialties and across health care facilities. It also looks at Government and other funder responsibilities for quality in health programs. Lastly, the chapter looks at early intervention risk management strategies.

5.4 There are other ways of minimising the human and financial costs of adverse patient outcomes, including prompt access to rehabilitation for those who have an adverse event, which is discussed in Chapter 6 of this Report, and various modifications to the tort system and its management, which are discussed in Chapter 7. This chapter focuses on activities to improve the overall quality of care and better risk management.

B. Data collection and quality

Views from submissions

5.5 Effective data collection is the basis for the development and implementation of effective preventive strategies and for improvements in quality of care. The PIR's recommendations in its Interim Report, relating to improve data collection received support from a number of correspondents concerned with improving quality of care.

5.6 One correspondent wrote that national statistics were urgently needed to permit analysis and development of quality assurance initiatives.[3] Another correspondent drew attention to the fact that the PIR had not addressed consumer input to the data formulation process.[4] Agreeing that the lack of information was a fundamental concern, the

correspondent advocated that the PIR, "... consult with consumers about what they mean by quality health care."

5.7 A cautionary note was sounded by a correspondent, who was concerned that statistics collected by health professionals would not be audited.[5] Concerns were expressed that because some data was legally protected from review, their validity might be suspect because they rely on self-reporting by potential tortfeasors. "The unaudited self-disclosures of a class of potential tortfeasors is not an adequate foundation of data of occurrences upon which to base a reasonable analysis."

5.8 The usefulness of strengthening recommendation 1 of the Interim Report was addressed by a correspondent who wrote that the support of the Australian Health Ministers' Advisory Council (AHMAC) should be sought for identifying and funding pilot studies on the effects of the quality of care of information collected on adverse patient outcomes.[6] Commenting from a rural perspective, another correspondent doubted that rural hospitals should be asked to collect further data for quality assurance purposes.[7] The real issue for this correspondent was whether the information already collected is assessed, analysed and used to improve patient care, rather than just being collected.

Minimising data duplication and provision of feedback

5.9 The PIR agrees that data collection for quality of care activities needs to be integrated into normal management data collection processes, and that duplication should be avoided as much as possible. The institutional incident monitoring pilots identified the same concerns, and an integrated reporting form, which can be used for a range of purposes, has been an important development. The current form has the capacity to allow the notification of identifying details to a hospital risk manager and the inclusion of information about an adverse event on a patient's hospital record, as well as identified information that is gathered for incident monitoring activities. It uses partially pre-carboned, tear-off pages on the front, to ensure the different needs of identification and anonymity can both be satisfied using the one form.

5.10 **The PIR recommends the continuation of the piloting of an integrated reporting form, which allows the collection of different elements of data from the same form for risk management, risk prevention and patient information, and the exploration of other ways of streamlining the data collection processes. This should result in the promotion of a final version, or range of options, through AHMAC and other appropriate bodies, once the pilots are completed and evaluated. (Recommendation 46)**

5.11 Another important point brought out in submissions is the central importance of feedback from data collection. Such feedback is also important for ensuring that people being asked to contribute the information understand why it is being collected and apply a degree of rigour to their involvement. In many sectors of the health care system, much information is collected, but this only serves a useful quality improvement purpose if people involved have prompt feedback. People must know where they are starting from and what progress is being made to see the reason for collecting data and thus to do so with care and enthusiasm. Again, the institutional and specialty-based incident monitoring projects involved early and informative feedback through a brief newsletter – in turn, this appears to have encouraged participation. **With the vast array of information that health care professionals have to absorb, and resource constraints, the PIR recommends that for the extension of effective**

data collection and analysis for quality improvement, priority must be given to the development and promulgation of inexpensive, effective ways of providing feedback from quality data collection to practitioners and others involved in the health care system, such as administrators and consumers. (Recommendation 47)

C. The culture of health professions and quality issues

5.12 The culture of professionalism can encourage the maintenance and improvement of standards. However, in a number of ways, it can also work against improvements in quality. Two of these issues will be briefly discussed here: the first is a profession's attitude to error amongst its own practitioners and the second is the self-image of super human endurance, as illustrated by the medical profession's approach to fatigue. The discussion will focus on the affect of these two cultural viewpoints on the practices of the medical profession, although they are likely to be of similar relevance to other health professionals.

Medical culture and error

5.13 To both maintain and improve quality, there needs to be an open recognition that departures from good quality and errors occur, even among the most expert of practitioners. There also needs to be an understanding that many of those which do occur can be prevented, if enough is known about the causes. The Quality in Australian Health Care Study (discussed in Chapter 2) and the PIR's incident monitoring pilots (discussed below in section G) were aimed at showing that such events occurred, that many were preventable and that the development of preventive strategies by health professionals was both possible and in most cases cost-effective.

5.14 However, the release of the data has led some doctors to argue that the study results exaggerate the issue. Whatever the validity of the different views on the results of the study, there is no doubt that it underestimates the rate of errors that occur in health care, because so many of these do not result in patient disability. Human error is a ubiquitous feature of modern health care[8] - not because practitioners are badly trained or of bad character, but because modern health care involves human beings, equipment and institutions in complex interactions. Why then are many health professionals unhappy recognising the occurrence of error, particularly if it is one in which they were involved?

5.15 Lucian Leape recently described the psychological and cultural approach of medicine to error.[9] He concluded that a doctor's training, and medical culture, leads him or her to expect "to function without errors" and to "view an error as a failure of character". This, in turn, leads to need to deny the existence of error at a very fundamental level, because the admission of an error is no longer simply a recognition of every doctor's essential humanity and the reality of health care. Another author has discussed the negative impact of perfectionism and the vision of absolute control in a doctor's capacity to deal with mistakes. "These processes that motivate the physician to maintain excellent standards of practice do not incorporate the notion of fallibility, in contrast to the premises of the science of medicine, which are founded on probability and error."[10]

5.16 Rather, admission of an error becomes "a confession of having a flawed character. Having erred is seen as the antithesis of the very self-perception that a doctor has developed over years of training and enculturation."[11] Where the error results in significant patient harm, there is an additional burden. It can trigger emotions such as shame, guilt, depression and

anxiety, as well as professional self-doubt. It may lead to psychological defence responses, such as denial, anger or blaming of someone else, even the patient. It can lead to an internal conflict where the doctor has a self-image as a hard-working, altruistic care giver, and yet it is aware of making an error, which resulted in patient harm.

5.17 These effects can be even more exaggerated where a health professional is sued, as discussed in Chapter 7. The inherent conflict between unreachable perfection and the reality of widespread error occurrence is a considerable impediment to many quality improvement activities. Even where a doctor feels comfortable in herself or himself in recognising the pervasiveness of error in health care, there may be psychological and system barriers to any broader analysis and even to any public admission of error. These include: fear of humiliation, fear of litigation, self-expectations of perfection, self-comparison with other physicians and concerns about external scrutiny by professional oversight bodies.[12]

5.18 There is a need for medical and other health professional training to include open discussion of mistakes, and the role error analysis and feedback can have in quality improvement and human learning. In addition, the role of those who are at senior levels in the health professions cannot be underestimated in this process of cultural change - if they are seen as claiming to be error free or at least not admitting to errors that occur, then it is unlikely that young professionals will feel comfortable talking about their errors and learning from them. All must recognise it is impossible to be infallible - the need for an illusion of infallibility can itself lead to" intellectual dishonesty, to cover up mistakes rather than admit to them".[13] **The PIR recommends that medical, nursing and health sciences faculties as well as professional colleges examine ways of training students and health professionals in error identification and analysis, as well as training them to seek appropriate supports when errors do occur, at undergraduate, post-graduate and continuing education levels. (Recommendation 48)**

5.19 Similarly, hospitals and other institutions need forums where errors can be discussed in a supportive environment, and where people can share their solutions and ways of dealing with them. The Anaesthetic Incident Monitoring Study (AIMS) workplace feedback groups have taken on this role in some hospitals, as discussed below in section G. **The PIR also recommends that health care institutions examine what support mechanisms exist in their facility to assist health professionals to deal with errors in a positive manner (eg an incident monitoring feed-back group, peer support mechanisms, team care support groups, confidential counselling). (Recommendation 49)**

5.20 There also needs to be studies on how such cultural change can be further encouraged within an environment where performance monitoring is also likely to become more pervasive. There can be a potential conflict of aims between greater individual assessment of performance, standard setting and standards monitoring, which could be seen as hand maidens to the aim of perfection and error free care, and greater openness and discussion about error. There are ways this can be addressed, though the need for individual identification of performance may mean different mechanisms need to be used.

5.21 For example, the incident monitoring pilots addressed individual's fears of admitting errors through anonymity and through the additional protection of the Commonwealth's quality assurance legislation (discussed below in section F). However, in performance measuring activities, the option of anonymity is not appropriate. Similarly, a professional

who wants to discuss an error with a colleague or another person may need to know that such information is not going to be used later to discipline them or measure their performance, before they are fully comfortable discussing the matter. The question then is whether a system that achieves these ends can be developed, either through separate activities or in the one activity. **The PIR recommends that the Department of Human Services and Health, examine how greater outcome accountability can co-exist positively with a greater recognition of error and positive analysis of errors to improve health care. (Recommendation 50)**

Fatigue and medical self-image

5.22 Health care service provision can be intellectually demanding, physically exhausting work. Often people are relying on a health professional for life-saving decisions - they are putting their trust into the doctors' hands. How many of these hands are plagued by exhaustion cannot be known: it is not something which has been widely studied. However, in evidence before the South Australian Industrial Commission recently, it was claimed that the performance handicap on a doctor who had been working continuously for 24 hours was about equivalent to the performance handicap from having a blood alcohol level of 0.1% or twice the legal limit for driving.[14] Fatigue has also been identified as a significant contributing factor in the administration of wrong drugs in anaesthesia.[15]

5.23 Standard work practices and training of doctors in particular involve very long working hours. Many doctors have a self-image which incorporates the capacity to stay alert and make good decisions even after very long hours of work. Stories abound of people working for 36 hours straight, and operating for 18 hours at one go. There is almost a view amongst some practitioners that showing physical tiredness is a sign of weakness - a sign that you "really aren't cut out to be a doctor".[16] These are reflected in resident work conditions throughout the world - for example in New York, residents work rules provide a maximum of 80 hours per week, with a 24 hour shift and round the clock availability for back-up. In Australia, extended shifts of 36 hours are common.[17] Similar practice patterns arise with specialists who, for example, schedule too many patients or, for example in the case of obstetricians, have over 200-300 patients to deliver each year. Medical officers also have very long shifts - usually in excess of 12 hours.

5.24 While studies on the effects on work performance of such long hours of work are not numerous in other areas of work, there are very few studies involving health care decision-making. Those that have looked at decision-making abilities show that errors are much more likely to occur when a person has been working long hours. Where the person has other concurrent factors, such as illness, medication, previous sleep deficit or stress, then this degradation can commence earlier. It can also be aggravated by the nature of the task.[18] For example, an intern working on a day shift in a high intensity situation would show impaired performance after 8-10 hours and in a low intensity situation after 10-12 hours.[19]

5.25 The systematic ordering of medical work patterns on the basis of long hours, with what evidence there is on the effect of fatigue on work performance, must be considered a real impediment to the maintenance of quality of care. This is so whether the work patterns are imposed by the institution through its employment practices, or where the practitioner chooses to work very long hours in private practice. It must also be recognised as a system factor which could leave an institution separately liable for an unsafe system of work.

5.26 Given the time and sleep limitations imposed on drivers, pilots and others responsible for the safety of others, the lack of appropriate controls on time at work and carrying out specific activities requiring a high degree of concentration in health care are of considerable concern. The culture of the never-tiring professional probably also leads to a reluctance on the part of others to address this, because the illusion of that culture is that it can be done while maintaining high standards of care.

5.27 It must also be seen as a real impediment to the participation in the medical workforce of those with family responsibilities, and of the sharing of home and family responsibilities in families where there are two income earners. Continual tiredness probably also contributes to poor communication with patients.

5.28 **The PIR recommends that the NHMRC examine the issue of health professional fatigue, its impact on health professionals, their families and patients, as well as its effect on quality of care. It should then establish national guidelines dealing with maximum safe working hours and minimum rest breaks for all health professionals and health care institutions. (Recommendation 51)**

D. Quality assurance activities in health care today

5.29 The PIR's Interim Report was criticised by some for failing to pay due regard to the plethora of quality related initiatives of bodies like the learned colleges. It is true that there is a range of activities being undertaken by the various medical and other professional colleges, which fits under the broad rubric of quality of care. Correspondence from the Committee of Presidents of Medical Colleges showed a wide range of such activities. Few of these seem to involve the collection of quality outcome data and the feedback of results to individual practitioners, practice units or facilities. Many fall under the general umbrella of education and training. Performance measurement only appears to be included in some accreditation or credentialling mechanisms, and then in most cases only at the beginning of a person's practice or possibly when they are seeking for the first time to exercise a new technology or skill. The development in various colleges of clinical indicators under the auspices of the Australian Council of Healthcare Standards would also seem to provide greater potential in these areas. However, there appears to be little systematic on-going performance measurement and feedback in any of these mechanisms at the moment.

5.30 It may be that individual practitioners are developing their own performance feedback loops and, if so, this is to be strongly supported. **The development of outcome self-monitoring mechanisms by professional colleges for their members, specifically in high-risk areas revealed either by incident monitoring, the Quality in Australian Health Care Study or other initiatives, for example, relating to clinical indicator development within specialties, could be a useful first step towards a greater outcome focus to health care. (Recommendation 52)** Currently, there does not appear to be a systematic use of data-based quality monitoring across professional groupings, or more broadly among practitioners. It is only through such feedback loops of collecting data on results, analysing it and acting on the conclusions that quality of care will be improved by any systematic fashion. The National Health Outcomes Program announced in the last Budget, which is outlined below, provides some Commonwealth funding to assist in this type of activity.

5.31 The issue of quality of care has also been an important part of the policy debate relating to hospitals in Australia. In a 1993 survey of hospitals discussed in more detail in paragraph 0, the PIR engaged the Australian Institute of Health and Welfare to include a number of questions relating to consumer complaints and quality assurance activities in a survey of hospitals. A brief report was provided to the PIR, which summarised the relevant findings of the survey.[20] So far as quality assurance is concerned, the survey results showed that complaints and quality activity is seen as a senior management responsibility in around three-quarters of responding public and private hospitals.

5.32 There was considerable variation between States about whether the chief executive officer of the hospital had responsibility for quality assurance – with high levels in New South Wales/Australian Capital Territory, Victoria and South Australia/Northern Territory (88%, 86% and 83% respectively), and much lower levels in Queensland, Tasmania and Western Australia (52%, 50% and 41%). The responsibility of chief executive officers for quality assurance had increased significantly from an earlier 1987 survey,[21] where in only 47% of public hospitals was the chief executive officer responsible for quality assurance,[22] and 35% in private hospitals.[23] Responsibility at this organisational level was seen as reflecting the seriousness with which quality of care was regarded in the hospitals.

5.33 The importance of improvements in quality of care to the effective and efficient running of hospitals, through the minimisation of adverse events, and as part of efforts to contain numbers and costs of legal action should not be underestimated. **Measurement, maintenance and improvements in quality of care must be seen as a senior management and senior clinician responsibility, and this should be reflected in the structures and policies in place in hospitals and other health care management units (for example individual practices and divisions, regions or areas). The PIR recommends that such structures and policies be encouraged, and where possible enforced, through appropriate funding measures at the State and Commonwealth levels. (Recommendation 53)**

E. Consumers and quality of care

Submissions

5.34 In the Interim Report, the PIR examined how to give health care consumers' greater confidence in the health system (see also the discussion in Chapter 8 of this Report). Commenting on ways to improve the partnership between consumers and health care professionals, the PIR noted that the National Health Strategy had proposed that health services and area management could review quality assurance procedures to identify areas where consumer participation could be initiated and strengthened.[24] This possibility was addressed by several correspondents.

5.35 Commenting on the feedback loop as a critical element in a successful risk management program, one correspondent stated, "... the [PIR's Interim] Report must recognise the important feedback loop presented by consumer experiences, and the need for this feedback to get back to providers".[25] This correspondent went on to comment on how important it is for information on providers and hospital activity to be available to consumers to enable them to make choices about quality. It was argued that, "... consumer input at all

levels into the definitions of quality, desired outcomes and adverse outcomes is necessary for any consumer focused system of compensation".

5.36 Another correspondent wrote that medicine in Australia was run as a command economy industry and the role of the consumer had been all but eliminated.[26] This correspondent said no real interest was evident in locating individual service providers who are causing most consumer dissatisfaction. It was thought that data on these providers, if collected and made public, "... would enable free market correctives to take effect, consumers could exercise free market choice and avoid purveyors of low quality medicine".

5.37 With respect to quality assurance, one correspondent wrote that consumers should be involved in the establishment and evaluation of pilot incident monitoring and claim minimisation activities and quality assurance activities of private health care professionals.[27] This correspondent said such involvement would include answering questions such as what the measures of quality are and what constitutes an incident, noting that consumers would answer the questions differently to professionals. Writing from the emergency department of a rural hospital, a correspondent advocated consumer input into quality assurance and credentialling.[28]

5.38 Examining the question of who defines health care quality, a correspondent drew attention to the view that quality is generally defined by, for and through health care professionals, with little reference to the consumer point of view.[29] More recently governments who fund health care have assumed greater control over what is available and, according to the correspondent, this has resulted in quality versus quantity debate and to greater consumer dissatisfaction. The correspondent then contrasted the situation where the perception of health care from the consumers' perspective is incorporated in the assessment of health care.

Patient assessment of quality of care

5.39 The PIR agrees strongly with the views in submissions that consumer interests are central to quality assurance and developing and maintaining a quality health care system. Some hospitals have already identified the need for greater consumer focus in their services. For example, the Victorian Hospitals' Association's Quality Review Working Party reported in March 1995 that:

> "A commitment to customer focus is essential, to reflect the purpose of the health system – to improve the health status and health outcomes of the community.
>
> At the immediate service level, care needs to be taken to avoid paternalistic definitions of the 'acceptability' of care by providers rather than consumers and instead, reflect patient experiences and priorities. Use of patient-focused questionnaires and focus groups are useful means to achieve this end".[30]

5.40 In the United States, the Office of Technology Assessment, which provides advice to the Congress on issues referred to it, has examined the use of patients' assessments of their care as measures of quality.[31] The report indicated that:

> "On the basis of the review in this chapter, one may conclude that it is possible to construct valid patient-based indicators of the quality of medical care and that there

are good reasons to use such indicators given the shortcomings inherent in alternative strategies".[32]

Patients were considered to be important assessors of the interpersonal aspects of the quality of care. While there was little evidence about the validity of patient assessment of the quality of the technical aspects of their care, the report suggested these could be useful, cost-effective adjuncts to other technical care assessment methods and certainly worth further exploration. One option it raised was "a promising but rarely employed strategy for patient-based assessments of the quality of care ... based on patients' reports of what does and does not occur".[33]

5.41 The collection of patient feedback information and early response to it in appropriate cases can be an important risk management tool. Much of the information shows that angry or dissatisfied patients are more likely to sue or complain, particularly if they feel they are not being listened to by relevant people in the organisation. At a proactive level, patient information can provide hospital managers and individual practitioners with feedback on how they appear to patients and their families, even where nothing has gone wrong. Given the apparent importance of good communication in preventing the development of legal action, if a health care professional appears to have persistent problems in communicating and dealing with patients as indicated by such feedback, it may provide a good indication of the need for professional development assistance in these areas. Where a professional refuses to address any significant short-comings in this area, there would seem to be sound management reasons to consider termination of their relationship with the health care facility, given the likely additional risk of complaints and legal action which can be generated by such dysfunctional professionals.

5.42 **The PIR recommends that effective health care consumer feedback mechanisms be widely implemented. Once sufficient data are available, linkages should be made between the incidence of formal complaints and litigation, to see if the feedback from such mechanisms is useful as a predictor of complaints or litigation. If such a connection is demonstrated, then it is arguable that these feedback mechanisms could be one of the elements used in performance appraisal, and in the determination of clinical privileges and visiting rights. (Recommendation 54)**

Health care consumers and quality assurance committees

5.43 Apart from their potential as sources of information, health care consumers could also provide an important different perspective in institutional quality assurance activities, such as the overall quality management committee or similar body. Where such committees exist at health regional or area level, consumers could have an important role to play too. Such participation could be an important educational experience for consumers, health care facility management and health care professionals. **The PIR recommends that health care facilities have health care consumer representation on their various quality of care committees and activities. (Recommendation 55)**

Consumer access to information on quality of care

5.44 Health care consumers also have a right to information on quality of care provided by a health care facility or practitioner in determining whether to use the services offered. The United States Office of Technology Assessment report listed a broad range of structural, process and outcome indicators, which are possible indicators of quality health care services at the institutional level. These included:

- structural indicators : accreditation status, credentialling processes, independent complaints mechanisms, staff turnover, volume of specific procedures and diagnoses, scope of services, procedures of the quality assurance committee, availability of home health services, active ethics committee;

- process indicators : disciplinary actions, performance for specific procedures or conditions, autopsy rates, removal of normal tissue; and

- outcome indicators : adverse events, patient ratings, malpractice compensation, nosocomial infections, hospital mortality rates, measures of functional status, hospital readmissions, drug and transfusion reactions.

5.45 These indicators extend significantly beyond those that currently form part of the Australian Council of Healthcare Standards clinical indicators program and the accreditation process, and would seem to provide some further areas for exploration in that environment. Most importantly, from a consumer's perspective, the data collected against these indicators in accredited hospitals is not publicly available. The need for greater public availability of such data is a high priority.

5.46 The Office of Technology Assessment also explored possible indicators of individual physician quality, which included:

- structural indicators : type of medical school attended (for example, teaching, non-teaching, hospital-based, foreign), specialisation, volume of specific procedures or diagnoses, hospital admitting privileges, emergency coverage arrangements;
- process indicators : disciplinary actions, performance for specific procedures or conditions, drug use; and
- outcome indicators : patient rating, adverse events, malpractice compensation, patient drug reaction.

5.47 The Office of Technology Assessment evaluated available data on some of these as measures of quality of care, and concluded that while "none of the indicators evaluated ... convey definitive information about the quality of an individual hospital or physician across the range of medical care, several of these can provide useful information to organisations and individuals".[34] However, the report indicates that there are interpretation difficulties, which could mislead consumers, unless the measures are appropriately qualified, and their significance explained. For example, the publication of mortality figures without any correction for the case mix of a hospital may give an unfair picture of the quality of a hospital – they may arise from the existence of a trauma centre or hospice in the hospital's facilities. With some qualifications, the report indicated much better information giving guidance on quality should be collected and made public than currently occurred.

5.48 Work is needed in Australia on which indicators can be collected and provided for consumers about the quality of care in facilities and by individual practitioners. Overseas studies and studies in Australia have shown very considerable variations in outcome between individual practitioners and facilities. Potential patients have a right to this information and to make their care choices accordingly. Which are the most appropriate indicators to best inform such consumer choice needs to be investigated as a high priority as part of the Commonwealth's outcome measurement work. **The PIR recommends that data on appropriate quality of care indicators, which are comparable between facilities and different health care professionals, be made available to users of the health care system, so that consumers can make truly informed choices about their individual and institutional health care provider, and about the risks and benefits of treatment options. (Recommendation 56)**

5.49 Once the most appropriate indicators are determined, the issue of communicating this information, together with other data described in Chapters 2–4 of this Report, to consumers becomes an important issue. As discussed in Chapter 4, communicating effectively with consumers is to be the subject of a Cochrane International Collaborative Review Group. It will be facilitated by the Public Health Branch of the Victorian Department of Health and Community Services.[35] Because of the breadth of the topic, the participants at the first exploratory meeting agreed that the logical starting point should be areas of particular interest, and areas about which people had information.[36] **The PIR recommends that the issue of the best ways of conveying information to health care consumers on relative quality of care in different health care facilities and the quality of care provided by individual health care professionals can be explored as a matter of priority by the Cochrane Review Group on Communicating Effectively with Consumers. (Recommendation 57)**

F. Quality assurance legislation

Introduction

5.50 In the Interim Report, the PIR outlined the alleged effect of fear of litigation on different quality assurance activities. For example, the possibility that information disclosed during participation in activities that contribute to improving quality of care, may be subpoenaed as part of subsequent litigation was argued to work against the participation of health care professionals in such activities. There was some evidence to suggest that activities such as morbidity and mortality reviews had ceased partly because of this fear. An additional concern was that health care professionals were discouraged from participating in credentialling committees that determined a colleague's clinical privileges or practising rights because of fear that they may be sued by a colleague dissatisfied with the outcome.

5.51 The Interim Report went on to describe briefly the Commonwealth and State legislation that had been enacted to protect the confidentiality of information gathered by various quality assurance activities. Since the Interim Report, one more State, Western Australia, has quality assurance legislation in place, which is expected to commence shortly after the finalisation of regulations. Only the Northern Territory remains without such legislation, though in some States the number of activities protected by the legislation appears to be very low. The PIR's Interim Report recommended examination of the need to modify or extend the Commonwealth's quality assurance confidentiality legislation or equivalent

State Government legislation to encourage risk management activities.[37] The PIR also looked at the operation of the Commonwealth's legislation since its introduction.

5.52 Several submissions considered quality assurance legislation, its limits and benefits. One correspondent commented that private hospitals have limited experience with Commonwealth or State Government legislation to offer confidentiality for quality assurance activities, but thought that the majority of hospitals would seek to gain coverage for their quality assurance committees' activities.[38] Another correspondent, writing from the perspective of a professional college about the PIR's recommendations covering risk management, credentialling and the quality assurance legislation wrote, "We are not convinced of the benefits of pursuing the actions outlined in recommendations 12, 13, 14 and 15".[39]

5.53 Two correspondents simply supported the recommendation to examine the need for modification or extension of the Commonwealth's quality assurance confidentiality legislation.[40] A professional association drew attention to a concern over former section 106N[41] of the Commonwealth's quality assurance confidentiality legislation.[42] This section permits the Minister for Health to breach confidentiality under certain circumstances. The association said this was a possible cause for concern and that it had lobbied for the removal of this section.

Commonwealth legislation: a summary

5.54 The Commonwealth quality assurance confidentiality legislation was developed to assist health care professionals to participate in activities that examine the quality of care provided and that aim to improve the quality of that care. The PIR had a direct interest in developing the legislation, as it was apparent that without the protection of the legislation it would have been difficult to encourage participation in a number of national research initiatives which were proposed, such as the Quality in Australian Health Care Study and national incident monitoring pilots.

5.55 The definition of a quality assurance activity adopted for the purpose of the legislation is broad and can cover, for example, clinical care assessment and other systematic approaches to quality improvement. The legislation is intended to encourage health care professionals to provide full and frank information, which may contribute to improving the quality of health care and the availability of information about health care quality.

5.56 The Commonwealth quality assurance confidentiality legislation (Part VC of the *Health Insurance Act 1973*), which was introduced in December 1992, provides a balanced framework of confidentiality and openness which is intended to encourage activities that will improve the quality of health care services provided to the public.[43] For those who have earlier copies of the legislation, it is important to note that the provisions were renumbered in alphanumeric order starting with section 124V and ending with section 124ZC in an amendment which was made in the *Health and Community Services Legislation Amendment Act 1994* No 12 of 1994. Accordingly, the Regulations were renumbered in the Health Insurance Regulations (Amendment) Statutory Rule No. 27 of 1994 so that they are consistent with the numbering in the *Health Insurance Act 1973*.

5.57 The Commonwealth legislation does not automatically confer protection on all quality assurance activities. The activity must be declared by the Commonwealth Minister for

Health. To have a quality assurance activity declared, a written application must be made to the Minister for Health on the approved form, and the Minister must be satisfied that a declaration is in the public interest. Therefore, those who seek protection under the Commonwealth legislation make a conscious choice to accept the provisions of the Act, as well as needing to demonstrate the public interest in protecting the activity. Importantly, if the Minister is satisfied that the activity would be equally effective without the protection of the Act, then it is unlikely that it would be declared.[44]

5.58 The Act provides protection from subpoena, and confidentiality for information that becomes known through declared quality assurance activities. The public interest in providing this confidentiality is balanced with the competing public interest in openness by requiring publication of non identifying information about the activity, in a manner specified in the declaration. Thus it seeks to increase the availability of useful quality information – information that can be used to prevent adverse patient outcomes and improve the quality of health care, and that, in all likelihood, would otherwise be unavailable from any source. It is important to note that the Commonwealth legislation only protects information that is known *only* because of a declared activity. If a medical record, for example, discloses a negligent act, then protection cannot be gained by its being subsequently brought into a declared quality assurance activity.

5.59 The Commonwealth legislation is intended to provide the framework for health care professionals to have quality activities protected in circumstances where it is not possible to obtain such protection under State law, for example, in jurisdictions where no legislation is available, or for a quality activity in which health care professionals from several States are participating. The Commonwealth legislation is intended to complement existing State legislation and is not intended to impact negatively on it or override it. This means, in most circumstances, those seeking protection for a quality activity should do so under existing State legislation. It would only be necessary to seek protection under Commonwealth legislation where it is not possible to obtain protection under State legislation.

5.60 Some quality activities also include the assessment or evaluation of the services, skill or performance of a health care professional, which may adversely affect that person's clinical practising rights. These activities are often referred to as credentialling. It has been argued that the fear of defamation action has discouraged highly qualified health care professionals from sitting on credentialling committees. The legislation also provides protection for members of credentialling committees who determine the clinical practising rights of their colleagues in good faith.

5.61 To obtain protection from suit for members of credentialling committees there is a requirement of procedural fairness. Procedural fairness demands that the health care professional being credentialled has the right to know the substance of any concerns, the right to respond to those concerns and the right to a fair and unbiased hearing. The health care professional must also have the right of appeal to an independent body in relation to any adverse decisions. The Act operates differently for credentialling activities than for other quality assurance activities. The purposes of the committee must include the disclosure of the identity and the clinical practising rights of the individual being credentialled. The person being credentialled must also be given information about the reasons for and the basis of any adverse finding.

5.62 These requirements co-exist with the overall requirement of non-disclosure of identifying information. A health care professional being credentialled has a right to all necessary information about his or her credentialling, and the credentialling committee can reveal the health care professional's name and his or her clinical practising rights to the public. However, the committee cannot more broadly disclose any other identifying information obtained in the credentialling process. The need for disclosure of certain information to improve or maintain the quality of health care is balanced with the need for protection of both members of the credentialling committees and the individual health care professional being credentialled.

5.63 Once the Minister signs the declaration, it is gazetted and tabled in Parliament, where it can be disallowed. Applicants are informed of the outcome and reminded of their reporting requirements and the need to inform the Commonwealth of any major changes to the purposes of the declared activity. A register of declared activities is kept so that those managing the activity can be contacted to obtain reports of the progress and outcomes of the activity and to determine if the activity needs to be re-declared in five years. Any activity that is covered and ceases in the future remains covered by the legislation even after cessation of the activity and revocation of the declaration.

5.64 There are currently 23 declared activities under the legislation, three of which are no longer operating and are soon to be revoked. There is also 1 pending declaration. There have been 7 unsuccessful applications – all of which related to activities proposed to be carried out in a single State and the State authorities considered it was inappropriate for the Commonwealth to cover. The declared activities are:

- Incident monitoring pilot in psychiatry
- Incident monitoring pilot in endoscopic procedures
- Incident monitoring pilot in obstetrics and gynaecology
- Incident monitoring pilot in intensive care medicine
- Incident monitoring pilot in anaesthesia
- Incident monitoring pilot in general practice
- Feasibility of institutional incident monitoring pilot
- Australian Hospital Care Study
- Australian and New Zealand Intensive Care Society Patient Database and Intensive Care Unit Registry
- Medical Advisory Panels for Nursing Homes and Hostels in the Northern Region of Tasmania
- Maintenance of Professional Standards Program for the Royal Australasian College of Physicians
- Field Testing of the Royal Australian College of General Practitioners' Entry Standards for General Practice
- Aus-Read Trial in general practice
- Australian Health Care Incident Monitoring Study
- A trial comparing alternative approaches to assessing general practices against draft entry standards
- The Royal Australian College of Obstetricians and Gynaecologists' National Quality Assurance in Colposcopy Project
- The Early Adenocarcinoma of the Cervix Study

- Maintenance of Standards Program of the Australian and New Zealand College of Anaesthetists
- Medicare Agreement: An Audit of Hospital Records
- The Alice Springs Hospital Morbidity and Mortality Review Committee
- The Northern Territory Anaesthetic Mortality Review
- National Audit of Minimal Access Surgery – Royal Australasian College of Surgeons
- A Review of Minimum Access Surgery by the Australian Health Technology Advisory Committee

Usage and awareness of the Commonwealth and state legislation

5.65 To ensure maximum effectiveness of the legislation, a brochure *Quality Assurance and the Law* which outlined the Commonwealth legislation was mailed to the chief executive officers of all Australian hospitals. Approximately 600 additional brochures were sent to health care professional journals, Australian Medical Association representatives, Australian Nursing Federation representatives, nursing organisations, medical colleges, professional associations and societies, medical defence organisations, State health authorities, university medical, dental and health faculties, medical, dental and nursing registration boards.

5.66 Approximately 400 information packages have been sent out to those interested in further information about the legislation and to those who were considering making an application. Distribution of the brochure raised awareness about the existence of both Commonwealth and State legislation. Many enquiries indicated a lack of awareness of the existence of State or Territory quality assurance legislation and many were informed that specific activities would be more appropriately covered under similar State legislation.

5.67 In 1993 the Australian Institute of Health and Welfare conducted the Quality of Care in Hospitals Survey. As part of its evaluation strategy, the PIR included several questions relating to awareness and use of quality assurance legislation. The Australian Institute of Health and Welfare surveyed participants about their awareness and use of State quality assurance confidentiality legislation. It also surveyed awareness of the Commonwealth legislation which had been only introduced a few months prior to the survey. Four hundred and thirty-nine public and 223 private hospitals were surveyed. They included all acute hospitals with 30 or more beds, 50% of hospitals with between 29 and 10 beds, and excluded all hospitals with fewer than 10 beds and public psychiatric hospitals. An overall response rate of 71% was achieved with 472 hospitals responding. This was 75% for public hospitals and 65% for private hospitals. Almost 80% of acute hospital beds were in hospitals responding to the survey.

5.68 The questions asked in the survey were:

- Are you aware of legislation in your State/Territory which protects documentation from quality assurance activities from being used in a court action? (at this time Western Australia and Northern Territory did not have such legislation) Yes No
- Has your hospital applied for coverage by this legislation? Yes No
- In the last 3 years how many applications have you had rejected? covered?
- In general have you found the protection given by this legislation has done what you wanted it to do? Yes No

- Are you aware of Commonwealth legislation which protects documentation from quality assurance activities from being used in a court action? Yes No

5.69 There was 69% awareness of State legislation in Australian hospitals with the greatest awareness in hospitals over 100 and 200 beds and in New South Wales, Australian Capital Territory, Victoria and South Australia, where the degree of awareness exceeded 80%. While the Commonwealth legislation had only recently been enacted, 59% of public hospitals and 52% of private hospitals were aware of its existence, with a similar pattern of larger hospitals being more aware than smaller ones. In public hospitals over 200 beds, the awareness rate was 76% – around 10% less than the equivalent awareness rate of State legislation.

5.70 Seventy eight hospitals or 24% of those who were aware of State legislation had applied for cover. However, the survey showed that there were only 30 activities covered at that time, although it is likely that some of these are committees which cover several activities.[45] Many indicated that they were still waiting to hear the outcome of their application – this may well have been because the legislation was reasonably new in a number of jurisdictions. There had been 7 activities rejected for cover.[46] Those covered by State legislation believed the legislation had done what they wanted it to. However, comments on the survey indicated confusion on a number of issues relating to the scope of the various state acts – that is whether they covered private hospitals and whether a quality assurance activity concerning non-medical staff could be covered.

5.71 In some of the PIR's consultations, there were also concerns about what were seen as *onerous* administrative processes required under some acts, and confusion about the differing coverage of the various acts. **The PIR recommends that AHMAC promote development of model legislation for quality assurance confidentiality legislation. This could allow the different States to achieve consistency of coverage of activities, streamlined administration and greater openness of information in protected quality assurance activities, for example through public reporting requirements, while minimising the confusion about coverage. Such model legislation could also set out the best interrelationship with the Commonwealth legislation from the States' perspectives. (Recommendation 58)**

Evaluation of the Commonwealth legislation

5.72 While the Australian Institute of Health and Welfare survey indicated that there was quite good awareness of the existence of Commonwealth quality assurance confidentiality legislation, it was too early to determine from the survey whether the Commonwealth's legislation was operating well, or whether there were amendments which might be made. The need for consideration of possible amendments formed part of the work of the PIR, and the following discussion summarises the main proposals for change and some unanticipated problems.

5.73 There were two main areas of coverage shortfall that had not been anticipated. The legislation currently allows coverage of quality assurance activities relating to health care services that involve Medicare Benefits, Public Hospital Services, Health Program Grants or prescribing of pharmaceutical products under the Pharmaceutical Benefits Scheme. Two additional areas have been identified as requiring such coverage and as being within Commonwealth constitutional responsibility. Firstly, coverage of veteran's repatriation

hospitals controlled by the Commonwealth, and secondly, the coverage of activities under the *Therapeutic Goods Act*.

5.74 Although repatriation hospitals are currently being integrated and the legislation will apply to them without amendment once they become part of the State health system, advice from the Department of Veterans' Affairs in 1993 indicated that this process would not be complete for some time. In addition, there may be a need for coverage of quality activities relating to veterans' health services other than hospitals, such as primary care hospital services funded by the Commonwealth under veterans' legislation, but offered in State or other hospitals, and pharmaceutical prescribing under the veterans' provisions.

5.75 Agreement was obtained from the Ministers for Health and Veterans' Affairs and the Prime Minister to amend the legislation in 1993. However, the amendment has not obtained sufficient legislative priority to be introduced. At this time, only one hospital remains under Commonwealth control. The proposed amendment would seek to include all health services provided to eligible persons under the *Veteran Entitlements Act 1986*; or for which a pharmaceutical allowance is payable under the Act by an extension of the definition of a quality assurance activity under section 124W(1)(a). **The PIR recommends that an amendment be made to the *Health Insurance Act 1973* to allow cover of declared quality assurance activities relating to veterans' health services. (Recommendation 59)**

5.76 Following discussions with the PIR, the Therapeutic Goods Administration (TGA) believes that the extension of the legislation to cover the *Therapeutic Goods Act 1989* could foster the development of various quality activities. Many of these may not be covered under the existing legislation. For example, proposed quality initiatives to establish implant and device registers and tracking systems of goods administered by TGA cannot be covered under the current Commonwealth legislation. **The PIR recommends that the Commonwealth quality assurance confidentiality legislation be amended to allow the declaration of quality assurance activities relating to the *Therapeutic Goods Act 1989*. (Recommendation 60)**

5.77 Concerns have also arisen in relation to the interaction between State and Commonwealth legislation in this area. The Commonwealth quality assurance confidentiality legislation was framed to complement rather than override that of the State's, because it was considered that, for quality activities internal to one State, it was more appropriate for State authorities to determine the coverage. It would be inappropriate for the Commonwealth to determine individual coverage of the multiplicity of quality assurance committees operating in single facilities – the administrative resources to do so would be significant. In addition, the experience of the Commonwealth legislation so far indicates the reluctance of State authorities to allow Commonwealth involvement in the cover of activities which are restricted to their own State. The Commonwealth has rejected several applications on this basis. In practice, when an application is received which involves a quality assurance activity being undertaken in one State that is not a national activity, officers of the Department of Human Services and Health seek advice from the relevant State authority as to whether the activity would be more appropriately covered under State legislation and whether it is in the public interest that the Commonwealth legislation protect the activity.

5.78 However, the Quality Assurance Network in Victoria, and some hospitals in New South Wales have expressed concern about the limitation of protection under their equivalent

State legislation, so far as subpoena of information under courts exercising federal jurisdiction is concerned. While this situation has not yet arisen, it is of concern to some authorities involved directly in the administration of State legislation.

5.79 One way of dealing with this, without imposing a significant administrative burden, would be to amend the Commonwealth legislation to enable the Minister for Health to declare activities under a State act to be covered by the Commonwealth act so far as courts exercising federal jurisdiction may be concerned. This could be done in either of the following ways:

- attach a schedule of State acts where the Minister for Health is satisfied that any activity covered by them should have this additional Commonwealth protection (the automatic option); or
- allow a class of activities under relevant State acts to be declared if the Minister for Health is satisfied that the coverage of that class is in the public interest (the class option).

5.80 Discussions with States about the most appropriate option could form part of the development of model quality assurance confidentiality legislation by AHMAC recommended above in paragraph 5.54. **The PIR recommends the Commonwealth begin preliminary discussions with State Governments on options to allow the coverage by the Commonwealth quality assurance confidentiality legislation of activities covered by equivalent State acts, so far as subpoena by courts exercising federal jurisdiction are concerned. (Recommendation 61)**

5.81 Concerns were also expressed by some State-based quality bodies and professional groups about the provision for the Commonwealth Minister for Health to authorise the release of factual information, not opinion, about serious criminal offences in some circumstances under section 124Z of Part V C of the *Health Insurance Act 1973*. This is a very circumscribed authority. Members of a Commonwealth declared quality assurance committee who wish to trigger this authority would need to apply to the Commonwealth Minister for Health, who would then consider whether the information should be disclosed. The Minister would only authorise the disclosure of this information for the purposes of law enforcement or a Royal Commission. The legislation does not give the Minister the power to compel members of committees to disclose information, nor is there a duty to disclose in the legislation. There has been no situation where this authority has been triggered. **The PIR recommends that no amendments be made to section 124Z of the Commonwealth's quality assurance confidentiality legislation (*Health Insurance Act, Part VC*). The provisions of section 124Z do not appear to be limiting the effective operation of the legislation at this time, and it is an important, but narrow safeguard for the community's interests in the prosecution of criminal offences. (Recommendation 62)**

5.82 Considerable concern was also expressed by the Quality Assurance Network in Victoria about whether the Commonwealth quality assurance confidentiality legislation could override State legislation and whether the Commonwealth Minister for health could authorise the disclosure of information relating to the affairs of a committee approved under the Victorian *Health Services Act 1988*. It is clear that the Commonwealth Act and the Victorian and other State acts each apply to quality assurance activities and committees only if the activity fits under the State act (usually by declaration at the State level) and declaration has been made also under the Commonwealth Act. For the latter to occur, the person carrying out

the activity must seek coverage – it cannot happen automatically. For example, if a declaration has been made under a State act but no declaration has been made under the Commonwealth Act, the State act will apply to the activities and the Commonwealth Act will have no application. Where a declaration has been made for the same activity under both a State act and the Commonwealth Act, the State act will apply to its full extent and the Commonwealth Act will apply only to the extent that the State act does not apply. Legal advice confirming this has been provided to the Victorian quality assurance network.

5.83 State acts do not contain a provision similar to section 124Z of the Commonwealth quality assurance confidentiality legislation act, which enables the Minister to authorise disclosure of information about a criminal offence. However, the State acts provide protection of information given to approved committees by setting out the circumstances in which information and documents may and may not be released. If section 124Z were to apply in relation to committees approved under a State act, this would lessen the protection otherwise available under the State act. This would be contrary to the Commonwealth Parliament's intention as expressed in section 124ZC of the Commonwealth Act.

5.84 Another issue that has arisen is where a quality assurance activity declared under Commonwealth legislation reveals actions by a health care professional which could render him or her open to disciplinary procedures, or which clearly endanger the safety of patients. Examples of these sorts of activities, which were reported by participants in currently declared quality assurance activities included :

- professionals claiming superior competence in technology or breaching advertising ethics; and
- a professional who was persistently breaching hygiene and sterilisation guidelines in a manner which could seriously endanger patient safety.

5.85 Those infringements that are not about patient safety are more easily dealt with. The PIR argues that the public interest in effective quality assurance activities overrides the commercial interests of practitioners. However, circumstances where patient safety continues to be at risk are more problematic. It is likely, for example, that poor practice is only uncovered because of the confidential nature of the quality assurance activities' investigations. To allow an extension of the waiver of confidentiality beyond criminal offences and Royal Commissions may effectively undermine the whole purposes of the legislation. It is also very difficult for a health professional not to act when actions putting patient safety in jeopardy have been revealed as part of a quality assurance activity. If a patient is killed or injured by such actions, criminal charges may proceed and the confidentiality processes waived for prosecution purposes. This might be of little comfort to potential patients or the health care professional concerned about patient safety. **The PIR recommends that the issues arising from revelation of practices which endanger patient safety in a declared quality assurance activity be examined in the AHMAC promotion of model quality assurance confidentiality legislation recommended above, as it relates to all such legislation, and the balancing of interests which underlie it. (Recommendation 63)**

G. Incident Monitoring

Introduction

5.86 Despite the limited information about adverse events available at the beginning of the PIR, it was recognised in the Interim Report that incident and accident prevention such as that promised by the Anaesthetic Incident Monitoring Study (AIMS), might be far more cost-effective than a system that compensated the injured person after an adverse event. The Interim Report described the funding provided by the PIR for several studies to determine the feasibility of extending incident monitoring both to other medical specialties and across the health care system as a whole. The results of these pilots are detailed below.

5.87 Recently released preliminary findings of the Quality in Australian Health Care Study, described in detail in Chapter 2, show a disturbing number of preventable adverse events occur in our health care system – enough to warrant more systematic consideration of adverse events in health care facilities. The first problem is to find out what is really going wrong in our complex health care system. Incident monitoring has significant value for this as it uses a multi-faceted approach to preventing and correcting problems in health care.

5.88 Incident monitoring is a method of collecting detailed qualitative data about any unintended incident, no matter how seemingly trivial or commonplace, which could have or did harm anyone, patient, staff or visitor. The incident may or may not have been preventable, and may or may not have involved an error on the part of the health care team. Incident monitoring can contribute to broader quality strategies and the reduction of adverse patient outcomes by developing understanding about contributing factors, causes and preventive strategies. Incident monitoring has been used successfully in aviation safety, industrial safety, diving, road and rail travel, nuclear power, hyperbaric medicine and anaesthesia for several years.

5.89 The systematic anonymous reporting of incidents in incident monitoring can be used as a warning device, flagging problem areas that impact on quality of care. Documenting changes in the type and frequency of incidents is not in itself a measure of changes in the quality of care. Changes in outcome measures must be established to assess improvement. Incident monitoring is just one facet of the drive for improved quality of care. The development and implementation of interventions based on the information derived from incident monitoring can link incident monitoring to broader quality of care improvements.

Human error psychology

5.90 Most investigations of adverse health care events have focused on the task of identifying people or equipment that were immediately responsible for a system breakdown and then specify the action necessary to prevent recurrence. While this practice should continue, there are inherent problems with accident investigation which may benefit from alternative approaches. For example, there is often distorted recollection of what happened, inadequate documentation, whether from fear of recrimination or lack of a mechanism, and outcome bias.[47] This can be particularly so where a tort action is likely. The tort system itself forces plaintiffs to seek someone to blame, which can be a reductive process that distorts the facts and simplifies the circumstances for forensic reasons.

Figure 1: Relationships between the theoretical elements of organisational accidents

5.91 This approach has changed somewhat in recent times. Theories of error and accident

causation have evolved, leading to a broader understanding of accident causation, with less focus on the individual who makes an error and more on pre-existing organisational factors that provide the context in which error occurs. For example, in the judgement regarding the capsize of the car ferry *Herald of Free Enterprise,* apart from identifying failures of members of the crew, the judge claimed the underlying causal factors lay elsewhere in the company routines. Similar findings were made in the investigation of causes of the Kings Cross Underground fire and the Piper Alpha oil platform explosion.

5.92 Incident monitoring is based on revised theories of human error psychology. Professor James Reason argues there are four basic concepts needed to understand the causes of accident in complex organisations:

- organisational processes;
- task and environmental conditions;
- individual unsafe acts; and
- failed defences.[48]

The sequences of accidents and the direction of causality is explained by Professor Reason in Figure 1.

5.93 Fallible decisions associated with the generic processes of organisations, that is, setting goals, managing and communicating, seed *resident pathogens* within the organisation. They are transmitted along departmental pathways to the workplace, where they give rise to task and environmental conditions likely to promote unsafe acts. Many unsafe acts may be committed but few are likely to occur at the same time as defences fail, though such actions can involve the bypassing or disabling of established safeguards.

5.94 The implications of failed defences, unsafe acts and error-enforcing conditions can best be illustrated by a case study which is drawn from the field of anaesthetics.[49] It demonstrates how easily things can go wrong, and the compounding effect of a series of events, none of which was a significant problem individually, but which collectively, gave rise to an adverse patient outcome with significant human and financial costs.

A patient was listed to have an operation performed under local anaesthetic. Because the patient was booked for a local anaesthetic, he was not assessed by an anaesthetist beforehand.

On the morning of the procedure, the doctor who was to perform the operation discovered that he was double-booked in the operating theatre, so he asked a colleague to carry out the procedure in his stead. The colleague, who had not seen the patient, agreed but insisted that the procedure should be carried out under a general anaesthetic.

The second doctor contacted the anaesthetic coordinator who found an available anaesthetist, but this anaesthetist was not told of the original booking under local anaesthesia, nor that the doctor performing the procedure was unfamiliar with the patient. The anaesthetist merely understood that the patient was an urgent addition to the operating theatre list.

The anaesthetist first saw the patient in the operating theatre where he was found to be belligerent, confused, and unable to give a coherent history. The nursing notes showed that the patient had fasted for 24 hours, but his chart revealed several complications. These included progressive mental deterioration, metastatic cancer in the lungs and liver, renal insufficiency, and anaemia.

Since the patient refused to be moved to the operating table, the anaesthetist decided to induce anaesthesia with the patient in his bed. Routine monitors were attached and appropriate anaesthetic administered intravenously. The patient lost consciousness, but then regurgitated more than two litres of fluid and undigested food. He was immediately turned on his side and the vomitus sucked from his mouth.

The patient's lungs were ventilated with 100 per cent oxygen and intravenous fluids were given. Investigations showed large quantities of fluid in the patient's bronchi. He was transferred to the Intensive Care Unit and died six days later.

Data collection for incident monitoring

5.95 Incident monitoring in the health care domain generally involves the reporting by participants of any incident which could or did reduce the margin of patient safety, though it can also be extended to harm to others in the health care system, such as harm to staff. The description of the process of data input and collection here is derived from that used by the Australian Patient Safety Foundation, which has been involved in the anaesthetic, intensive care and institutional incident monitoring pilots. Other pilots may have used slightly different processes, though the general approach is likely to be similar.

5.96 Information is collected on a written form, which includes a significant section of free narrative, where a person is encouraged to provide as much information as possible about the circumstances leading to the incident. People are encouraged to fill in the forms as soon as possible after an incident occurs, so that their memories are fresh. An integral component

of the concept of incident monitoring is that the information is collected anonymously. The advantages of a structured anonymous incident monitoring system include the ability to elicit details about contributory factors, human error, factors minimising adverse events and corrective strategies. Anonymity is a key factor in encouraging the reporting of incidents and data collection. Incidents are more likely to be described openly when the system is anonymous and no effort is made to apportion blame.

5.97 Education of clinicians about incident monitoring is achieved by providing presentations with overheads; a video has been prepared for potential participants. Incident reporting forms are placed at multiple locations along with locked mailboxes. Participation is also encouraged by discussing incidents at clinical review meetings and during other quality activities whether at a specialty college level or within a hospital setting.

5.98 Once the forms are completed, there is usually an on-site local coordinator, who collects them from the mailboxes, and ensures they are totally anonymous. Some feedback to participants often occurs at this level, with local meetings discussing some of the incidents – particularly if it looks as if some local action could address the causes or contributing factors. The forms are then sent on to a central data collection point. This is an important step, because the value of this type of information, is heightened by creating a database of incidents, and looking at patterns over large numbers of incidents. Once analysed, the data show patterns of human error, system error, and contributory factors, which would not be apparent in information from one site. The information can alert management and health care professionals about the need to reassess systems, equipment, environments or work practices and indicate appropriate preventive strategies.

5.99 An alternative data collection pilot project was conducted as part of the AIMS work discussed below, using electronic data input at the local level through a Health Communications Network pilot. This showed faster input times and also allowed the local co-ordinators to compare their data with national data more easily. There was also some difference in reporting patterns, which may have indicated greater comfort with the anonymity of keyed data rather than hand written information, although the project's limit of around 457 electronic forms was too small to draw any firm conclusions.

5.100 When the forms are received at the data-collection and analysis point, they are checked to ensure that any identifying information has been removed. Any such information is whited out, the form is photocopied and the original destroyed to ensure that the reports remain anonymous. The narrative is read and standardised. Keywords are substituted where appropriate, and additional keywords are identified by the analyst. The form is allocated a unique sequential number and is checked for consistency between the tick boxes and the narrative. Sometimes more than one incident is reported on a form, so the form is copied and processed as two incidents, using the same identifying number, with a different suffix.

5.101 After this checking procedure, the data from the form is keyed in to a central computerised database, and a proprietary database program is used for data entry, error checking, storage and retrieval of data. When the free narrative is keyed in, any unclear passages are checked with one of a number of clinicians, who are also responsible for proof reading the free narratives and making any corrections if necessary. The modest funding from the PIR allowed the inputting and checking of the free narrative in all reported incidents, as well as improving the turn-around time from incident occurrence and receipt of the report

to data input from several months to a few days. This has significantly improved feedback to clinicians, units and other interested parties.[50]

5.102 Data analysis and classification is generally undertaken by teams of 2-6 analysts. Initially for simple reports, at least two analysts will read and classify the relevant report forms independently, and then the group meets and agrees on a classification. In larger databases random allocation of incidents between more analysts is used, and a similar method followed. Topics for investigation and further analysis, such as through the establishment of a clinical situation-based database managers, can be chosen for any number of reasons. Some examples are investigated because: they show a high incidence; they are perceived to be important for good patient management; they are important in the context of patient morbidity or mortality; other studies have identified problems in the area; and because of topical interest, for example, through media attention or because of frequent complaint or litigation.

5.103 Information about the data and analysis, as well as consequent preventive strategies that have been implemented, are reported to clinicians to encourage their continued participation in the data collection, and special database managers with particular interest in specific clinical situations are forwarded relevant incidents for inclusion in analysis. Feedback is also provided through articles and speeches to scientific meetings from these database managers.

5.104 In summary, incident monitoring gives clinicians direct input into developing strategies for preventing adverse patient outcomes. They witness the things that go wrong and their detailed accounts can contribute to the development of strategies to prevent them happening again. Clinicians provide information voluntarily and free of charge, time excepted, by filling in an incident reporting form. The methodology appears to offer a cost-effective, participative means of identifying problems and potential problems in the health care system.

5.105 The major disadvantages of incident monitoring as described in the literature is that this methodology does not provide a denominator. Therefore, the incidence of a problem cannot be assessed and reporting rates cannot be calculated. It is estimated that only a small proportion of incidents are reported. With regard to reporting bias, participants are more likely to report unusual, interesting or particularly dangerous incidents rather than the seemingly trivial or mundane and there is more likely to be reporting bias with delay between the incident occurrence and reporting.[51]

5.106 The major costs associated with incident monitoring are education of clinicians about the need to report incidents (who then become the source of future incident reports), the establishment of a database, and data coding, input and analysis. However, at an estimate of around $100,000 annually for 1,500 incidents per year it is a cost-effective method of data collection, analysis and safety improvement.

Incident monitoring in anaesthesia: the beginning

5.107 The PIR first became aware of the Anaesthetic Incident Monitoring Study (AIMS) in 1992. The AIMS had been conducted with very limited resources under the auspices of the Australian Patient Safety Foundation with the support of the Australian Society of Anaesthetists and the Faculty of Anaesthetics in the Royal Australian College of Surgeons since 1988. The PIR recognised the potential of the work and sought some Commonwealth

funding to develop the work and to ensure additional efforts were directed at the implementation of preventive measures.

5.108 The findings from the first 2000 incident reports were set out in the October 1993 issue of the *Journal of the Australian Society of Anaesthetists*, 'Anaesthesia and Intensive Care', which is dedicated to 30 papers on the work of the AIMS. The potential for this work to improve patient safety in anaesthetics is very significant. For example, the paper *Which Monitor?*[52] examined the relative efficacy of various monitors in detecting incidents and patient harm in a patient under general anaesthesia. The data and subsequent analysis showed that around half of the incidents were detected by a monitor and half were detected by humans. Of those incidents detected by monitors, the two most frequent modes of detection were oximetry (either through a pulse oximeter or a saturation monitor) and capnography.[53] Oximetry allows a non-invasive measurement of blood oxygen levels, while capnography measures carbon dioxide when a person breathes out.

5.109 The circumstances for all incidents were then analysed, to determine which of 17 different monitors would have detected an incident and which would have detected it before major organ damage could have occurred. The combined use of capnography and oximetry alone was shown to have theoretically allowed detection in 88% of incidents, 65% before there was any potential for organ damage. This was significantly better than any other combination – the addition of a blood pressure monitor and oxygen analyser increased the figures to 95% and 67% respectively. Other monitors, such as an Electrocardiogram increased the beneficial yield by less than 0.5%.[54]

5.110 This kind of information, which is based on what went wrong in real clinical situations, provides important basic information for clinicians, service funders and patients. It may be, for example, that anaesthetics should only be allowed to be given when this equipment is present and in proper working order. It also provides a priority shopping list for equipment purchasers interested in minimising the potential for patient harm, and data upon which to base resource allocation decisions. To a potential consumer of health care services, it indicates questions that might be asked about the facilities where a person may undergo anaesthesia.

5.111 The AIMS database now contains in excess of 4000 incident reports, with AIMS now being active in 80 hospitals across Australia and 30 overseas countries. There are now over 40 national database managers, who have responsibility for the analysis of all incidents relating to a particular clinical situation. Examples of some of the clinical situations from the national databases are: difficult intubation, air embolism; patient awareness under anaesthesia; problems with vaporisers; recovery room problems; equipment failure and industry liaison; anaesthetist fatigue; and patient obesity and anaesthesia.

Achieving change in anaesthetics through incident monitoring

5.112 In its final report to the PIR, the AIMS project outlined the effectiveness of incident monitoring in creating safer anaesthesia.[55] It also listed some 115 topics for development, which had flowed from the AIMS database. Many of these were practice changes arising from incident monitoring. They were seen as occurring at a number of levels:

- At the level of the individual anaesthetist: Those who had participated for some time

in AIMS indicated that it had altered their attitude to professional practice and led them to be more proactive in seeking to change things for the better. In turn this made them feel less helpless when working in large systems, and provided a means to achieve genuine change directed at better clinical practice, greater job satisfaction and greater safety for the patient. Around 43 of the topics for development and implementation identified personal involvement by individual clinicians as an important element in achieving the change.

- Local, institutional or practice level: Feedback on the analysis of a set of forms by the local AIMS coordinator often provides an opportunity for further local action. The comparison between local and national patterns of incidents can also sometimes serve as a trigger to further local investigation of problem areas, and subsequent action – many examples are provided in the AIMS Report. Some local actions then spread through to a national level. Over 70 of all identified topics are of direct relevance to local administrators or heads of departments.

- Data coordinator level: The Australian Patient Safety Foundation (APSF) co-ordinates a number of uses for the data. Relevant incidents go to database managers, and information on the collected incidents is provided to participants through the local coordinator and newsletter. When larger projects, like a checklist, form, video or classification system need development, the APSF identifies a project manager and co-ordinates the necessary development. Over 30 such projects are currently under way, some with funding from the Australian and New Zealand College of Anaesthetists, the Australian Society of Anaesthetists and industry sources. The current production of an AIMS handbook, which provides a ready-reference for clinicians to the information provided to database managers from AIMS and from other research sources. Database managers agree to keep up-to-date and provide this information and other publications in their specific areas.

- College/society level: These bodies, The Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists, provide forums to promote the information obtained as part of incident monitoring – ranging from a section in quarterly newsletters, through scientific and continuing education meetings to funding and project development assistance. Twenty four of the action areas indicated in the final report of AIMS for the PIR require the involvement of the College and Society.

- National level: The APSF liaises with State Governments and the Commonwealth Government in relevant areas, such as the Therapeutic Goods Administration and national standards association to ensure that the results of AIMS work affects changes at these levels. A formal industry liaison mechanism - AIMS/Industry Liaison (AIL) - has also been established between APSF and manufacturers of medical equipment and supplies. Meetings are held to exchange information and AIL-registered members are able to request a search of the AIMS database for information about specific equipment on a fee-paying basis. Fifteen of the actions identified require the interaction, co-operation and commitment of industry.

- International level: The World Federation of Societies of Anaesthetists is seeking to encourage the use of incident monitoring in other countries, through its Quality of Practice Committee. National projects are already under way in Australia, Sri Lanka,

Hong Kong, India, Malaysia and New Zealand, with projects in 12 other countries (including England, South Africa, Oman, Greece and Uruguay) begun or soon to commence. Nine other countries have made enquiries and have been supplied with basic information on the technique. APSF also liaises directly when required with a number of multi-national medical industry companies on its findings.

5.113 Some of the changes that have already resulted from the analysis of anaesthetic incident monitoring data include the following:

- It was discovered that various pieces of tubing can be incorrectly connected, with potentially serious consequences to patients. For example, deaths have occurred from suction tubing being connected to a portion of a pump that was *blowing* and not *sucking*. A simple flange can prevent tubes being connected to the blowing connection, and hospitals are making such changes.

- Data showing problems with specific anaesthetic equipment, which occurred only once in each hospital but at many hospitals throughout Australia, were sufficient to influence manufacturers to recall their equipment and modify it.

- Anaphylaxis was traditionally believed to present with tachycardia (faster than normal heartbeat) and a classic triad of symptoms – low blood pressure (hypotension), breathing difficulties (bronchospasm) and a skin rash. While there was some recognition in the literature of rare presentations that were different from this, the AIMS database showed there was frequent delayed diagnosis in cases of anaphylaxis and infrequent follow-up, because of the traditional views about the symptoms likely to be present. These delays could theoretically result in death or brain damage in a severely afflicted patient, and in a failure to diagnose an allergic sensitivity in those with a mild response, with subsequent risk of greater harm if the patient was anaesthetised again. The analysis of such incidents on the AIMS database showed, for example, that bradycardia was a relatively common presentation, and that any one of the triad of symptoms, rather than all three, was likely evidence of anaphylaxis and follow-up should occur in these cases to determine whether or not the patient was allergic to the relevant drug.

- Data showed that the most frequent cause of arterial desaturation was inadvertent placement of an endotracheal tube too far down the trachea and into the bronchus, potentially leading to brain damage and death during anaesthesia, because both lungs were not being ventilated. Companies making endotracheal tubes have now agreed to place new markers on the tubes so that the anaesthetist exactly can see exactly how far the tip of the tube is below the larynx at the time of placement. This involves minimal increased production cost but will greatly reduce the risk to patients.

- Guide wires for a central venous catheter were found to have a sharp end and a floppy end. Patients died because the *sharp* end was inadvertently inserted instead of the *floppy* end, perforating a vessel and causing the patient to bleed to death. There was nothing to stop guide wires being manufactured with two *floppy* ends, which would preclude the problem. Negotiations with manufacturers have indicated this change will be made.

Beyond anaesthetics – the extension of incident monitoring

5.114 Until the funding of incident monitoring pilots discussed below, there were few other examples of this method of incident reporting in the health care sector. The nursing profession has traditionally been responsible for a highly organised method of enforced incident reporting, which is not anonymous. Nurses reported their mistakes after the occurrence and it was generally perceived to be a disciplinary tool. There is some evidence that nurses attempted to avoid reporting incidents for fear of reprisal and there was also concern that the information was collected but never used in a positive way to prevent the recurrence of errors, but rather to *punish* the individuals concerned. The nursing model is significantly different in nature from the model discussed here. An exception to this is in relation to hyperbaric medicine. Many clinicians involved in hyperbaric medicine are anaesthetists, and they have developed incident monitoring over the last year and collected data on hundreds of incidents.

5.115 Other areas of the medical profession were initially sceptical of the value of incident monitoring when it was presented to them as possible preventive tool. The common view expressed to the PIR was that it worked for anaesthetists because of their predominantly machine-human interface. This reaction belied the fact that the impact of incident reporting extends far beyond equipment errors and failures. For example, incident monitoring identified a marked increase in the occurrence of incidents and accidents for anaesthetists working long hours without a break. Based on this information, management in some hospitals now requires that anaesthetics limit the length of shifts and have a sufficient rest break between shifts.

5.116 The Commonwealth Government agreed in 1992 to provide funding to pilot incident monitoring in other areas of medicine and at an institutional or regional level, as well as to provide funding for the extension of the work in anaesthesia. The expertise of anaesthetists involved in the AIMS and the APSF has been integral to facilitating the development of incident monitoring in other disciplines. Pilot studies were funded in intensive care, general practice, gastroenterology, obstetrics and gynaecology, emergency medicine and psychiatry as well as continued funding of anaesthesia. The pilot projects commenced in mid-1993. After a significant period of development, a further pilot project to examine the applicability of the method across facilities (rather than within particular specialties), commenced with six hospitals in four States in mid-1994.

5.117 Progress on the six incident monitoring pilots in specialties other than anaesthesia and the pilot study in six hospitals across the health care system confirms that it is possible to get useful information using this methodology in disciplines other than anaesthesia. As part of the National Health Outcomes Program, funding to complete the next phase of this work will be provided over the next two years, after which incident monitoring will have to become self-funding. This is discussed below, after the individual pilot project results are described.

5.118 Each pilot project broadly adopted the principles of incident monitoring. However, they developed the projects in ways that best suited their particular specialty. The data collection instruments varied considerably in their complexity, as did their overall work plan. For example, some projects undertook a preliminary investigation to determine if there was acceptance of the model and invited clinicians to provide retrospective vignettes of incidents. This approach was taken to see if clinicians in those specialties were prepared to participate in incident monitoring. Some of the pilot projects established extensive data collection points

within a number of hospitals and from a targeted group of practitioners have collected hundreds of incident reports. Allowing each discipline to work out its own system constituted a valuable experience in examining the strengths and weaknesses of different approaches and for determining the viability of incident monitoring among various specialties.

5.119 A co-ordinating committee with representation from each of the pilot projects met on a regular basis. The main purpose of the meetings was to provide a forum at which each project team could provide an update on progress and share ideas and problems with other committee members.

5.120 In their final report each of the pilot projects reported on:

- the methodology used;
- evidence of rigorous data analysis;
- any problems encountered in the running of the pilot;
- estimation of costs in maintaining and extending the pilot project; preventive and educative strategies to use the information obtained from the project; and
- ways that the project can be applied or modified to identify and prevent incidents that reduce the patient safety margin in their specialties, in other specialties or within other health care professions.

With some modest additional funding, five of the specialty-based pilot projects (all except psychiatry and gastroenterology) continued until 30 June 1995. The detailed results of these projects will be published as a supplement of the *Medical Journal of Australia* in late 1995. Their results are summarised below.

5.121 The PIR held a national incident monitoring and risk management conference on 29 and 30 November 1994 at which consultants reported on the outcomes of each pilot project, including an analysis of the findings. The aim of the conference was to provide a forum at which the specialty-based incident monitoring pilots could report on findings. The conference consisted mainly of presentations from the speciality-based incident monitoring pilot project, as well as presentations on issues of patient safety, risk management and communication skills as components of undergraduate education. The conference was opened by Dr Andrew Theophanous MP, on behalf of Dr Carmen Lawrence MP, Minister for Human Services and Health. Professor James Reason from Manchester University, an expert on human error psychology, was the keynote speaker. The conference attracted a number of overseas and local experts. The conference proceedings were taped and subsequently published.

Obstetrics and gynaecology pilot project

5.122 The Royal Australian College of Obstetricians and Gynaecologists (RACOG) targeted 17 hospitals ranging from large teaching hospitals to small rural ones for its project.[56] RACOG developed a comprehensive information education package for clinicians. Although the response over the six months from October 1993 – May 1994 was limited in the numbers of incidents received, around 34, there was considerable interest from the expert specialists who analyse the incidents, and a number of other hospitals expressed interest in joining the study. Twenty-four of these incidents related to obstetric cases, where over one-third showed the need for, or value of, a team approach to obstetric care. Ten incidents related to gynaecological procedures – the largest single group relating to laparoscopic procedures.

RACOG promoted the pilot project through its journal and opened the process to all practitioners about eight months ago and the database has built to over 150 incidents. No final report of the extension of the pilot was available at the date of writing.

Psychiatry pilot project

5.123 The pilot of the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) involved the development of a questionnaire which was sent to all Fellows of the College requesting reports of incidents in which they were involved and also whether or not they saw merit in developing an incident reporting system.[57] An incident reporting form was developed, based on a review of other reporting forms from psychiatry and other specialties. The form was piloted and modified. Eight psychiatric inpatient services in New South Wales and Queensland were invited to participate in the study. An investigator attended meetings at participating centres to give background information and explain the rationale for the study. The investigator visited the centres at the completion of a three-month period. At the completion of the pilot project 98 forms were collected for analysis.

5.124 Although there were only 307 returns of approximately 1900 questionnaires sent to all Fellows of the RANZCP, 62% of those responding considered that an incident reporting system would be of value to their psychiatric practice.

5.125 Retrospective reports of incidents revealed a range of incidents attributed to medication, violence and/or attempts at self-harm by patients. It was concluded that broadening the concept, from where only adverse outcomes were reported to include incidents which did not go to plan but where there was no adverse outcome, increased the number of incident reports. It was felt that this strengthened any conclusions drawn without significantly altering the type of incident reported.

5.126 A prospective incident reporting form which piloted in several public and private settings met with some success. The most significant difficulty related to the fact that most services had a pre-existing reporting system so that the pilot study was seen as repetitive. It was concluded that the acceptance of this system would require it to merge with existing systems. The same statistics could still be collected at the hospital level, but statistics should be combined with data from other hospitals using the same system to produce information on a greater number of incidents from which conclusions could be drawn. Other difficulties experienced with the project concerned the multidisciplinary nature of the practice of psychiatry, leading to confusion as to who should fill in the form. The fact that many psychiatric incidents occur with few or no witnesses further reduces the reliability of some reports.

5.127 Although it was considered that this pilot could not explore whether provision of regular and clinically useful feedback would improve the rate at which incidents are reported, the study did generate interesting findings both in terms of the incidents reported, some of the contributing factors and actions taken as a result of incidents. It was concluded that further refinements to the incident form (to make it briefer and reduce repetition) and the accumulation of a greater number of incidents on a database would allow a more sophisticated analysis of the relationship between certain types of incidents, contributing factors, outcomes and action which may prevent recurrence.

5.128 The study also indicated the patient linkages across several specialty groups in psychiatric incidents. For example, some incidents which arose from psychiatric care became apparent in emergency rooms, general practice or in cases of successful suicides, or other psychiatric-related deaths, through the coronial system. The absence of effective links between relevant sectors of the health system, and the difficulties of creating them in an anonymised system was one issue discussed at the incident monitoring co-ordinating committee meetings.

Emergency medicine pilot project

5.129 The Australasian College for Emergency Medicine's Critical Incident Monitoring Study in Emergency Medicine commenced with a very complex reporting form that attempted to categorise what the researchers saw were the likely incidents. It has since been refined considerably.[58] The simplified incident reporting form is less time-consuming to complete and should lead to enhanced incident reporting.

5.130 A total of 221 incident reports was analysed in the period from December 1993 to April 1995.[59] Incidents related to the areas of:

- Clinical management (37.1%)
- Misdiagnosis/failure to admit (20.4%)
- Patient dissatisfaction (10.4%)
- Triage (8.2%)
- Medication error (7.7%)
- Self discharges (5.4%)
- Resuscitation and stabilisation (5.4%)
- Deaths in the emergency department (4.1%)
- Transfers (1.4%)

5.131 In four of the top five of these – that is all except patient dissatisfaction, which arose almost exclusively from perceptions about excessive waiting time – a major contributing factor was the involvement of inexperienced, junior staff and the unavailability of appropriate senior staff.[60] Overall, this appeared to be a problem particularly during busy times, late at night and at weekends or in holiday periods. The effect or otherwise of over 75% of the incidents being reported by senior medical staff on the significant attribution of causation to junior staff factors was not explored. Less than 3% of the incidents were reported by junior medical staff and a similar proportion by nursing staff, with the reporter's status being unknown in the remaining 17.6% of incidents.[61]

5.132 In analysing the causes attributed to the incidents, many of these issues were classified as system factors. Provider factors, for example, lack of knowledge, failure to consult by an RM and inappropriate priorities, were also a direct by-product of inexperience. System factors were solely implicated in 32.6% of all incidents and partially implicated in over 70% of all incidents, with provider factors being solely implicated in 14.5% of all incidents, but partially implicated in 53%.[62] The importance of addressing these two sets of factors, and the issues relating to inexperienced staff, was clear. In all, 86.4% of the incidents were judged to be preventable.[63]

5.133 The study drew the following conclusions.[64] Even allowing for under reporting, there appears to be a comparatively low critical incident rate when expressed as a percentage of

patient contacts. Based on the frequency of incidents reported, the principal areas of emergency medicine that require attention are triaging, misdiagnosis/failure to admit, clinical management, and unexpected deaths. While most of these incidents were judged to have been preventable and some were of a fairly serious nature, very few resulted in a demonstrable adverse patient outcome. The investigators consider that critical incident reporting as a mechanism for data gathering, has major potential for contributing to informed risk management programs and in-service educational activities.

Intensive care medicine pilot project

5.134 The pilot of the Australian and New Zealand Intensive Care Society's (ANZICS) followed the model of AIMS very closely.[65] The reporting form was trialed at the John Hunter Hospital at Newcastle, Austin Hospital at Heidelberg and the Royal Adelaide Hospital. A preliminary report was presented to the ANZICS meeting in late 1993. The reporting form has been revised and information start-up kits were designed and distributed widely to intensive care units.

5.135 Currently 30 intensive care units throughout Australia are registered to participate in the project. There is a considerable length of time involved in starting up and many units are in the development phase. Only 10 units are submitting data. A total of 953 incident reports have been entered into the database. A major aspect of the development of this study has been the formulation of a keyword system whereby each incident is coded. This permits the grouping of incidents so they can be retrieved for further analysis, thus allowing evaluation of contributing and limiting factors. The database is approaching a size at which incidents can be analysed to develop intervention strategies, thereby closing the loop between incident monitoring and improvements in quality of care in the intensive care environment.

5.136 Local intensive care units are encouraged to hold regular review sessions and feedback is an integral part of the project. This project has also investigated the need for a direct data entry program for participating intensive care units. Such a program would simplify data entry, make local data available for each local unit to review in a timely manner and allow incorporation of national summary data as a form of feedback.

5.137 The investigators concluded that incident monitoring is a helpful tool for identifying problems that are occurring and studying how they are being handled in intensive care units. It will contribute to the design of prospective studies and preventive strategies as well as the planning of continuing education for intensive care unit staff.

Endoscopic procedures pilot project

5.138 This pilot project was conducted by the Royal Australasian College of Physicians and the Department of Social and Preventive Medicine at Monash University.[66] Data collection began in July 1993 and continued to June 1994. Data were collected on incidents from six university teaching hospitals on the gastroenterological procedures of gastroscopy, colonoscopy, cholangiopancreatography (ERCP) and liver biopsy.

5.139 For the first six months demographic data on all patients having procedures was collected whether or not an incident occurred. Of the 6483 procedures, 215 incidents occurred. This provided information on the absolute frequency of incidents. In the final six

months data were collected only on incidents for the high-volume procedures. For 7197 procedures, 69 incidents were reported.

5.140 One of the major problems encountered during this study was that forms were incomplete and considerable time-consuming checking was required to obtain basic information.

5.141 The outcomes of incidents ranged from nil to minor (no intervention required) to major, involving the need for drugs, intravenous therapy, admission, prolonged stay, admission to intensive care or a high dependency unit, an operation or death. Sixty per cent of all incidents had no adverse outcome requiring intervention.

5.142 In the assessment of reasons and preventability for gastroscopy incidents, the leading reasons were patient's symptoms, error of judgement, equipment fault, haste and inadequate prior assessment. It was judged in some cases that the outcome could have been prevented, for example, by less or slower titration of sedation.

5.143 Colonoscopy incidents were less common, the main reasons being sick patient, equipment fault, error of judgement and inadequate prior assessment. Lack of expertise and faulty technique were seldom given as an explanation. Major morbidity incidents were attributed to diverticular disease, poor bowel preparation, equipment fault or bad luck.

5.144 Many of the incidents associated with ERCP were complications for which there is evidence linking them to the nature of the procedure. Admission for precautionary observation was the reason behind 20 major incidents. The sick patient and equipment fault were cited as the most common reasons. Two major incidents were assessed as preventable, one by having anaesthetic assistance.

5.145 Liver biopsy incidents were very few in number. The underlying health of the patient was a significant reason for four major incidents. They were considered to be possibly preventable and management of such patients has since been changed.

5.146 Generally incident monitoring was considered to be a quality assurance tool which is relatively simple to use and in this pilot study has been shown to detect incidents occurring in hospital gastroenterological practice. It was found that the medical and nursing community participating in this study rapidly became used to the method of reporting, although not all were enthusiastic. It was assessed that incident monitoring has the potential to be effective on a larger scale.

General practice pilot project

5.147 This pilot was a collaborative project of the Family Medicine Research Unit at the University of Sydney and the Research and Health Promotion Unit in South Australia under the auspices of the Royal Australian College of General Practitioners (RACGP).[67]

5.148 General practitioners were recruited to participate in the study from the Australian Sentinel Practice Research Network, sentinel members from Central, Southern, Western and Wentworth health areas of Sydney and the national RACGP membership list. By the end of June 1995, 324 general practitioners were participating representing all States. A total of 744

incident reports had been received and 500 of these have been analysed. Incidents were classified as:

- Pharmacological (52 %);
- Non pharmacological (37 %);
- Diagnosis (28 %); and
- Equipment mishaps (5 %).

5.149 Factors contributing to these mishaps were identified as poor: communication between patient and health professional; error in judgement; action of others; poor communication between health professionals; patient had consulted another medical practitioner; failure to recognise signs and symptoms; inadequate review of patients' history; and omission of checking procedure.

5.150 It was considered that 26% of incidents had potential for severe harm. Thirty-five incidents resulted in immediate death of the patient. Seventy-six per cent were considered to be preventable and 45% were considered to have consumed additional resources. Incident outcomes were frequently mitigated by factors associated with chance such as good fortune, the patients' good physical or psychological condition and early intervention by the general practitioner, rather than the existence of systematised fail safe practices.

5.151 Analyses uncovered a relationship between incident type and the factors that contributed to their occurrence, but there were some contributing factors that were common across all types of events. Some mishaps occurred as a result of slips and lapses when the GP was tired or rushed and these often involved lack of systematic review of the medical record or failure to gain an adequate medical history. Such events often led to knowledge-based errors. Another group of knowledge-based errors involved missed diagnoses where the subtlety of presenting symptoms in the early stages of the disease process led to errors in diagnosis and therefore in treatment. Lack of experience with relatively rare conditions often contributed to knowledge-based errors.

5.152 Other knowledge-based errors resulted from system inadequacies. There were inadequate mechanisms in place for the transfer of information between: multiple health providers about a particular patient; GP and patient (particularly where verbal communication was the only form of information transfer); and different sectors of the health care system. Other incidents regarded as preventable arose due to a lack of fail safe systems within the surgery, for example, an alert to the GP to read important test results.

5.153 One interesting issue which relates to other work of the PIR related to patient medical records. Lack of access to and inadequacy of, the patients' medical records was a common underlying problem. Access of information was frequently difficult because the patient attended multiple GPs and/or multiple practices. Where the record was available it frequently failed to provide the practitioner with easy access to important information.

5.154 In an interesting analysis, the pilot project looked at the potential costs arising from incidents in general practice, $50 million – $500 million, and the relative cost effectiveness of incident monitoring. According to its second report:

> The cost of this pilot has been approximately $200,000. Long-term continual incident monitoring in general practice, including development of preventive strategies, and evaluation of their impact would cost approximately $150,000 per annum. Even a 1% reduction in incidents could save up to $5 million per year as well as reducing the significant morbidity load on the community.[68]

It was concluded that the monitoring and analysis of incidents in general practice, together with the development, promotion and evaluation of interventions should continue under the auspices of the Royal Australian College of General Practitioners.

Australian Health Care Incident Monitoring Study

5.156 The Australian Health Care Incident Monitoring Study was established in early 1994 to develop incident monitoring across entire hospital systems.[69] The APSF was commissioned to conduct this study and six hospitals in four States were recruited to participate – The Royal Adelaide and Women's and Children's Hospitals in South Australia, Monash Medical Centre in Victoria, the St George and Royal North Shore Hospitals in New South Wales, and the St John of God Hospital (Subiaco) in Western Australia.

5.157 The support of Chief Executive Officers, medical and nursing administrators and a range of functional units within each of these hospitals has been generated. Functional units can use the information as part of their clinical reviews or to resolve problems which are specific to their area, for example a slippery bathroom floor, a malfunctioning machine or poorly implemented procedural guidelines. Each incident report is processed by the APSF and analysed to develop information that can be reported to functional units and hospitals.

5.158 This study is at a preliminary stage and has been under way in most hospitals since mid 1994. Of the six hospitals participating, only four have commenced collecting a significant number of reports. One thousand and six reports have been analysed. Preliminary analysis of the hospital wide data revealed that a satisfactory pattern of incidents is being reported and that deaths, morbidity and additional hospital days were being found. There was considerable participation by nurses who are reporting traditional types of incidents such as falls and medication errors. While the rate of reporting by medical staff and other disciplines has been initially low, there has been a gradual increase. This appears to be in response to a monthly newsletter distributed to all units participating in the study. This type of study provides a systematic approach to analysing data from both specialties and hospitals, which may yield better information about many of the more expensive and harmful accidents and incidents such as have been exposed by the Quality in Australian Health Care Study.

5.159 An encouraging aspect of the study is that the rate of reporting of actual adverse events (as defined by the Quality in Australian Health Care Study) is about 80 per 1000 incident reports. In the first 1006 reports there were five deaths, three cardiac arrests and some severe injuries such as fractured femurs. A total of 28 patients spent at least an extra 115 days in hospital and there were 78 injuries. There were other reports of injuries but these would not result in an increase in hospital stay or a disability. In addition, another 95% of the incident reports contain a wealth of detail of relevance to avoiding morbidity and mortality and improving the processes of the health care system.

5.160 The incident reporting form used by all participating hospitals raised a number of issues, particularly that *this was yet another form to fill in*. Some hospital staff have up to

eight different reporting forms which they are expected to locate and complete in the event of an incident. This leads to poor compliance and raises the question, if such large amounts of data are being collected, what is being done with it?

5.161 The form has been adapted in an attempt to satisfy the requirements both for events in which the patient and reporter need to be identified as well as for the anonymous incident monitoring. This form includes two additional detachable front pages in carbon copied form. These pages satisfy the needs of managers who require identifying information regarding risk management, insurance, complaints, nursing and medical administration, and occupational health and safety. The remainder of the form, which is detached from these identifying pages satisfies incident monitoring by being anonymous and non-identifying. It includes space for free narrative, structured questions and a page to accommodate the requirements of individual specialties or functional units. It is currently being tested.

Incident monitoring: the next phase

5.162 The results of the specialty-based studies and the pilot study in the six hospitals of incident monitoring across the whole system confirm that it is possible to get useful information using this methodology in disciplines other than anaesthesia. One issue which has arisen is the multiplicity of reporting forms – in hospitals where the institution-wide projects are progressing as well as a number of specialty-based projects, this causes confusion and probably discourages participation. Similarly the need to notify certain incidents for other reasons and different systems in an identifying manner was an issue that has been addressed in the latest *multi-purpose* reporting form currently being field tested in the institutional pilot project.

5.163 It is interesting to note that there were many common conclusions about the nature of the incident reporting forms by the different participating colleges. The variation between them was significant at the beginning. Forms were much more similar to each other at the end of the projects. The form currently being field tested as part of the institutional pilot drew on these common features together with what had been learned from the various pilots projects about useful questions and formats. The challenge now is to build on the common features and to address the more significant issues to do with multiple reporting.

5.164 Two significant developments which need to be completed are the finalisation of the user-friendly Windows-based incident inputting and inquiry software, and the further development of the incident classification method. The developments are both parts of the General Occurrence Classification system discussed further below.

5.165 The Commonwealth has, under the National Hospital Outcomes Program, proposed to fund the establishment of a national health care incident monitoring system to build on the pilot projects funded by the PIR. The emphasis of this project will be on :

- the development of a single national incident monitoring database under the control of an independent, non-government agency, which collects and analyses incidents from hospitals participating in the project so that incident monitoring can achieve a national focus;

- the involvement of colleges, different levels of government, industry and health care consumers on the board of the independent agency to ensure that the national data gathered is used most broadly for the improvement of patient safety in Australia;

- the development and finalisation of an acceptable common form, probably with the capacity to have one page with specific questions for different specialties or specific institutional based studies included, and the General Occurrence Classification system, with the involvement of colleges and health professionals;

- the testing of feedback mechanisms and referrals to interested groups, for example, colleges, States and individual hospitals, in a manner which protects the anonymity of individuals, facilities and incidents, while meeting the specific information needs of these groups; and

- the endpoint, within two years, of a self-funding national database, funded and managed by the users.

5.166 The need for a common form and data collection point is important as different jurisdictions determine whether they wish to extend the operation of institutional incident monitoring more broadly and as individual hospitals decide to participate. For example, the South Australian Government decided that all public hospitals are to participate in incident monitoring, and many enquiries have been received from other hospitals elsewhere who are keen to participate. **The PIR strongly supports the continued development and refinement of incident monitoring under the National Health Outcomes Program and other quality initiatives at the state basis, with its extension to a national self-funding patient safety improvement system across all disciplines being the end-goal. (Recommendation 64)**

5.167 Whether a single data collection point across hospitals and general practice is necessary for effective continuation and expansion of incident monitoring in both hospital and non-hospital sectors is probably less certain. With the moves towards more integrated health care overall, there is much to be said for it. Such an integrated model would allow better detection of system interface problems, and allow the analysis of cross-sectoral difficulties, as identified in the psychiatry pilot. An integrated model may also be useful, were analysis of incidents to be undertaken at a regional health care level in the future, that is, across all service providers and a number of facilities.

5.168 So far as hospital-based data collection is concerned, given its existing expertise and infrastructure, its independent status, and its capacity to modify its board composition to meet the aims set out above, the Australian Patient Safety Foundation is elsewhere seen as being the starting point for the next phase of development. Proposals will be sought from current participating medical colleges and societies and hospitals to continue incident monitoring within the context of this revised national focus.

The General Occurrence Classification (GOC)

5.169 As incident monitoring has progressed, it became clear that the various available classifications, including those used in the Quality in Australian Health Care Study grouped together large amounts of useful information into aggregated information, which was much less useful determining preventive strategies. In its final report to the PIR, the AIMS pilot

project noted:

> The data only became of practical use when a body of information is obtained about clinically identifiable phenomena. For example, it became apparent, when teams of analysts were working on the "Which Monitor?" ... project [discussed above in paragraph 5.108] that identifiable entities, which came to be known as "clinical situations" were the key to obtaining a useful tool for reducing morbidity and mortality.[70]

5.170 This led, to the development by the APSF of a classification based on these clinical situations. While the classification was quite detailed, the study showed that :

> … 80% of all the incidents occurring in association with general anaesthesia were accounted for by only 20 "clinical situations", and 99% of all incidents under general anaesthetic were accounted for by only 60 "clinical situations". In fact 98% of all incidents reported to AIMS could be classified into about 100 "clinical situations". This reveals that the world of anaesthesia morbidity and mortality is more finite than one might have imagined.[71]

5.171 However, when the APSF came to look at the classification of incidents as part of the institutional pilot project, a broader classification need was identified. A system was needed to allow the analysis of events by clinical situation, and also to allow analysis using other variables and subsets, in a very flexible manner. For example, a hospital pharmacist might be interested in all wrong drug cases, where as a clinician may want to know about all wrong drug cases in their specialty. A manufacturer or therapeutic goods regulator may want to know all incidents involving a particular drug. Nurses may want to examine drug errors involving nursing staff. The challenge was to determine a relatively simple and user-friendly classification system, which would allow these diverse groupings of factors to be adequately and simply coded, that is, without duplication, or using complex numbering systems, and then easily accessed from all incidents reported across the health system.

5.172 A major conceptual breakthrough in developing this classification was the realisation that most existing classification tools did not describe the essence of an event:

> The only real feature [of an incident] is that it is a readily identifiable phenomenon. Virtually all people with experience in the area, on reading the free narrative, will come to the same conclusion about "what happened". ... The GOC is so set up that a coder can classify the essence of an event using easy to access choices which have been determined by groups of expert analysts.[72]

The GOC currently under development provides a framework for the classification of an event or incident in just such a manner. The classification tool allows the classification of a subject (usually a patient in this form of incident monitoring, though it could be a piece of equipment, member of staff or visitor to the facility), the process which affects them, and the outcome for the subject, as well as information about the time and place or context, the disciplines involved, various environmental and organisational factors, the actions involved (including preventive actions) and the errors (and any defences to these).[73]

5.173 The coding currently being developed is an infinitely expansible but structured

database, presented in a Windows format for the analyst or coder. It presents the coder with a series of windows seeking further information, but for ease of operation anyone window only contains 5–6 choices, systematically timed to flow logically through an incident. It allows classification of multiple contributing factors, and several incidents arising from the one report – in such cases the relevant data is electronically linked but can be analysed separately as well. It allows the tagging of reports from different sources in the one database (which can then be separated if necessary), or the common coding of such events in a number of databases which can be compared when a particular clinical situation is being examined across different databases. For example, it is hoped that as well as being useful for classifying incidents, the adverse events from the Quality in Australian Health Care Study will be able to be classified, as will other potential data sources, such as patient complaints and legal cases. If the development of the classification is successful, it may provide a useful tool for national data collection by medical defence organisations, State based complaints bodies and public sector health care professional indemnity litigation.

5.174 The development and refinement of the GOC is a major focus of the next stage of incident monitoring. The current institutional incident monitoring pilot project is using the prototype successfully, but much work is required to develop the screen descriptors in various specialty specific areas. **The PIR strongly supports the development of an integrated General Occurrence Classification system, which is based upon common occurrence descriptors, as is currently being developed through the Australian Patient Safety Foundation. (Recommendation 65)**

H. Funder responsibilities for quality of care

Credentialling and accreditation (certification)

5.175 Credentialling was discussed in the context of risk management in the Interim Report. The PIR recommended its use in health care establishments, but noted the potential for unintended and inappropriate consequences in restricting the practice of some individual health care practitioners.[74] Accreditation, or recertification, was also examined with respect to health care professionals and their professional associations. The PIR sought submissions on the effectiveness of such strategies in preventing adverse patient outcomes and maintaining professional standards of practice.[75]

5.176 Expressing support for the Interim Report's initiatives to minimise the number of adverse patient outcomes, a correspondent noted simply that a number of the initiatives should be pursued as a matter of urgency including, "... a broader use of credentialling, to apply across the whole range of health professionals."[76] In more detail, another correspondent wrote about private hospitals' experiences with credentialling.[77] Doctors' training, experience and history, including adverse outcomes, are taken into account when they apply for permission to provide services within a hospital. Hospital boards are alert to the possibility that doctors may wish to protect their patient population from competition. There was also concern about a hospital's possible risk of incurring litigation should it refuse to credential, modify or withdraw privileges from a doctor. It should be noted that under most State quality assurance confidentiality legislation or similar legislation, there is no protection comparable to that offered under the Commonwealth's legislation discussed above. Few activities of this kind have been sought to be declared under these provisions.

5.177 From a nurse's perspective, another correspondent noted that evidence of studying or working in relevant fields was a condition of certification in Queensland.[78] This correspondent said, "One cannot maintain skills without practice." Credentialling, it was thought, would cause some upset in the professions and lead to withdrawal of services in some areas, but it may also be responsible for better-trained and skilled staff.

5.178 One professional medical college provided the PIR with extensive information on its quality assurance activities, including details of its policies on credentialling and re-certification.[79] The role of credentials committees was listed as, "... to define clinical responsibilities of appointees, including continuing responsibilities and withdrawal of responsibilities". Requirements for re-certification include regular and adequate involvement in continuing medical education and surgical audit programs, together with credentialling.

5.179 In recounting personal experiences with accreditation, one correspondent wrote that nothing beats a regular examination, say every seven years, to assess a health care professional's ability to continue to practice.[80] This correspondent also noted that professional colleges may resist the proposition as it would mean re-studying subjects and many college members are likely to be of advanced age and not interested in sitting exams again.

5.180 One real problem with the implementation of effective credentialling and recertification at the moment is the absence of adequate performance data at an individual level and the absence of specific performance standards against which to make judgements about individual performance. Without such performance standards, and then follow-up measurement of actual performance, it is unlikely that credentialling or recertification would improve standards of patient care. In fact, it is more likely that it would be used as a restrictive trade practice and to support the existing supply monopolies of various established elites in health care without any guarantee of improved patient safety and care. The lack of such information was also identified as a problem in the recent Baume report on surgery in Australia.[81]

5.181 Similarly, it seems unlikely that the broad approvals traditionally accompanying visiting rights at an institutional level are providing a useful guarantee of quality of care. For example, to be credentialled to practise surgery would give no greater guarantee of quality of care than similarly broad visiting rights now provide.

5.182 Credentialling and recertification need to have standards and sub-divisions of practice rights related to specific skills to be exercised by the practitioner to the requisite standard. By specifying standards in this way, rather than primarily on an educational qualification, it is possible to limit the restrictive trade practice elements that often accompany discussions about credentialling. Such skill-based assessments of tasks are not new - the National Office of Overseas Skills Recognition has been encouraging the development of competency-based assessment in the professions for some years. **The PIR therefore continues its support for credentialling activities as an effective quality assurance activity, but only where such credentialling is based upon evidence-based, skill-specific standards, which can be demonstrated to benefit patient care and outcomes, which can be measured and which are measured in an individual health professional's practice. (Recommendation 66)**

5.183 Once such skill standards are established and measured, the question is whether such information or parts of it should be made available to individual patients. The issues discussed in Chapter 3 relate to this. Is it sufficient for a patient to know that the particular professional has practising rights in a specific procedure or area, or does the patient also need to know information such as the individual's adverse event rate or other performance measures compared to his or her colleagues (and potential service provider competitors). Given how far we are currently from having any such standards and standards monitoring upon which to base proper credentialling, the PIR will not seek to answer this question at this time. The question will, however, need to be considered in the future, as part of the broader debate about patient access to provider performance information discussed above and in earlier chapters.

Government obligations for quality assurance in its own health care programs

5.184 As discussed in Chapter 4, the PIR believes that the promotion of specific government-funded health programs brings with it various responsibilities for the level of government that is the funding source. It can be argued that one of these responsibilities is the overseeing of effective quality assurance activities, including the establishment of strict performance standards and adequate performance monitoring. Ideally, funding should be linked to adequate performance to ensure that patient safety is as strongly protected as it can be.

5.185 To provide an example at the Commonwealth level, the PIR explored these issues in relation to the operation of the Commonwealth Government's National Cervical Cancer Screening Program, discussed in some detail already in Chapter 4. The importance of quality and performance standards and specific problems in these areas were identified by the 1991 report of the Cervical Cancer Screening Evaluation Steering Committee (CCSESC), which was established by the Australian Health Ministers' Advisory Council.

5.186 The CCSESC identified that the quality of Papanicolaou (Pap) smears was sometimes poor, the standard of cytology within the pathology laboratories was low and there was no consensus on the best management of abnormal smear results.[82] To address these problems the CCSESC recommended the establishment of a Steering Group on Quality Assurance in Screening for the Prevention of Cancer of the Cervix to examine and strengthen quality assurance activities in the prevention of cancer of the cervix.

5.187 The report of the Steering Group, titled *Making the Pap Smear Bette*, was released in early 1993. It notes that effective prevention of cervical cancer depends on each step of the screening procedure being carried out effectively and reliably.[83] The Steering Group made recommendations for improving the quality and reliability of all stages in taking, testing and reporting on Pap smears and associated diagnostic procedures, together with revised guidelines for accreditation of laboratories. Those that relate to smear-takers are discussed briefly in Chapter 4.

5.188 An effective quality assurance program in cervical cytology in the laboratory should aim to minimise the number of invasive cancers and pre-cancerous lesions are not detected that is false negatives, as well as the number of cases where an abnormal result is given in the absence of disease, that is false positives. As discussed in detail in Chapter 4, there is great

variability between different laboratories so far as the error rate is concerned. The PIR received submissions which indicated that even for detection at the CIN3 level, world standard laboratories had an irreducible 10% laboratory error rate, arising from the inherent limitations of human and machine screening, and abnormal cell identification difficulties in some cases. However, for consumers, it is not possible to know which laboratories are world standard laboratories, as error rates are not available publicly and, in fact, are not measured by many laboratories. The PIR notes error rates are not available for other areas of laboratory and medical practice and this problem for consumers is not limited to cervical cytology.

5.189 Theoretically laboratory accreditation could be one way of addressing this difficulty for consumers, particularly if funding for the procedures is linked to accreditation. Such a model is already in place in Australia, with a Commonwealth pathology accreditation process in place for laboratories requiring to receive Medicare benefits. National quality guidelines for laboratories performing cervical cytology were developed by the National Pathology Accreditation Advisory Council (NPAAC) and published in 1993.[84]

5.190 When these guidelines are examined, what is striking is the absence of actual performance measures or standards. In particular, they do not set out any standards about false-negatives or false-positives, nor do they provide any guidance about how such important performance indicators should be derived, if a laboratory wants to do this. They are principally about organisational requirements – minimum staffing levels (so that no primary screener does more than 80 slides per day), staff training and identification of slides. The standard on Quality Control is non-specific, simply requiring participation in an external quality assurance program and having some internal quality control mechanisms in place. The standard on reporting is more specific about what should be included in a Pap smear report.

5.191 Practitioners have traditionally claimed that there are problems with creating more specific standards because of inherent difficulties in the test. For example, the currently widely recognised criteria for the histological definition of CIN are considered to be highly subjective and considerable inter-observer variation is recognised. Thus defining and measuring false-negative and false-positive rates are problematic. If this is such a degree of definitional uncertainty, questions must be asked about the so-called 10% world standard and whether it has any significance in Australia today.[85]

5.192 There is a range of procedures which could be used by individual laboratories to improve and maintain the quality of internal test reporting:

- re-screening samples of slides with negative reports;
- analysis of screening reports for each Pap smear reader;
- reviewing earlier Pap smears where there has been a worsening of diagnosis;
- comparing positive smear results with subsequent biopsy results; and
- reviewing earlier Pap smears of cervical cancer cases.

Some of these are already in place in existing laboratories, though there are no industry-wide standards in these areas to allow the laboratories to determine their relative performance.

5.193 The National Cervical Screening Program recently developed draft performance standards for laboratories, addressing some of these areas. Following funding in the recent

Budget, these will be trialed in conjunction with the Royal College of Pathologists of Australasia. The draft performance-based standards cover:

- the profile of cytology reporting, that is, proportion of slides reported as unsatisfactory and reporting categories for satisfactory smears;

- accuracy of cytology reports predicting a high-grade abnormality, i.e. proportion of women predicted on cytology to have a high-grade intraepithelial lesion where histology confirms such a lesion; and

- review of preceding negative cytology in women with CIN3.[86]

5.194 The PIR notes that performance-based standards are expected to become a requirement for laboratory registration and accreditation. Moreover the Commonwealth Government's National Cervical Screening Program does not control standard setting, or the laboratory accreditation process. The NPAAC is the authority on standards and the Health Insurance Commission administers accreditation. Where there are a number of bodies involved in different aspects of standard-setting, effective co-ordination is critical for the standards to be implemented. The NPAAC has revised its standards for gynaecological cytology to include reference to performance-based outcome measures which bodes well for the future.

5.195 In relation to another issue of interest to the PIR, there is no inclusion of any reference to carrying adequate professional liability cover in the event of damage to a patient from misdiagnosis. Anecdotes provided to the PIR indicate some laboratories do not hold separate cover, but rather rely on their employees holding their own cover. Given the laws on vicarious liability, as well as laboratories' probable independent duty of care obligations, this would seem to be totally inappropriate and fiscally irresponsible. **The PIR recommends that the holding of adequate indemnity cover be required for pathology bodies to be accredited under the Commonwealth legislation. (Recommendation 67)**

5.196 Significant efforts are clearly being made by the National Cervical Screening Program to provide some guarantees of service quality for health care consumers, and for the funding provided. Setting rigorous performance standards and requiring adequate performance and monitoring of performance for accreditation and funding are still some way off, but clearly substantial efforts have been directed at achieving this over a considerable period of time.

5.197 Where performance monitoring is put in place, there are good reasons for the resulting data being made available to consumers, so that they can choose services with the best quality to meet their health care needs. At a minimum, health care consumers should know the broad standard of performance of a service provider in government-funded programs.

5.198 **The PIR recommends that all government-funded health programs should develop and put in place specific and appropriate performance standards and monitoring processes where they are not already in existence. This should include adverse event recording in these programs. Such performance data should be used by government to inform itself about the overall efficacy of the program and of different service providers. Funding should be contingent upon these measures being in place, and upon continued reporting of this information in an appropriate manner.**

Consumers should be able to have access to this information - both about the program overall, and about specific providers. (Recommendation 68)

5.199 The Commonwealth has identified quality of care as an important issue in hospital funding. Not only does the Medicare Agreement specifically refer to the issue of quality of care, but the new National Hospital Outcomes Program funded in the last Budget, is seeking to develop an Integrated Quality Management Model for Australian Hospitals. Demonstration activities will be funded which assist hospitals to review their management practices and respond with quality and outcome improvements, including ways in which patient records and other relevant data can be routinely reviewed and problems identified and acted on.

5.200 A public tender process has commenced for a consultancy to develop and implement a comprehensive integrated quality management program at one or more acute care hospitals in Australia, which can be adopted as a model for the hospital industry. The quality program must have a strong focus on developing and implementing a structured mechanism for reviewing patient medical records, including a mechanism for identifying quality problems and implementing corrective strategies to improve patient safety.

5.201 Such quality obligations on service funders have also started to be acknowledged at the State level, for example, in the recent Victorian Department of Health and Community Services issues and options paper *Towards a New Framework for Quality in Victoria's Hospitals*. This paper, which was prepared by the Health and Community Services Committee on Quality established last year, concludes that a broad quality strategy is needed for Victoria's public hospitals and the Department of Health and Community Services to inform consumers, encourage hospital-wide quality improvements and satisfy government responsibility for monitoring and public accountability.[87]

I. The tort system and quality of care

5.202 The tort system is theoretically supposed to improve or maintain the quality of care, through deterrence of poor behaviour by health care professionals and through publicity of cases educating the public and professionals about what is an appropriate standard of care. As was discussed in Chapter 3 of the Interim Report[88], there are also some possible negative impacts on quality of care due to the tort system, such as the practice of defensive medicine and fear of litigation leading people to deny problems, rather than recognise and address them at an early stage. The tort system is also cited as a reason for secrecy and non-disclosure of information, which can indicate quality problems.

5.203 The information within the tort system can provide a rich data source on the kinds of events which cause patient harm and give rise to litigation, as well as possibly providing some indication of individual performance or communication problems. As discussed in the Interim Report, the failure of communication in many different ways can lead a patient to sue, and good communication may avoid such action, even where there is negligence. While a single legal action against a practitioner may not indicate a professional in need of assistance, a series of such cases could indicate problems in relation to either quality of care or communication, which may require assistance to be overcome.

5.204 Unfortunately, at the moment there are generally no mechanisms that allow either a system-wide analysis of tort data or any individual feedback methods, except in South Australia, as was discussed in the Interim Report.[89] This section outlines how analysis and

feedback from the tort system could operate, as well as providing information on so-called defensive medicine.

Tort system-wide feedback

5.205 One of the claimed benefits of the tort system is to encourage the maintenance and improvement of standards by providing compensation for damage that arises from a shortfall in the acceptable standard of care that should have been provided. This can only be achieved if systematic feedback mechanisms exist, for example between medical defence organisations and professional colleges.[90] There are currently no systematic feedback mechanisms from the tort system to service providers, funders or professional standards bodies about the kinds of cases which are giving rise to tort actions.

5.206 If the tort system is to achieve its objective of improving and maintaining standards and deterring poor conduct, it cannot simply rely on the small number of cases that are publicised when they reach courts. These cases are a very small proportion of those where litigation commences. They usually involve the issue of negligence is, and so can give a very biased picture of the health system's trouble spots. There is a need to look at all cases commenced, and probably even all incidents notified, if the tort system is really to help improve quality of care.

5.207 Given the individual reluctance of medical defence organisations and insurers to provide such data for commercial reasons, probably the establishment of a non-identifying national database on these cases, as discussed in Chapter 2 and Chapter 9, could further these processes. The development and use of an appropriate classification system as discussed above in relation to incident monitoring is also an important element in effective feedback provision.

Individual notification of tort claims

5.208 The PIR has actively examined the South Australian system, where any settlements or judgements involving a medical practitioner must be notified to the South Australian Medical Board under section 72 of the *Medical Practitioners Act 1983*.

5.209 Previous studies indicated that negligence claims against a medical practitioner are not, on their own, a good indicator of poor quality of care, partly because so few cases of negligence result in a tort action and tort actions sometimes do not involve negligence.[91] One problem identified by the United States Office of Technology Assessment (OTA) in using tort data to examine individual performance was the poor quality of available data on tort cases.[92] In the late 1980s, following the passage of the United States *Health Care Quality Improvement Act 1986*, a National Practitioner Data Bank was established, where all settlements or judgements made in medical negligence cases had to be reported, and the OTA recommended that this issue be re-examined once sufficient data had been collected under that system.[93]

5.210 The Data Bank is available for potential employers of doctors to search to identify their claims history, but it is not currently open to scrutiny by consumers. Subsequent analyses have shown that there is a predictive value for future claims through looking at past claims. The analyses show that the predictive value increases with larger claims and with

multiple claims, but that even where there is a history of having a single unpaid claim, the chances of a future claim occurring almost double.[94]

5.211 While there is still considerable debate about whether claims history is a good predictor of poor quality care, there is certainly good evidence that it can be one sentinel indicator, particularly if there are a number of claims.[95] It can serve as a trigger (perhaps somewhat belatedly given the time delays and the fact that patient damage may well have resulted) that there may be quality concerns with the individual practitioner which justify further investigation and remedial action, if appropriate.

5.212 The data currently collected in South Australia from section 72 reports are not publicly available and very little analysis is undertaken of the data in any on-going way to determine patterns of poor practice. The Board considers there are legislative barriers to it investigating behaviour that occurred some time before, and considers that this would need to be addressed both in its own and any other similar legislation, if proper follow-up was to occur. When the Board becomes aware of someone with multiple claims, ad hoc action may be taken. A major drawback is that the Board only receives notice after the cases have been finalised - often very many years after the alleged negligence. The Board considers the notification of any claim commenced could address this issue.

5.213 Even with these limitations, the PIR believed that the data on the reports could provide useful closed claim information. A study was commissioned by the PIR with the Medical Board of South Australia in December 1994 to provide de-identified information from a review of the section 72 submissions made by medical practitioners to the Medical Board. An analysis of this information is included in Chapter 2. As noted there, while this information is useful in terms of payment patterns, it cannot provide data on emerging claims trends. Amended legislation as suggested by the Board may be able to fulfil this need. If other efforts to create a national database of claims information are not successful, this could provide an alternative source for de-identified national data.

5.214 The advantage for quality of care of the data lodged with the Board compared to de-identified claims data is that it does identify individual practitioners, and so the Board can use it as a trigger to undertake further examination of practitioners if they have repeat actions settled against them. **The PIR recommends that similar legislation to section 72 of the *South Australian Medical Practitioners Act 1983* (SA), which requires a doctor to provide details to the Medical Board of any finalised tort case, where he or she is a defendant, be enacted in all Australian jurisdictions. (Recommendation 69) The PIR further recommends that similar legislation should be explored for all other registered health professionals, to provide a positive quality link between the tort system and the registration system. (Recommendation 70)**

Defensive medicine

5.215 The PIR's separate reports on defensive medicine showed that while there appeared to have been many practice changes because of fear of litigation, many of these changes were probably beneficial for patient care. These included better record keeping, spending more time explaining things to patients, seeking second opinions and a range of other practice changes which may, in fact, have enhanced quality of care, even where this had possibly led to additional costs to the health care system.[96]

5.216 However, there are claimed to be practice changes that have arisen because of fear of litigation, and that they serve no useful purpose for the patient. This is a quality of care issue. The tort system relies on evidence about the efficacy of certain tests or procedures. If they serve no purpose except to allegedly protect a health professional from being sued, the opposite could be the result. Recent judgements have suggested that a doctor's overriding consideration in determining what to do should be the interests of the patient rather than self-protection.[97] The direction of these cases would seem to indicate that treatment and diagnostic processes that serve the doctor's rather than the patient's interests may also be a breach of duty.

5.217 **To address both the fears and uncertainty of doctors and other health professionals and the need to maintain and improve quality and appropriateness of care for patients, the PIR recommends the identification of areas where defensive health care practices are said to exist, followed by the development of clinical guidelines to indicate whether, and in which circumstances, these processes are necessary or clinically advisable. (Recommendation 71)** This would allow an evidence-based adjudication by the profession of these areas of concern and hopefully minimise unnecessary and sometimes dangerous interventions on patients.

J. Risk management

5.218 The theory of risk management was discussed broadly in the Interim Report and that information will not be repeated here. There are two main related but separate directions being pursued in relation to risk management – proactive risk management, which attempts to reduce risks before an adverse event occurs and reactive risk management, which occurs after an event has happened. Both models have been observed overseas and serve useful purposes in minimising the human and financial costs of adverse patient outcomes. Neither model was broadly used in Australia at the time of the Interim Report, but both are now being pursued with vigour in some places.

Proactive risk management

5.219 Proactive risk management activities is a generic name for a range of different activities directed at minimising the risk of adverse events occurring. Proactive risk management starts with experiential data, such as that produced by incident monitoring, retrospective studies like the Quality in Australian Health Care Study, complaints and claims data, and surveys that seek the views on risks of people working in particular areas. These data are used to develop checklists and similar tools that can be used by managers to ensure that the chances of something going wrong are minimised – in the terminology used earlier in relation to human error psychology, the number of resident pathogens waiting for the right circumstances to cause harm are reduced.

5.220 Other industries have used these error prevention techniques with great success, though they are a relatively new phenomenon in health care. They are based on a philosophy similar to that of various treatment protocols, crisis algorithms and guidelines in that they act as reminders for prompt, appropriate action.

5.221 The PIR is aware of the extensive development of these techniques by different organisations in Canada and in England, and some preliminary efforts in this direction in Australia. The Healthcare Insurance Reciprocal of Canada (HIROC), which is a mutual

insurer covering private and public sector hospitals across Canada, provides Risk Management Assessment modules to its members, in areas of hospital function where HIROC has experienced significant claims frequency or severity.[98] These modules are self-administered by management in their member organisations. Their operation was described in the HIROC annual report in the following manner:

> The purpose in creating the Assessments was to provide a tool that would assist hospital management in educating staff in the specifics of risk management, and help in reviewing risk management activities. It should not take long for each service head to assess individual operations using the module and then decide what changes, if any, should be made.[99]

HIROC also provides individualised risk advice, and puts members with similar problems in touch with each other to share solutions.

5.222 Related United Kingdom initiatives were presented by Mr David Bowden of Merrett Health Risk Management Ltd at the PIR's incident monitoring conference in November 1994.[100] He emphasised the importance of proactive risk management, rather than simply waiting for something to happen, through :

- ensuring staff want to identify all those risks with the potential to develop into adverse events and claims;
- keeping people informed about what is expected of them;
- undertaking a holistic risk identification and assessment survey and audit;
- involving staff by asking their views; and
- placing management emphasis on prevention rather than cure.[101]

The Clinical Risk Assessment methodology developed by Mr Bowden includes the assessment of risks in a broad manner – covering staffing, facilities, standards of care, communications, clinical support services, incident reporting, training and education, security issues, contingency plans and organisational issues – either by the manager with guidance or by an external expert consultant.[102]

5.223 The United Medical Defence MDO has recently introduced a proactive risk management process, whereby it sends out risk managers to inspect practices of members to identify risks and inform practitioner members how to minimise them. Initial visits have, to date, shown high levels of unprotected risks in many practices. The system has not been in place long, but return visits have shown improvements in the management of risks.[103]

5.224 A self-assessment or practice-based proactive risk management methodology could also be a useful tool in quality improvement for general practice, particularly given the information on incidents being gathered in the general practice incident monitoring project discussed earlier.

5.225 **The PIR recommends that proactive risk management methods be developed and implemented in all parts of Australian health care practice. The data being obtained from incident monitoring and the Quality in Australian Hospital Care Study will provide important basic information to facilitate this. These methods should be included in an Integrated Quality Management Model for Australian Hospitals to be developed as part of the National Hospital Outcomes Program. Priority should also be given to developing useful proactive risk management assessment tools for general practitioners and other primary health care providers. (Recommendation 72)**

Reactive risk management

5.226 Even with the best proactive risk management systems in place, there will be some adverse events. Risk management after the event shares the aim of reducing the human and financial costs, but it operates through overcoming the consequences and ameliorating the effects of an event, rather than preventing it occurring at all. It often links closely into legal claims management and is often seen as a defensive strategy against the incidence and cost of litigation.

5.227 The Victorian Health and Community Services Department's insurance broker Steeves Lumley[104] actively pursues risk management as part of its claims handling processes, as does the South Australian government[105]. Various medical defence organisations are also becoming more active in risk management. Similar processes are used in various overseas jurisdictions such as the United States and England, through organisations such as Professional Risk Management, the work of which was summarised in the PIR's Interim Report.[106] These organisations appear to have been very effective in controlling the costs of litigation, even in such high litigation places as California. The outline of the methods of reactive risk management used by these organisations is generally similar.

5.228 An important first requirement is very early reporting of incidents – often within hours of the event in potentially serious cases. This takes various forms. It can be through a phone call, a written report or both. In the English model used in the University College London hospitals, there was a list of *notifiable events* which staff were required to notify to management, within various timeframes.[107] These included obvious incidents such as unexpected death and injuries specifically related to health care, where the health professional believed legal liability might subsequently flow, as well as incidents where claims, complaints or other data showed up as matters for concern, whether or not any error was suspected.

5.229 Early notification allows:

- prompt, sensitive and full communication with the person who is at the centre of the incident and the family about what occurred and what, if anything, can be done to overcome any ill effects of the incident, and to answer any questions the person or their family may have;

- early efforts to ameliorate the consequences of the incident and, where possible, make things right, for example, through appropriate apologies, remedial care or waiver of accounts;

- the collection of evidence while it is still fresh and untainted by later activity;

- the gathering of contemporaneous statements about the event from those involved and adequate documentation of the events;

- where appropriate, prompt counselling and support for the professionals involved;

- early action to prevent recurrence in appropriate cases;

- sensitive and prompt handling of the person and their family, to minimise anger and resentment, both of which can lead to litigation; and

- the early determination and payment of liability, when costs are likely to be least.

5.230 After early notification, the continuing process of risk management is designed to ensure the injured person and the 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. If payment of compensation is later sought by a patient, the risk manager is in a good position to advise on whether or not payment should be made, all the necessary evidence will be already collated, and the case will be able to be prepared for defence or settlement promptly and at lower cost.

5.231 A pilot study, looking at whether or not risk reactive management processes could be cost-effective and how they could relate to incident monitoring was conducted as part of the PIR's research. This study was funded jointly with the South Australian Health Commission. The South Australian Risk Management Study took place in two of the hospitals participating in the institutional incident monitoring pilot, the Royal Adelaide Hospital and the Women's and Children's Hospital.

5.232 The aim of the project was to ascertain whether or not institutional incident monitoring could be integrated with risk management and quality activities and whether it could be demonstrated to State, regional and hospital authorities as an option for preventing and managing adverse patient outcomes and minimising recourse to the tort system. The incident reporting form alerted the person completing the form that if they thought the incident could result in a formal complaint or legal action by a patient or relative, they should alert their hospital risk manager and complete separate documentation for that purpose.

5.233 Risk managers were employed in both hospitals to undertake this work. This pilot sought to demonstrate that through early intervention, costs of litigation can be controlled and assistance can be better targeted to those who experience an adverse outcome, as well as providing assistance to health care professionals who are involved in potential or actual litigation. The success of this pilot may provide a useful model for other States. This pilot was due to be completed in mid-1995, with the results thus far indicating a high level of management satisfaction, and the likelihood of continuation and expansion of the initiative.

5.234 The report from this study identified an anomaly.[108] Systematic risk management and early reporting can initially lead to an increase in the number of legal files opened because the possibility of suit has been identified, whereas it once was not.[109] The duration of the study

(12 months) was too short to determine whether there was a corresponding increase in claims actually commenced and what the effect of the risk management program was in terms of speed and costs of resolution.

5.235 Similar results have been experienced in other States and some medical defence organisations. Early notification of incidents appears to have increased generally, though whether this follows through to an increase in actual claims commenced is not clear. This is likely to be a positive development. For some time a major complaint from funders of health care professional indemnity has been that claims occurred many years after the event. While no data have been able to be provided by the medical defence organisations to indicate this is a large problem, the early notification of potential cases can stop this occurring, and allow early collection of necessary information when it is still readily available.

5.236 It is still far from clear whether the increase in notification of incidents is being accompanied by a similar or different increase in actual cases proceeding to litigation and payment. The increased notification of incidents is, however, likely to increase premiums, as the numbers of notified incidents are built into the potential liabilities required to be met in future years. MDOs are likely to take a financially prudent approach to the laying aside of reserves to cover potential liabilities – particularly during the period of uncertainty when the notified organisations are assessing the likelihood of incidents notified crystallising into cases commenced.

5.237 **The PIR recommends the broader use in Australia of reactive risk management strategies to minimise the human costs to those who are injured by an adverse event, and to minimise the financial costs and delays arising from these, whether or not the event gives rise to litigation. (Recommendation 73)**

5.238 In the Interim Report, the PIR raised questions about whether extensions to quality assurance confidentiality legislation may be necessary to protect risk management activities. Where the actions are taken as part of a legal process, then the information collected will be subject to legal professional privilege. However, when risk management activity is separate from legal processes, difficulties may arise. **The PIR recommends that the need for statutory protection of reactive risk management activities, particularly where they are administered in circumstances where legal professional privilege may not apply, be considered in the context of the recommended development by AHMAC of model quality assurance confidentiality legislation. (Recommendation 74)**

Chapter 6: Meeting needs: the priority areas for action

A. Compensation and community assistance

6.1 In its Interim Report, the PIR speculated that very few people who have adverse patient outcomes appeared to seek assistance for the costs (including loss of earning capacity and loss of ability to perform household services) arising from any consequent disability through the tort system[1]. The data from the Quality in Australian Health Care Study discussed in chapter 2 confirm the relatively small role the tort system plays in meeting the disability-related costs of people with adverse patient outcomes. They also showed a significant number of people who had adverse patient outcomes resulting in disabilities that lasted longer than 1 month (30% of admissions), and with minor and major permanent disabilities (2.3% of admissions - with 1.5% less than 50% and 0.8% over 50%).

6.2 The PIR also indicated in the Interim Report that, rather than creating a separate no-fault scheme, which would bring with it its own anomalies[2], its preferred direction for reform was to address the obvious deficiencies in both existing systems.

> "A package of reforms needs to be developed which addresses the manifest shortcomings of the tort system, at the same time as improving the quality of the community's provisions for those with disabilities."[3]

The no-fault conundrum

6.3 As outlined in the Interim Report, most suggestions for specific no-fault schemes for medical misadventure, immunisation injuries or "brain-damaged babies" ignore the real problems of causation and separating out who should be compensated differently from others with similar disabilities and why. In chapter 7, various options for speeding up proof of causation and/or fault are explored, within the context of current defendants paying for these cases. There are strong arguments for using these mechanisms in some cases, where the spreading of the costs of these cases across the relevant sector of the industry is appropriate.

6.4 For example, the PIR received many submissions claiming that there should be no-fault compensation in cervical cancer screening cases, where an abnormality present on a slide is missed by a screener and a woman is later diagnosed with invasive cervical cancer, because it is claimed that there is an irreducible 10% screener error rate even in world standard laboratories.[4] Given that either an inherent system failure or substandard performance may have led to the slide being misread, strict liability could attach in these circumstances, and damages would thus be payable to all these women without proof of individual fault. The costs of similar arrangements for the very rare immunisation injury cases could be attributable to the manufacturers of vaccines. In both cases, these would spread the apparently "unpreventable losses" across the sector that is gaining a direct financial benefit from the process.

6.5 However, it is also true that society as well as the individuals concerned, gains something from these processes, so some argue that any costs of no-fault or strict liability should come from taxation revenue. If such a position were adopted, without any

contribution from those who currently pay for negligence cases, the effect would simply be to increase the proportion of the costs of negligence paid by the community and the injured person, and reduce the contribution to these costs currently met by those who were negligent. This in turn would reduce the overall resources available to meet the needs of those with disabilities, unless more tax resources were diverted to these costs. This does not seem equitable.

6.6 Where a person has a disability from any cause, there are a range of potential sources of assistance - the community, the person and their family or someone else. The current law in Australia is that someone else only has to pay where the disability was caused by their negligence. These costs are often shared among all of a risk group through insurance. In some states, risk groups cover more injuries related to their risk-inducing activity through no-fault arrangements eg motor vehicle owners through no-fault motor vehicle arrangements. However, where no such arrangement has been developed, unless the person with a disability can demonstrate fault and causation, their costs are borne either by the community or themselves. Where compensation measures are inadequate and do not cover the disability-related costs incurred by the injured person, then the shortfall in meeting the person's basic needs will have to be met either through the community or the person's own resources.

6.7 Both State and the Commonwealth governments in Australia already have significant financial responsibilities for many of the costs of disability - health services, various long-term care services, aids and appliances, social security income support. They are already meeting these costs for those who have adverse health care outcomes using ordinary entitlement measures (that is, without regard to causation). In the no-fault medical misadventure schemes in the Scandinavian countries these costs are likewise met by the social welfare system. Their schemes do not fund these costs - they are universally available to all who need them, including those who have adverse patient outcomes, funded from taxation revenue.

6.8 The Scandinavian schemes only provide no-fault non-economic loss and loss of earning capacity gap compensation (that is above their high-level earnings-related social insurance income replacement benefits). These are funded by the health care providers in most cases, sometimes under a statutory scheme, but sometimes under a voluntary scheme of arrangement between the funders without legislation. This can operate because of the different collateral source benefit rules that apply, making the community-funded systems the first and only call for all care needs and for primary income support. Rather than relying on the alleged economic deterrent effects of tying costs back to the health care system to improve the quality of health care services, as was discussed in Appendix D of the Interim Report, quality issues are dealt with more directly.

6.9 In Australia, most legislatures and program managers have opted to put the costs that would otherwise fall to the community on a no-fault no-causation basis, back to compensation arrangements, rather than to act as the first port of call for assistance. This leads to the many practical complications discussed below, including cost-shifting and double-dipping. However, recently economic theorists have justified these practices on the basis that if systems pay the full costs of the results of their actions, they are more likely to produce safe behaviour. While this may be theoretically attractive, there are many reasons

why applicability is limited in the health care and tort system of today. These reasons were discussed fully in the Interim Report[5] and will not be repeated here. Among other things, to work it relies on 100% detection and attribution of costs to the system controllers in cases either involving negligence or where the damage was preventable - a goal that the current system falls far short of on any measure.

6.10 The second, and probably more traditional reason for having the compensation system as the first port of call in compensable cases is the general desire of consecutive Australian governments to reduce taxation or at least contain tax expenditure. Taxpayers' funds are limited, and even demand-driven programs like social security and Medicare are under constant pressure to minimise their expenditure. Finding another funding source is, therefore, seen as reducing the drain on the public purse, while allowing more people to have their needs met from the several sources.

6.11 Whether or not the overall costs to the Australian community are minimised by the existence of multiple potential sources of provision and entitlement determination is a moot point, beyond the current scope of the PIR's work. However, in some areas, there would seem to be scope to rationalise arrangements in a manner which would not reduce the assistance available to those who were compensable, but that might reduce the complexity of arrangements and save the community some costs overall.

Are adverse patient outcomes a special case?

6.12 As a matter of principle, it is unclear why on public policy grounds, a causal connection between a health care incident and a disability should give such a person a greater call upon the public purse than any other person with a similar disability from some other cause. Is a person who is quadriplegic from an illness less deserving of community assistance than someone whose quadriplegia develops as a known complication of their health care?

6.13 It is also unclear why taxpayers' funds should be used to provide a higher level of income support or compensation for non-economic loss in these cases, when the basic needs of those with significant disabilities, (where there are clear public policy reasons for tax payer funded assistance), are not being met to an acceptable standard. Such additional assistance must be considered an "optional extra", which could be considered among a range of other spending options, once all the basic assistance needs of people with disabilities were being met.

6.14 As noted above, many overseas medical misadventure no-fault schemes are funded from health care funds. The need to prove a causal connection between the disability and the medical care is usually supplemented by the need to prove the outcome was unexpected and preventable - thus reintroducing some element related to fault. This is generally because funders are willing to bear the "optional extra" compensation costs arising from those events which it is broadly accepted should not have occurred, in exchange for not having to incur the high administrative costs of litigation. However they believe that the "optional extra" costs of those outcomes which were accepted as a known consequence or risk that was not preventable should not be borne by them. These limitations have a direct effect on eligibility for assistance.

6.15 Because of these limitations and the difficulties in these schemes of demonstrating causation, at least half of those who seek compensation are unsuccessful. However, because what is being sought from the compensation scheme is really at the "optional extra" end of assistance, the overall results are considered more fair and equitable - that is, those who are deemed ineligible for compensation still get all their care needs met to a universally acceptable and adequate standard.

What about "brain-damaged babies"?

6.16 The other group the PIR has received many representations about are neurologically impaired neonates - the so-called brain-damaged babies or children with cerebral palsy. These descriptions are not synonymous, nor are such people an identifiable, homogenous group. Cerebral palsy can develop after birth, as can an acquired brain injury. The levels of disabilities of children within these broad descriptors can vary enormously, as can the nature of their disabilities. The major concern about this group among those who provided submissions to the PIR seemed to be about their impact on the professional indemnity premiums of birthing service providers. These issues are discussed fully in chapter 10. However, there were a range of submissions recommending that a "no-fault" scheme be introduced for such children, and that damages not be available.

6.17 It is now common ground that a small proportion of cases of cerebral palsy arise in the immediate process of birth, and that even fewer probably arise from substandard care at birth.[6] However, there also seems to be a core of opinion that an inappropriately managed birth can, and does in a small number of cases, lead to severe disability and probably more often to the baby's death.[7] Such cases (and ones claiming to be in this group) are the stuff of the current tort system.

6.18 Little research has been done to determine if it is possible to determine with certainty when and why cerebral palsy occurred in any particular child. In some cases, this may be easy, in others (probably the majority at present) it will not be known for certain, with current scientific knowledge, whether or not the condition was in any way related to health care treatment, either before, during or after birth. Any one child's case will be a matter for speculation on the balance of probabilities - the risks of this process and the forensic difficulties are undoubtedly one reason why many tort-based cerebral palsy cases involve relatively low payments.

6.19 Any so-called no-fault system which relies on a connection with health care treatment will face the same problems as the tort system. Inevitably, it will involve high administrative costs (because of the difficulties in demonstrating causation), and will not assist most children with cerebral palsy or children with many other conditions which result in severe neurological impairment or other severe disability.

6.20 If causation is not a useful determinant for assistance, then perhaps it could be linked to the activity of being born. However, it is difficult to see why a taxpayer-funded program should deal differently with those whose disability was temporally related to birth. If a child develops a disability as he or she gets older or even an adult it is difficult to see why on public policy grounds the one whose disability commenced at birth should get preferential assistance.

6.21 Some have argued for a "condition specific" option - that is, special assistance based on cerebral palsy. Once again, it is difficult to see why a child whose disability arises from cerebral palsy should be treated preferentially from a new born child, whose disability clearly arises from some other cause eg unknown genetic problems or unknown teratogenic chemical exposure.

6.22 The one characteristic that seems to make sense and to be equitable is basing the assistance for the child upon their level of need for assistance, whatever the cause, and as they grow, or if they acquire a disability at some later stage, ensuring they continue to have appropriate assistance. These notions already underpin the various government programs for people with disabilities, and this is why the PIR recommended addressing shortcomings in these programs as an important part of reforming assistance for those with adverse patient outcomes.

Views from submissions

6.23 The PIR received a number of submissions which discussed a needs-based approach to providing care and services. In support of a needs-based approach, one correspondent wrote that definitions of need should be consumer-focused.[8] This correspondent pointed out that the needs of people with disabilities change over time and are influenced by new technologies. A consumer-controlled needs analysis was advocated.

6.24 Another correspondent supported needs-based assistance, noting there were inconsistencies, gaps and overlays between the welfare system and the tort system.[9] As the systems had developed separately, they have different responses to people's needs and inequities have resulted in the way services are provided. The correspondent suggested differentiating between the question of services for people with disabilities and the question of justice for people with disabilities as a result of an adverse outcome.

6.25 One correspondent expressed the view that the rights (to pursue compensation via the tort system) should not be, "... diluted to the level of the lowest common denominator determined by those who have no right or entitlement to damages".[10] Removing or limiting such rights was said to require a substantial "balance of justice" to be demonstrated in its favour. Offering general support to a needs-based system of compensation, another correspondent wrote that there was an on-going need for litigation in relation to health services.[11] Litigation was seen as encouraging desirable risk management activities by health care professionals. Nevertheless, this correspondent thought the use of litigation should be minimised, noting the role of the welfare system in keeping the rate of litigation low in Australia compared to countries like the United States. The extension of the welfare safety net, through more comprehensive needs-based support was said to be likely to reduce the litigation rate to a minimum.

6.26 On the topic of needs-based support, one correspondent said that in an ideal world all people with disabilities would receive support sufficient to put them in the same financial position as an average person without disabilities.[12] Observing this was not likely to eventuate, the correspondent advocated provision of, "... full compensation for injuries caused by negligence [which] corresponds with the ordinary person's idea of fairness".[13]

6.27 The PIR and the related Compensation Review (described in Section B below) have issued a number of publications that relate to the substance of this chapter. For example, Chapter 4 of the Interim Report[14] summarised the assistance available to those with severe disabilities under the tort system and the various state and Commonwealth-funded community assistance arrangements. Chapter 5[15] of the Interim Report described rehabilitation arrangements. The Compensation Review's 1993 Discussion paper detailed the complex interfaces between the various Australian compensation arrangements with health and community service programs of the Department of Human Services and Health. The PIR's final discussion paper described the differences in assistance available to compensable and non-compensable people.

6.28 None of this information will be repeated in detail here, but the Final Report draws on the research work, which underpinned these publications, in the development of its recommendations for those who have an adverse patient outcome and require community assistance. Chapter 7 will deal with reforms to the tort system.

B. The Compensation Review

6.29 When the PIR was being conducted, the same area of the Department of Human Services and Health was asked by the then Minister for Health, Housing Local Government and Community Services Mr Brian Howe MP to examine the relationship between compensation and health and community services programs more generally. The Compensation Review's terms of reference are set out in full in Appendix F.

6.30 The Compensation Review looked at all compensation systems, including workers' compensation schemes and arrangements funded through motor vehicle compulsory third party premiums, as well as the tort system more generally. What emerged was a confused patchwork of systems, characterised by complex and inconsistent policy approaches. The lack of administrative and financial transparency allowed double-dipping by compensable people and cost-shifting to the Commonwealth and States from insurers and compensation payers. There were also gaps in assistance for people with similar needs. A separate consultancy paper on these issues was prepared by Tom Brennan and John Deeble and was released in July 1993.[16]

6.31 The Compensation Review identified how the involvement of three levels of government and many service providers leads to gaps and duplication in services. Gaps occur where services are not available. They can also occur when those that are available are not appropriate. For example, a person who requires assistance with preparing meals may be offered meals-on-wheels services, where a more appropriate response may have been cooking lessons. Overlaps occur when, for example, physiotherapy services may be available through a local hospital out patient clinic and also through a community service. While such a situation could mean a choice for the consumer between the services, lack of co-ordination and information can mean the consumer may not get to either service at the appropriate time, and sometimes it can leave resources underutilised.

6.32 As noted above, the complexity of the system provides opportunities for cost-shifting or double-dipping. Double-dipping may occur when a person receives compensation to cover medical and other health care needs but does not reimburse the cost of services already

received. In effect, the services are paid for twice, once through insurance and also through subsidies for Commonwealth programs and services. Cost-shifting may occur where an insurer or compensation payer was not previously paying the compensable medical and nursing home costs, but transferring them to community programs.

6.33 As a result of both these exercises, Mr Howe asked the PIR to :

- examine the gaps and inequities in provision of services for people with disabilities, especially the differences in experiences of compensable and non-compensable people; and

- outline more clear and equitable arrangements for meeting the needs of people with disabilities, regardless of compensation status.

The PIR's findings and conclusions from this work were set out in the PIR's final discussion paper *Compensable and non-compensable people - equal needs, unequal assistance*[17] (Disability discussion paper).

6.34 The Disability discussion paper brought together the work of both the Compensation Review and the PIR in this area. Its scope extends beyond the difficulties faced by those who have had adverse patient outcomes. It deals with this group of people only as a subset of all those who have disabilities and who may or may not be eligible for compensation. It also provides details of other policy initiatives impacting on compensation arrangements and on those with disabilities[18], including the Council of Australian Government's examination of health and community services programs[19], the National Policy on Acquired Brain Injury, the commencement of the Australian Disability Strategy, the Industry Commission's work on Workers' Compensation and the recent Strategic Review of the Disability Services Program[20].

6.35 The Disability discussion paper identified a number of issues, that appeared to be common to many of these reviews and to the PIR's work. Many of these reduced the efficiency and cost-effectiveness of service delivery, and impacted adversely on the ability of individuals to adequately meet their care and support needs. Common elements of reforms to address these problems included :

- ensuring that the achievement of specified consumer outcomes is the measure of success for the program;

- simplifying and standardising assessment and eligibility criteria;

- standardising benefits and entitlements;

- simplifying co-ordination arrangements where a package of services is required; and

- containing costs.

6.36 There also appeared to be significant administrative costs associated with transferring people between the different systems, and disagreement about which system should pay in

any one case and in multiple entitlement assessments. It is crucial to address such problems, not only because they profoundly affect the lives of people who are often already vulnerable to disadvantage because of a disability, but because the capacity of such programs to meet needs are adversely affected by such waste.

6.37 The Disability discussion paper highlighted the need to:

- improve access to support services by reforming arrangements which discriminate between people with similar needs;

- remove the opportunities and incentives for uncontrolled shifting of costs between different arrangements through improved financial transparency; and

- define what is an acceptable level of assistance for a person with a disability.

6.38 Similar themes underlie much of the current work on reform of health and community services being undertaken by the Council of Australian Governments. Trials proposed for coordinated care are examining reforms, which require a joint Commonwealth/ State approach, foster best practice and flexibility across programs and jurisdictions, and target people who require a package of services over an extended period of time or who are unable to access appropriate services.[21]

6.39 The PIR's Interim Report stated that the preferred goal for reform of community assistance arrangements is that there should be equitable access to appropriate services for all who have similar needs, and that having access to necessary services should not be dependent upon the cause of the person's disability or their compensable status.[22] However, the interaction between Commonwealth and State community assistance programs is really only one of areas which needs to be examined. For example, the Secretary of the Commonwealth Department of Human Services and Health, in opening the Third National Rehabilitation Conference, observed:

> If there is a single underlying focus in the area of health and community services it is the notion of meeting people's needs better ... how systems might be better structured to fit individuals' needs better rather than how individuals can be shaped to fit systems. There is ample evidence to suggest that the concept of coordinated care needs to be brought to bear across secondary and tertiary rehabilitation, job outcomes and social security benefits, as well as to related health services.[23]

6.40 The PIR's work would extend that examination further, to employment-related assistance, such as sick leave, disability assistance under superannuation arrangements (including invalidity retirement) and private insurance. This breadth of study is suggested because it was clear from the PIR's research that the advantage of being compensable was (at least until the money ran out) having the financial capacity to purchase services which may not have been available from community programs. Thus 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.

6.41 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. However, this Final Report has limited its discussions to the main areas of damages and tax-funded community assistance. Examination of how other systems can also assist is clearly another large project. Possible use of these other arrangements will only be mentioned as examples in the remainder of this chapter. Similarly, the chapter does not deal with reforms to programs of other Departments, such as the Department of Social Security, which could also be used to increase the service and aids purchasing power of people with disabilities.

6.42 There is a need to examine better ways of ensuring that those who receive compensation have money available for as long as is necessary to meet their needs. Too often the case studies of those who have significant long-term future care show that even very large lump sums prove inadequate to meet these needs over a person's lifetime. Structured settlements, which are one way of ensuring a stream of income over a long period of time to meet these needs, are examined in detail in Chapter 7.

C. Does compensation affect access to assistance?

6.43 The PIR undertook research into the needs of people with severe disabilities, focussing on whether compensation status affects ease of access to appropriate support and care services, and whether there are differences in access, service quality, and information resources between people who receive, or do not receive, compensation[24]. This included consultations with those who have disabilities and those who provide care for people with disabilities. The central role of informal carers, that is family members and friends, in providing for the support and care needs of a person with a disability, cannot be underestimated. Several case studies from these consultations were presented in the disability discussion paper to illustrate the range of difficulties experienced by members of the community in accessing needed disability-related services.

6.44 The PIR's research shows that people who have similar care needs are affected in their capacity to meet those needs by whether they are eligible for compensation or not. There are also cases where a person can also be disadvantaged when their compensation status has yet to be determined - they can be more disadvantaged in these circumstances than if they are not compensable at all. Another important factor that affected how well a person with a disability was able to cope (often whether or not they were compensable) was the availability or willingness of family members and friends to supplement the care given by service providers.

6.45 The following sections summarise some of the major problem areas identified in consultations, in submissions and in informal discussions with the PIR. Some of these such as problems in accessing accommodation, support services, and aids and appliances were of particular concern to those who are not compensable or those who are awaiting compensation. Others, such as access to medical services and rehabilitation, were problems for those awaiting determination of their compensable status. The lack of available information on service options and assistance was a particular problem for those whose

disabilities arise from an adverse patient outcome, because there are no coordinators of such assistance even if the person is compensable. Other concerns, particularly those relating to support for carers, education and transport, were probably issues for all people with disabilities with special needs in these areas.

6.46 A sentiment that was frequently expressed was that medical advances have meant that more premature babies who have or develop disabilities and more people with quadriplegia as a result of injury now survive the initial trauma and may live out a normal life span. The commitment to saving lives has not generally been matched by increased funding to provide for their disability-related needs and to ensure that people with severe disabilities have an acceptable quality of life in the community.

6.47 This provides an incentive in many cases to pursue compensation - to provide money for the purchase of services and assistance to allow a minimal acceptable quality of life to be reached by a person with a severe disability. The more inadequate the levels of community assistance, the more people will seek another funding source, such as compensation, as occurs in the United States. Where levels of community assistance are adequate for people with severe disabilities, the role and consequent costs of the tort system or other compensation mechanism tends to be much less, such as in the Scandinavian countries.

Accommodation, support services and carers

6.48 People with disabilities who receive compensation are generally able to pay for any necessary modifications to their housing or, if necessary, purchase a purpose designed dwelling from their own compensation, though the period of uncertainty before their eligibility is determined can be difficult. In medical negligence cases, this can be a very significant period of time.

6.49 A non-compensable person or someone awaiting compensation may be able to obtain access to home modifications as part of a rehabilitation program through government-funded services like the Commonwealth Rehabilitation Service (CRS) or special public housing assistance, though they may be limited in their options for modifications eg by cost limitations imposed by these services.

6.50 Where a person with a disability has high level support needs, receipt of compensation can be vital to enabling them to live in the community, rather than in a nursing home. There is a general shortage of supported accommodation, with the support services generally being the limiting factor rather than the accommodation itself. The degree of independence achieved by people with a disability is affected by the affordability, accessibility and appropriateness of services available in the community and whether the range of services is available on an on-going basis.

6.51 Many people with disabilities do not need 24-hour care, but need assistance with bowel or bladder care or other forms of regular support, and such assistance is said to be in short supply. For those requiring round the clock support outside of an institution, there are also often significant difficulties in obtaining necessary support services. Where people are able to obtain services from a service provider, there were many concerns raised about the lack of continuity of carer. Sometimes there were rotations or very frequent staff changes,

which did not enable a person with a disability to develop a working relationship with their carer.

6.52 For those who were obliged to live in an institution or in a shared facility, such as a group home, there were concerns about a lack of suitable accommodation. Some long-term shared accommodation is provided by agencies such as Paraquad and the Australian Quadriplegic Association for people with high support needs. This can include transitional accommodation, where people can learn independent living skills. Respite care can be provided, where the person lives at home.

6.53 Lack of flexibility in the way that support services are provided was also consistently raised in consultations. Flexibility in responding to the circumstances and needs of individuals is very important, together with promoting independence and choice for the person. The PIR notes this is consistent with the principles and objectives of the Commonwealth's *Disability Services Act 1986*.

6.54 Home and Community Care Program services are delivered in different ways between States and regions. In many cases the services provided are largely controlled by the service provider and may not be particularly appropriate for individual clients.

6.55 The PIR notes there are examples where assistance is responsive to the needs of individual clients and specific locations. For example, the Community Options Scheme utilises a case management approach, and in one rural area the local hotel delivers counter lunches to clients with disabilities where economies of scale would otherwise exclude the provision of meals-on-wheels.

6.56 The Attendant Care Program, funded by the States under the Commonwealth/State Disability Agreement, provides more support but is still insufficient for people who need 24-hour care or assistance with regular functions such as going to the toilet. Access to the Program is very limited and most services have long waiting lists. One of the advantages of this Program, however, is that it gives individual clients control over the way that program resources are used. For example, a group of people with disabilities in shared accommodation can pool their entitlements to ensure access to 24-hour care.

6.57 In most States policies on de-institutionalisation and early discharge have resulted in savings, which have not been fully re-invested in community based services and support. This has, in many cases, impeded the potential for successful independent living for many people with disabilities. Limitations on and access to personal care and home-help influences where people with disabilities can live and work, and the amount of independence they can achieve. There is also some competition for available services from people discharged from hospital who require short-to-medium term support following acute illness or trauma.

6.58 Those with compensation money available can sometimes purchase services, either from the same service providers or through private provision. Some people in this situation indicated to the PIR that they hired their own carers because it gave them greater continuity of care. However, others talked about the added responsibility required (and not always

welcome) when hiring and firing someone, as well as the additional costs, such as workers' compensation coverage.

6.59 Many who had received compensation were also concerned that the cost of services was greater than had been provided for in their award, and, if they lived a normal lifespan, they would not have adequate money to meet their needs. The complexity of investing the lump sum to be able to draw sufficient income to continuously meet the expenditure needs for support services was also seen as a significant worry by some. Some parents of minors who had received compensation attempted to save money for such contingencies by providing care themselves, and relying more on family and friends where possible.

6.60 Support in accommodation can be provided over a short period of time by informal carers such as family and friends. However, as a long-term option, this requires consideration of the interests of the carer as well as the person being cared for. The burden of caring can create ill health in the carer and leave them no time for any other activities. A breakdown of the underlying relationship can arise because of the heavy toll of caring, or simply from role conflict (eg the conflict between the partner/lover role, with the very different role of carer). In any circumstances, there is a need to ensure adequate respite and other support for the carer, including regular and emergency respite care, and family support counselling to help keep families together.

6.61 Community assistance provided to carers is still significantly less than for full-time supported accommodation provided in the community or in health care facilities. Under current arrangements, a carer who gives up a job in the paid workforce to take on a caring role, is generally severely financially disadvantaged. Where the person is married or living with someone in employment, no assistance will generally be available through income support.

6.62 Where compensation is awarded, the financial circumstances of the family can be better. However, the compensable person may not give the carer access to adequate funds in exchange for caring. Where a family member or friend wants to provide such assistance, there are some States where such an intention can lead to reduced damages. For example, in motor vehicle personal injury actions in NSW[25], significant financial limits are imposed upon damages that can be awarded for gratuitous services provided by a family member or friend, and in Tasmania damages for such amounts are abolished all together[26]. This can significantly reduce the damages otherwise payable, and make it very difficult for the compensable person if that other person refuses or is unable due to ill health to continue to provide those services for free[27]. Neither the common law or statute provides any guarantee to a carer in these or other cases that they can share in the compensation received in exchange for services rendered.

6.63 In those States without such legislative restrictions, the High Court confirmed in 1992 that the appropriate compensation for such costs, even where they were likely to be delivered gratuitously, was the market cost of such services.[28] During consultations the issue of a carer's right to access income or assets of the person with a disability was raised as an issue. There was seen to be a need to protect the interests of both the person with a disability and the carer

in circumstances where the person with a disability had income or assets, perhaps as the result of a compensation claim.

6.64 A useful model, discussed in more detail in Chapter 7, is that which applies under the Tasmanian no-fault motor accidents scheme. In brief, where a person requires at least 2 hours of daily care, the costs are met on an on-going basis through a case management arrangement, and are not able to be included in a damages award. The case manager can pay a family member to provide these services while they are able and willing to do so, or pay another service provider. Individualised and flexible assistance with support services is possible under this arrangement, which is fully funded by Tasmanian motorists.

6.65 Other workers' compensation and motor vehicle accident no-fault schemes also manage individualised support service assistance, and have considerable case management experience, which may be useful more broadly.

Aids and appliances

6.66 Consultations with people with disabilities also revealed significant unmet need on the part of non-compensable people for aids and appliances. The contrast between what compensable and non-compensable people could obtain in this area was particularly apparent. Compensable people can purchase, or may be provided with, a large range of aids and appliances that are not available to non-compensable people. These can include high cost items such as computers to aid communication and workforce participation, electric wheelchairs, and portable respirators. Such aids and appliances can have a substantial positive impact on the quality of life and independence achievable for a person with a disability.

6.67 Again, sometimes the first of these items can be provided as part of an immediate post-disability rehabilitation program funded by the CRS, so long as the person is eligible for these services. CRS programs are generally only available to those of working age, so assistance is not generally available for aids and appliances or home modifications where the person with the disability is a child or an older person. Where a replacement item is required at some later stage, the person with a disability faces these problems identified below.

6.68 For non-compensable people, State governments are responsible for the delivery of almost all aids and appliances. Access is rationed in most States, with only those on low incomes being eligible. As part of the consultation process, anecdotal evidence was given of agencies running out of money for aids and appliances within three months of the start of a financial year. There were also reports of agencies providing inappropriate assistance such as wheelchairs for mobility in the home, which could not be used outside. A wheelchair athlete was told to discontinue his sporting activities as he was wearing his wheelchair out too fast. When appliances such as wheelchairs had to be repaired the person with a disability was often given no choice but to stay in bed for days or weeks as there was no replacement available. In addition, individuals and agencies consulted considered that there had been
diversion of available funds away from disability-related support to medical support such as provision of oxygen.

6.69 People with disabilities who do not have access to compensation and cannot afford to purchase services or appliances, are frequently advised to seek assistance from service and charitable organisations – a process described as begging which was seen as further reducing a person's dignity and right to privacy.

Medical services and rehabilitation assistance

6.70 The PIR's Case Study Report showed that coping with the costs of rehabilitation was the most important concern for people who had sought, but not yet received, a compensation settlement for medical misadventure.[29] The PIR also received correspondence from people who complained of being unable to access services, either because health care professionals did not want to become involved, or wanted cash payment for services, rather than bulk billing. This is important because delayed rehabilitation and access to medical services can preclude optimal recovery.

6.71 Both Medicare and CRS have provisions that allow "provisional payment" of costs by the Commonwealth with recovery to occur at the time of settlement. Existing provisions, particularly in Medicare, have been of limited use, and have precluded compensable people from using bulk-billing arrangements in many cases. The double-dipping legislation discussed below addresses these problems, and should ensure prompt payment in all cases, as well as full recovery of Medicare costs at the time of settlement or judgment. The legislation ensures also that a compensable person and the compensation payer know the level of the debt at the time of finalisation, so that the compensable person is not unknowingly left with inadequate compensation.

6.72 The lack of coordination and connection between State and Commonwealth-funded rehabilitation arrangements is long standing and well-documented. The PIR's Interim Report noted that rehabilitation is often delayed while a determination for compensation is decided and that delay in the recovery process often leads to higher levels of disability.[30]. The period immediately after an injury occurs is the most significant for rehabilitation. Research has demonstrated the importance in many cases of timely rehabilitation and the adverse consequences if rehabilitation is delayed.[31]

6.73 The Industry Commission's report on workers' compensation in Australia [32] discusses the need for prompt rehabilitation and return to work wherever possible. It describes how rehabilitation has generally proven to be cost-effective where employers and employees agree on treatments and programs and where employers are responsible for maintaining contact with, and support for, employees suffering from work-related injury or illness. Early referral was also considered important for effective treatment and speedy return to work, if necessary without any acceptance of liability on behalf of the employer.

6.74 The Industry Commission recommended statutory obligations on both employees and employers in relation to rehabilitation participation. Such provisions also exist under other compensation statutes covering common law damages. For example, the *Motor Accidents Act 1988 (NSW)* includes a statutory licence condition which requires an insurer to ensure the provision of rehabilitation assistance to an injured person as soon as possible after admission of liability[33]. If rehabilitation assistance is provided prior to the determination of liability, payments made are not considered to be an admission of liability[34]. Correspondingly, a

failure to participate in rehabilitation is said to be a failure to mitigate damages, and can reduce the amount of compensation payable to the person concerned.[35]

6.75 **The PIR considers that rehabilitation obligations on compensation payers and injured people ameliorate some of the perceived anti-rehabilitative effects of common law damages and recommends that similar obligations to those under sections 38 and 39 of the *Motor Accidents Act 1988* (NSW) be extended to all areas of common law damages for personal injury through a nationally coordinated approach by the Standing Committee of Attorneys-General. (Recommendation 75)**

6.76 The National Goals, Targets and Strategies for Better Health Outcomes[36] has set as its goal increased access of people with trauma injuries to comprehensive rehabilitation programs and appropriate long-term care and community support. The first indicator established for this is a full policy review of Commonwealth and State rehabilitation services in Australia, due for completion in December 1996. Its report states that:

> In Australia, rehabilitation is provided through a complex and largely un-coordinated network of services. Services are offered in the national and State public health systems, the private system, in combination with other services in a few rural areas and by occupational physicians in workplaces. ... Equity in relation to access to rehabilitation services has been consistently identified as the major issue in the area of rehabilitation in a number of reports dating from the 1970s.[37]

6.77 The issue of lack of timely access to rehabilitation, whether a person was compensable or not was identified in consultations as a real barrier to effective rehabilitation. Those whose compensation claim was being looked after by a claims manager or a risk manager tended to be able to gain earlier access to rehabilitation - whether or not the person was subsequently successful in obtaining compensation. **The PIR strongly endorses the National Health Goals and Targets Review of Rehabilitation Assistance in Australia, and recommends it examine ways of ensuring people with severe disabilities obtain early access to rehabilitation services. (Recommendation 76)**

Information needs and coordination

6.78 Consultations indicated that one of the real problems for people was not the absence of assistance, but finding out what was available and how to access it.

6.79 Information relevant to a person with a disability and their carer can be obtained in a variety of ways, and some appear to work well. For example, effective discharge planning arrangements at hospitals or other health facilities can assist the person with a disability and their carer to adjust more easily to going home. Such planning is particularly important for those who live in non-metropolitan areas where services and support are less likely to be locally based.

6.80 In South Australia, for example, a support package to assist with the care of a child with a disability is devised by the Crippled Children's Association and the State Departments of Community Services and Education in conjunction with the family of the child. This is available prior to the child's discharge from the Women and Children's Hospital. Even so,

children with disabilities in rural communities of South Australia have reduced access to services particularly in the area of paediatric therapies. Secondary rehabilitation in some remote Aboriginal communities is assisted by a resident disability support worker who co-ordinates individual requirements in a culturally appropriate way.

6.81 The Carer's Kit funded by the Commonwealth Department of Human Services and Health was also considered a useful resource, with contact points for further information and support.

6.82 In general, people with disabilities and their carers saw a need for better dissemination of information on service availability and the need to better co-ordinate service administration. For example, many people with disabilities saw it as an invasion of their privacy and a waste of their time and energy to have to provide personal information to a range of service providers, and to go through an eligibility assessment for each service required.

6.83 Many people with disabilities claim that they found out about service and support group availability from other people with disabilities or their carers, rather than through any coordinated information source.

6.84 There was also considerable frustration expressed in trying to co-ordinate different parts of the system, once they were known about, to ensure needs were met adequately. This was particularly so where multiple eligibility assessments were required and eligibility criteria seemed to be inconsistent. Such multiple assessments were seen as intrusive, time-consuming and administratively wasteful. Some suggested a single model for assessment, like the Aged Care Assessment Teams, used in determining service level needs of older people.

Education assistance

6.85 Early intervention to assist children with disabilities to reach their full potential needs to start prior to school age if it is to be fully effective. Access to appropriate services varies significantly, with parental involvement and lobbying having a major influence on whether services are provided. Assistance is also provided in special schools for children with severe disabilities, with current education philosophies favouring integration of children with less severe disabilities into mainstream schools, particularly where their disabilities are mainly physical.

6.86 In both special and State schools, resources provided are not always adequate. There may be some difficulty in coordinating the additional services these students may need, such as out-of-school hours care (particularly for those over 12 years of age). The ability of students to benefit from their educational opportunities may also be limited if appropriate post-school options are not available. Additional issues face students with severe disabilities who have come to the end of their compulsory years of schooling and for whom paid employment is probably an unrealistic goal.

6.87 In rural or remote areas access to appropriate services is likely to be even more difficult and families may have to consider moving to a better-serviced location. State Governments provide a compulsory education for all children with varying levels of support

for children with disabilities. In some cases, funding ceased for children who wished to attend school beyond the compulsory period.

6.88 Consultations undertaken as part of the preparation of this material suggest that there are particular gaps in assistance available for students with disabilities in mainstream schools. There is also some concern about assistance available to students seeking higher education, although higher education facilities are gradually becoming more attuned to the needs of students with disabilities and sometimes employ counsellors to assist in meeting the needs of individual students. Having access to compensation can give a child with significant disabilities access to higher education and help to defray additional costs, such as attendant care that may be required to enable the child or young adult to participate fully in education.

Transport

6.89 Lack of access to affordable and appropriate transport is a particular impediment to the greater participation of people with disabilities in the community and the workforce. While pensioners are generally eligible for transport concessions, people with disabilities who cannot access buses or trains must rely on taxis or private transport. This can be very expensive, so compensable people can be better served by these mechanisms. For example, sales tax concessions are available for some people who purchase specially modified new vehicles, but the significant capital cost of the vehicle must otherwise be met from compensation or personal savings. Such concessions do not assist those who cannot afford a new vehicle.

6.90 While taxi fare concessions provided by State Governments are available for people with disabilities who cannot access other public transport, the costs of taxis fares for access to work or regular appointments can still be prohibitive, even when the Mobility Allowance is taken into account. For people with disabilities who can only use special-purpose taxis, access may also be limited by the availability of these taxis, particularly in rural or remote areas but also in many metropolitan areas, especially at peak times.

Conclusions

6.91 This brief discussion indicates that there are differences for those who are compensable and those who are not in many areas of assistance covered by Commonwealth and State health and community services programs. People with disabilities who do not receive compensation or who receive inadequate compensation,[38] depend mainly on government programs and relatives and friends for their income support and care needs. If the services required are not locally available at an affordable price from private providers, if the government service is seen as a more attractive option and if there are no compensation costs recovery mechanisms in place, many compensable people also use government programs for their care needs.

6.92 The main advantage where someone has access to compensation following an adverse patient outcome, appears to be the possible increased financial resources they have to draw upon for their long-term needs. However, they can have similar problems of access to assistance in the period before compensation is determined, and if they are unsuccessful, the costs of litigation may further reduce their immediate financial resources to meet their

disability-related needs. There are universal difficulties in accessing information and services in a timely fashion, in eligibility assessment and in coordinating appropriate assistance.

6.93 Where compensation is available, the costs of services can be greater than the amounts provided, particularly after a considerable period of time. The dissipation of a sometimes inadequate lump sum to meet the costs of living can aggravate these difficulties. The broader availability of structured settlement products can address some of these problems, though not all of them, given there is no provision under such arrangements to re-open a case should a person's condition become worse than expected. Inconsistent policies on charging and cost recovery can also increase the difficulties for a compensable person seeking access to assistance. Where no such cost-recovery is undertaken, the result is double-dipping, where the compensation was adequate, or cost-shifting, where it was not adequate to meet these needs. In either case, it reduces the money available to meet the needs of the community for such services.

6.94 It is hoped that some of the problems identified above may be overcome in the longer time through initiatives at the Commonwealth[39] and State levels which aim to reduce the systemic discrimination people with disabilities face, for example, in relation to building access, transport and education.

6.95 However, many of the other concerns will need to be addressed as part of the forthcoming evaluation of the Commonwealth-State Disability Agreement, particularly those relating to support services, accommodation and aids and appliances. While these are generally considered to be the responsibility of state governments, the lack of such assistance can severely impact on the employment options for a person with a disability, which puts it back in the Commonwealth's direct sphere of interest.

6.96 **The PIR recommends that the evaluation of the Commonwealth-State Disability Agreement examine the key areas of difference between compensable and non-compensable people with disabilities. These include access to aids and appliances, on-going support to live in the community, assistance for carers, early and coordinated access to rehabilitation and difficulties relating to education and transport. (Recommendation 77)**

6.97 **The PIR also recommends that the evaluation look at the issue of access to information for people with disabilities, to ensure they are aware of what services are available, and have the opportunity to access them, if necessary with the assistance of someone as their advocate or case manager. (Recommendation 78)**

6.98 Other than the financial advantage a compensable person may have in accessing services, those who have someone to help them access available assistance seem to fare best. Periodic compensation systems, such as workers' compensation and motor vehicle accident compensation, often use case managers for those with significant disabilities to help ensure prompt and appropriate access. This case management expertise has not generally been available for broader use by people with disabilities.

6.99 While schemes operating in some States, such as Queensland, rely heavily on limited benefit payments, lump sums and short-term assistance and thus will be of little assistance, many other States have good quality case management mechanisms in their compensation systems, which could conceivably be used for broader purposes on a contract basis. For example, the Tasmanian Motor Accidents Insurance Board, the Victorian Transport Accident Commission and the New South Wales Motor Accident Authority, all have considerable experience providing coordinated packages of assistance to people with severe disabilities, as do many workers' compensation agencies. Other potential sources of case management assistance could be the CRS and community outreach staff in public health facilities. In the latter case, it would be important to ensure that assistance was not focused on the medical model of assistance, which sees disability as an illness, is strongly rejected by many people with disabilities.

6.100 **The PIR recommends that State and Commonwealth disability programs consider the possible use of existing compensation case management resources to provide case management assistance for people with disabilities more generally. The broader use of case managers in the Commonwealth Rehabilitation Service or in other parts of the health system should also be examined. (Recommendation 79)**

6.101 Whatever case management is provided, there also needs to be a single assessment point, which can then be used to access appropriate services and benefits. Such an integrated mechanism for return to work assistance has been piloted by the Department of Social Security, the Commonwealth Employment Service and the Commonwealth Rehabilitation Service, as part of the Disability Reform Package, with some success. There is no reason why a single assessment point cannot be developed, which serves the purposes of multiple service providers and benefit payers, and minimises the administrative costs and delays inherent in current multiple assessments. The use of Aged Care Assessment Teams for determining the care needs of older people also provides a useful model. **The PIR recommends that the Commonwealth Department of Human Services and Health consult with Commonwealth, State and community agencies, and people with disabilities and their carers to develop a single assessment point for disability related needs for non-aged people with disabilities. (Recommendation 80)**

A pilot of a coordinated care model for people with disabilities

6.102 The discussion in this chapter has highlighted gaps in access to, and provision of, support services for people with disabilities. Consultations also made it clear that accessing a package of support services generally entails a person with a disability and/or their carer negotiating a complex system of multiple eligibility and assessment requirements to obtain a suitable package of assistance from services that are currently available. While the next section of the chapter discusses the need to define a minimum level of assistance for all people with disabilities, problems with accessing existing services can sometimes lead people with disabilities to believe there are fewer services available than there are.

6.103 If we are going to match needs and service provision in a better manner, and if we are to determine where there are real shortfalls in service provision and assistance, there is a need to pilot better mechanisms for getting people to the services they need. Some of these mechanisms such as a single assessment point have been the subject of earlier

recommendations in this chapter. Each of these could form part of such a pilot, could explore the savings from reducing the numbers of assessments (which could then go to increasing the amount of services and assistance provided) and the benefits for the person with disabilities in having a "one-stop shop" for obtaining access to assistance. It could also explore the use of existing case-management services provided either by State compensation bodies or the CRS, as appropriate.

6.104 **The PIR recommends that a pilot program for coordinated assistance for people with severe disabilities and their carers be developed between the Commonwealth and States, using a case management approach, which is consumer-centred, and, where possible, uses existing disability case management resources, rather than creating new ones. (Recommendation 81)** The pilot program must look at the best methods of coordinating care, and how to fund and manage an integrated package which crosses funding programs, levels of government and non-government sources. Appropriate funding for the pilot program could be considered as part of the Review of the Commonwealth/State Disability Agreement. Avenues for early commencement of the program could be explored through the Disability Services Sub-Committee of the Standing Committee of Community Services and Income Security Administrators.

6.105 **The PIR recommends that this pilot focus on people with severe disabilities and trial a single eligibility assessment process. The pilot program should include people with different kinds of disabilities; people who have different levels of support from unpaid carers; those who live in rural areas, which may involve additional difficulties; those who have access to compensation; and those who have significant financial disadvantage. (Recommendation 82)** Choosing participants in the pilot projects from a wide range of circumstances will allow an evaluation of the contribution made to meeting the person's needs from each of the sources, will identify where special needs and gaps in assistance may exist and will enable the piloting of various cost recovery policies in the case of compensable people.

6.106 This pilot could also benefit from the experiences of the coordinated care projects, which are being conducted as part of the current Council of Australian Government's Commonwealth/State Task Force on Roles and Responsibilities in Health and Community Services, outlined in Chapter 1 and in the Disability discussion paper[40]. The pilot program will also need to take into account of the proposals for the wider use of structured compensation settlements discussed in Chapter 7, to ensure projects under the pilot program take advantage of the flexibility of structured settlements to provide for the long-term disability-related needs of a compensable person. The pilot will also need to take account of any developments which rationalise the relationship between compensation and community assistance arrangements. Where appropriate, the pilot should also include access to appropriate health care and rehabilitation services, because of the perceived importance of their timely provision in achieving long-term recovery and positive outcomes for people with severe disabilities.

6.107 The evaluation of the pilot program should include:

- assessment by the person with a disability and their carer of their satisfaction with the level and type of service provided and with the role of the care coordinator;

- the identification of gaps in assistance, particularly when the minimum and optimal level of assistance standards recommended later are finalised;

- assessment of the role of health care services and rehabilitation in achieving the goal of minimising the levels of functional disability and maximising independence;

- assessment of outcomes sought/expected and outcomes achieved - there is a need to recognise that the desired outcomes for people with disabilities are like to vary a great deal, and will need to incorporate situations where the person's condition deteriorates and goals therefore need to change;

- assessment of the effectiveness of a care-coordinator in enabling the person with a disability and/or their carer to access suitable services in a timely manner, compared to a person or carer on their own; and

- assessment of the effectiveness of a care coordinator in organising a package of services and promoting co-operation between carers and service providers involved in the care of the person with a severe disability, recognising that the outcomes of a package of services for a person with a severe disability, and their carer, are generally the result of joint efforts by a number of formal (service provider) and informal (family and friends) carers.

D. Defining an adequate level of assistance

The philosophical basis for government involvement

6.108 The role of government in a modern social democracy has for many years included the provision of a safety net of assistance for all citizens, below which it is not considered people should have to exist. While it has varied in its comprehensiveness, income support assistance for people with disabilities has been a feature of our democracy since the Commonwealth was formed[41]. The role of government has also included more recently the protection of human rights[42].

6.109 At its most basic level, the Australian community accepts that someone with a severe disability, accident or disease has a basic human right to life, because it recognises the inherent value of people whether or not they have a disability. However, in a modern, civilised society, our community's obligations extend beyond merely sustaining life - we must at least ensure a minimum acceptable quality of life for those with disabilities. While the level of provision will always be contingent upon what resources are available to the community, there is generally a belief in the community that there exists a minimum below which it is inappropriate for people to fall, and that the role of government is rightly to ensure people exist at or above this minimal level.

6.110 In its consultations the PIR became aware of a view that for some people with disabilities, the question of whether they were eligible for compensation was used as an informal criterion for whether maximum efforts would be made to sustain life. Health professionals indicated that when looking at the situation of a person who would have high level support needs if they survived the initial trauma causing the disability, they considered compensation to meet on-going care needs made such a fundamental difference in the quality of life of the person, that its potential availability (or absence) affected the rigour with which they pursued the person's survival. That our community does not provide a minimum level of assistance to all who have such needs, so that the relevance of this factor in questions of life or death is removed is an indictment of our society. It is also in conflict with statements about the rights of people with disabilities in our community.

6.111 Such statements range from the statements of principles and objectives in the *Disability Services Act 1986* to more recent statements of rights. For example, in 1994, the Commonwealth Government recognised the following series of rights for each person with a disability in the Commonwealth Disability Strategy :

- to be recognised as a valuable citizen;
- to have equal access to the systems of society, the environment and community life;
- to have the opportunity to contribute to the economic, social, political and cultural life of the community;
- to have their needs recognised in the planning and administration of public services and infrastructures;
- to maximise opportunities for their independence;
- to participate in decisions which affect their lives and the communities in which they live; and
- to form and maintain relationships of their choice.

6.112 The PIR's research shows that the rhetoric of such statements is not currently matched by the provision of assistance to facilitate the achievement of these aims, either at the Commonwealth level[43], or it seems from our research, at the State level. At a statutory level, the Commonwealth has made it clear that its disability programs operate within budget constraints[44], and yet there has to date been no attempt to define the scope for assistance in the foreseeable future.

Defining a minimum and optimum level of government assistance for people with disabilities

6.113 The existence of a minimum level of assistance for people with disabilities and other citizens that is acceptable to the community is the underlying premise of many of our

government health and assistance programs, including Medicare and the social security system. The level of provision varies over time, but in both these programs, there is an inherent social contract that entitles people to assistance. There has been a definition of the so-called *safety net*. In both these cases, there is a common understanding of entitlement, and where people wish to self-provide above that, they do so with an awareness of their basic entitlement to community assistance.

6.114 The concept of improving the quality of life and rights of people with disabilities underpins many of the programs of Commonwealth and State-funded assistance for people with disabilities. However, in this arena we have never defined the minimum level of assistance broadly acceptable to the community. In his recent evaluation of the Commonwealth's Disability Services Program (DSP), Professor Peter Baume drew similar conclusions :

> Currently, access [to Commonwealth disability services] depends on luck, serendipity and the presence of powerful advocates - a situation which is not just and which should not be acceptable.
>
> Government must decide whether its commitment is to some eligible people with a disability or whether it has a commitment to offer support to all eligible people with a disability.[45]

6.115 A direct consequence of this is that it is usually not possible to know whether needs are being met adequately, or to what extent funding increases or other forms of assistance may be necessary to meet such a standard. Again similar conclusions were drawn by Professor Baume, in commenting on employment-related assistance under the Commonwealth Disability Services Program (DSP) :

> At the commencement of the Strategic Review, the dearth of data related to program planning or performance of DSP-funded services was astonishing ... For a long period the DSP was unable to supply data on demand for funded services, the extent of unmet need, the number of people being assisted, the cost of support or the type of assistance being provided ... the program had no data on the size of the potential target group for DSP-funded services or its characteristics. Therefore it is not clear what percentage of its target group is receiving services nor how need correlates with receipt of service.[46]

6.116 Giving substance to the various statements of rights of people with disabilities must be a high priority for governments generally. An important next step must be to ensure that the basic disability related needs of those with disabilities in the community are being met in an appropriate manner. The first step to achieving this must be the establishment and definition of a minimum level of government-funded assistance for people with disabilities that is broadly acceptable to the Australian community - a definition of the safety net in this area, if you like. In addition, it would also seem desirable to define long term aims. Sometimes these two things will be the same, but in those areas where we are falling furthest short of the optimum, having a minimum to aim for in the shorter term is likely to increase the likelihood of step-by-step improvement.

6.117 **The PIR recommends that Commonwealth and State governments, with the assistance of the Australian Institute of Health and Welfare and relevant consumer groups, establish minimum and optimum levels of government funded assistance for people with severe disabilities as a matter of priority. The Commonwealth Department of Human Services and Health should initiate discussions with this aim in the Disability Services Sub-Committee of the Standing Committee of Community Services and Income Security Administrators. (Recommendation 83)**

6.118 Such levels of assistance should be set out in a manner that is measurable and outcome-focused. The standards should identify the services and other assistance that should be available, as well as the degree of self-provision or family assistance, if available, considered necessary or appropriate at both levels. Such standards will also provide a framework against which the adequacy of government and community assistance can be judged over time. The standards will also provide a framework to judge the adequacy of the assistance provided by statutory and common law compensation systems - for example, the optimum level may become the standard for what is "reasonable and necessary", - the phrase generally used to describe compensation provisions in these areas. The standards will also allow the identification of opportunities for private provision of assistance through insurance or superannuation disability provision.

6.119 Determining the minimum and optimal standards of assistance may not be an easy exercise. It will involve asking the community some basic, but complex questions, as well as determining priorities for action and assistance. For example, it is generally stated that a desirable goal is for people with disabilities to be able to live independently in the community - to many people that means continuing to live in their own home, or being able to earn money to purchase a home over the period of a mortgage or to rent suitable accommodation. However, we have never determined whether this will be the aim for all people with disabilities, or only some. Is this goal to be universally applied to all people with disabilities, whatever the costs, so long as this is what they want? What if they cannot express a view about their desires or if they comatose? Courts have for a long time grappled with exactly these questions in determining what is reasonable and necessary provision for a severely disabled person[47]. Is the goal to be traded off against the levels of taxation the community is happy to bear, and if so, who should miss out? What of those who require 24-hour care, but are intellectually able to look after themselves? Does the age of the person affect our views - do we believe a young person and an old person have the same need to live independently? How does the goal apply to people from different cultural backgrounds, who may have different aspirations and lifestyles? What happens if people change their mind about their goals at different stages of their lives?

6.120 Until we determine the answers to these questions and set out our primary goals in relation to provision of assistance, we can never measure our progress towards these goals. We will also inevitably make ad hoc, poorly coordinated and undefined progress in meeting the minimum and optimum needs of people with disabilities. It will also be impossible for people to determine appropriate self-provision mechanisms, such as insurance.

Why start with severe disability?

6.121 The PIR's view in its Interim Report was that the place to start any action to meet needs was with those with severe disabilities. While their needs are most likely to be the greatest, a failure to meet these needs is likely to have the most severe consequences so far as quality of life is concerned. Equally, people with short-term and temporary disabilities often have other sources of assistance, which no longer apply when the disability becomes long-term and severe.[48] Given adverse patient outcomes strongly affect aged people, as well as all other groups such as babies, the definition of adequate assistance cannot be restricted to those of working age.

6.122 **The PIR recommends the further analysis of the Quality in Australian Health Care data to better define the characteristics of those people who were categorised as having 50% or more disability, as a starting point in terms of identifying those groups of people who have severe disabilities from adverse patient outcomes and are likely to require on-going assistance. Other groups that may be illustrative of the needs of those with severe disabilities are children with cerebral palsy, and the very small number of children who suffer neurological damage following immunisation. (Recommendation 84)**

6.123 These groups are suggested as illustrative of the range of people with severe disabilities, though there are likely to be others, including those whose disabilities arise from disease and other trauma, such as fire, acquired brain injury or spinal injury. These are not seen as categories for eligibility assessment. A more appropriate measure is look at the effects of disabilities on the normal activities of daily living, as is done in Australian Bureau of Statistics surveys of people with disabilities. The advantage of looking also at the circumstances of individuals is that a fuller picture of the needs can be obtained, and possibly create solutions developed with the involvement of affected people.

Defining levels of assistance to and by unpaid carers

6.124 An underlying issue is the need to examine what is an acceptable level of support to be expected from unpaid carers. There is no doubt that carers provide an enormous amount of support, without which the demand for government-funded services and support and probably compensation would be even greater. For many in the community, it is seen as appropriate that family and friends not only provide support but assume the role of primary carers. The PIR is not aware of any definitive public discussion regarding what is an acceptable level of support to be expected of carers, or what is an acceptable level of assistance to be provided to carers to support them in the caring role.

6.125 **The PIR recommends that Commonwealth and State governments, with the assistance of the Australian Institute of Health and Welfare and relevant consumer groups, establish minimum and optimum levels of government funded assistance for the carers of people with severe disabilities as a matter of priority. The Commonwealth Department of Human Services and Health should initiate discussions with this aim in the Disability Services Sub-Committee of the Standing Committee of Community Services and Income Security Administrators. (Recommendation 85)**

E. Making the relationships between compensation and community assistance more transparent

Introduction

6.126 The broad move to a consumer outcome focus in the health and community services field has underlined the importance of a number of issues:

- achieving equity by focusing reforms on ensuring similar access to assistance for people with similar needs;

- defining what are the minimum and optimum acceptable levels of government assistance for a person with a disability;

- who should bear costs where government support is not appropriate, and under which circumstances; and

- the extent it is appropriate to expect individuals and families to provide for their own disability-related needs.

6.127 The drive to improve performance in government programs and to obtain maximum community benefit for each dollar provided by government has also led to the identification of areas of waste and overlap in the complex financial interfaces between compensation and community assistance, including double-dipping and cost-shifting. One reason for this complexity is that there has not been any attempt in Australia to consider all potential sources of assistance to determine the most cost-effective blend to meet the needs of the maximum number of people with disabilities. There has also been little concentration on how costs should be divided between government sources, private provision and compensation assistance. Most reviews have looked at issues from the compensation perspective, the Commonwealth perspective or that of a State government, without any attempt to determine the most cost-effective methods overall of meeting these needs.

6.128 Discussions of cost-shifting are a good example. They have centred around who currently funds services and how to remove the opportunities and incentives for cost-shifting by current providers. However, the current division of responsibility between different funding sources has usually developed in an ad-hoc fashion without any consideration of their effectiveness or efficiency. It seems highly likely in many cases that they are not the most effective and efficient manner of meeting the relevant needs from the perspective of the Australian community.

6.129 The existence of multiple potential sources and the lack of transparency and certainty between them often leads to significant administrative costs in moving people between different systems to have the same needs met from different sources. Many of the administrative and legal costs of systems are spent on defining and maintaining these fences, which were often not established on the surest of foundations.

6.130 For sound economic and equity reasons future arrangements must recognise the interconnectedness of compensation arrangements and other community systems in funding and providing assistance for people with disabilities and those with on-going health care needs. If government assistance is to meet the needs of all people with disabilities to either a minimum or optimum level, it is likely that additional resources will be required.

6.131 Taxation or targeted levies on certain groups could be one way of achieving this, as could an expansion of superannuation or private insurance assistance to provide improved disability-related benefits. Compensation could also be used in a better manner to assist in meeting these costs, for example through structured settlements and measures to prevent compensable people from accessing government-subsidised services (double-dipping). This in turn could result in more resources to provide government assistance for non-compensable people. Various administrative streamlining options are included in the earlier recommendations of this chapter, including using a single eligibility assessment point for all necessary services. All of these measures could increase the resources available to meet the needs of people with disabilities.

6.132 It is also important to recognise these interrelationships when determining whether to remove costs from compensation arrangements to reduce the premiums of specific groups (such as been argued for by some doctors). For example, removing costs from the common law system by capping damages would not result in greater funding for government assistance, but rather would increase the number of people seeking government assistance from the same limited budget. On the other hand, the option of removing some elements from the tort system (and other compensation systems) may have sufficient cost benefits to justify it without any cost transfer. In many other circumstances, it might be sensible to have the one administrative or payment system, but to require the contribution to these costs (once removed from the compensation system) by a levy on or contract payment from the previous compensation payers.

6.133 The PIR does not consider there is a single best model for addressing these interfaces. The Commonwealth Government's current model for the prevention of double-dipping and certain forms of cost-shifting against Medicare and nursing home benefits is outlined below. The final section looks at the option for using community assistance as the system of first resort, rather than last. The consideration of the most appropriate interfaces in different programs and areas is a matter for the Commonwealth and State governments, both separately and together.

6.134 For example, it may be that the most rational longer-term option for health care services for the Australian community is that these costs are removed from compensation arrangements and provided under Medicare. Courts themselves have highlighted the sense in such a proposal, as was discussed in the Interim Report[49]. In the area of medical negligence, this could reduce contributions by doctors. It is also consistent with the submissions received from bodies like the Committee of Presidents of Medical Colleges, where it is strongly argued that future care costs should be removed from the arena of medical negligence and provided by the Commonwealth[50].

6.135 However, in other programs - particularly those that are currently limited in budget - double-dipping prevention and cost recovery options may be more appropriate in the short term at least.

6.136 **The PIR recommends that the evaluation of the Commonwealth-State Disability Agreement should report on the current approach of State and Commonwealth community services to assistance to those who have received compensation. (Recommendation 86) The PIR further recommends that the Commonwealth and state Governments then determine the most effective arrangements between compensation and other relevant programs of assistance to maximise financial transparency and coordinated care. The aim should be to clarify arrangements in a manner which does not disadvantage those who receive compensation, but which looks to minimise any opportunities for double-dipping and cost-shifting, and that aims to better mesh the systems of compensation and community assistance. (Recommendation 87)**

Double-dipping legislation

6.137 The Compensation Review found that many people receiving compensation designed to meet the full cost of health and community services were obtaining free or heavily subsidised services through programs funded by the Commonwealth Government. This double-dipping generally occurred when a person received a compensation payment to cover health and other care needs relating to the compensable injury and then did not reimburse the cost of services already received. Such double-dipping meant that the community paid twice for a service – once through insurance and again through Commonwealth subsidised programs.

6.138 It became clear in the consultation process on the legislation discussed below that the proposed legislation would also address cost-shifting, which was occurring when the compensation payer did not provide any reimbursement to the injured person or the Commonwealth for past costs paid by Medicare or the nursing home benefits program. Some insurers also noted that they do not inquire about costs if a person does not present any medical bills, even when the injury is quite significant. Other insurers stated that they only paid the person's out of pocket costs, that is services outside Medicare and the costs above those paid by Medicare. This cost-shifting benefits those who pay premiums and the company's shareholders at the expense of the taxpayer. Some (but not all of these problems) will be addressed by the new legislation described below.

6.139 The legislation does not address double-dipping or cost-shifting in relation to costs arising after settlement. Options which will need to be considered in the future include: preclusion from benefits where the person has relevant future care costs related to their compensable condition (the current law); allowing a person to "buy in" to Medicare using part of their lump sum at the time of settlement; precluding payment for future medical costs from compensation payments and providing access to Medicare (with or without a levy on current compensation payers); and better use of structured settlement moneys to meet these costs.

6.140 Earlier legislation aimed at preventing double-dipping in Medicare and nursing home benefits was flawed and widely circumvented. A package of four Bills was introduced into the Commonwealth Parliament late in 1994 to address this situation.[51] One of these Bills,

relating to the imposition of an administration fee on insurers, was defeated in the Senate, prior to the passage of the amended Bills by the House of Representatives on 17 October 1995[52]. The *Health and Other Services (Compensation) Act 1995* and its cognate Acts seek to address the issue of double-dipping in Medicare and nursing home benefit programs through the development of improved systems to identify compensation claimants and recipients, and to recover benefits paid until the time compensation becomes payable.

6.141 The legislation provides for the Health Insurance Commission to recover all Medicare and nursing home benefits paid to the compensable person in relation to their injury up until compensation becomes payable in one transaction. Where the amount of compensation is reduced because of contributory negligence, the amount of benefits to be recovered will be reduced accordingly, so as not to disadvantage the compensable person or impose costs inappropriately on the compensation payer. It was estimated that annual savings to the Commonwealth of $40 million could be realised by preventing double-dipping in relation to the Medicare and nursing home benefit programs. Additional savings from cost-shifting were not included in these savings estimates, but the monitoring of recoveries made will enable the identification of all savings once the legislation is implemented.

6.142 The legislation aims to balance the interests of compensation recipients with the competing interests of others in the community whose needs must be met as far as possible from a finite budget allocation. The new provisions will allow potentially compensable people to access both bulk-billing and Medicare payment recoveries pending determination of their compensation case, and recovery will be made at the time of settlement. There are provisions to ensure that both parties know how much will be payable for Medicare and nursing home benefits prior to settling a case.

6.143 The legislation is particularly targeted at lump sum compensation payments. Double-dipping is not considered a significant problem under statutory, no-fault schemes that provide for periodic payments with expenses reimbursed as they are incurred.

6.144 After an initial 18 month period, the legislation also provides for contractual bulk-payment arrangements, where a compensation payer is excused from various reporting and administrative requirements under the legislation, in exchange for agreed payments.

6.145 Once this legislation commences on 1 February 1996, it will enable the collection of accurate data on compensation payments. Further savings could be made if similar measures were extended to cover other programs. As noted above, the issue of double-dipping with respect to future care costs still remains to be tackled.

Using community assistance - first or last resort?

6.146 As noted earlier in this chapter, the position generally adopted in Australia to date has been that compensation should be the primary source of assistance, where it is available. In economic terms, this is supposed to provide maximum incentives to safe behaviour, by putting the full costs of unsafe behaviour back onto the activity which generated those costs. In reality, dual payment arrangements almost invariably fail to achieve this goal.

6.147 Instead, significant hidden costs move into the community-based arrangements and considerable administrative resources are spent classifying people, monitoring that the right sources are being used and recovering any cost-shifting or double-dipping, that is unearthed. These result in further costs for the community, often much stress for the injured person and, in the end, distort any economic message intended to be delivered.

6.148 Another alternative is to have only one payment mechanism or primary source of assistance. This works best where there is an entitlement based program like Medicare already in place. Under this model, rather than being compensable, medical costs would be precluded from recovery under compensation arrangements, at least so far as they were payable by Medicare. As noted earlier, this model underpins many of the successful "no-fault" schemes that operate in Scandinavia. The primary care costs of anyone suffering a medical misadventure there are met under their community arrangements, not under the compensation provisions. The "no-fault" component only meets the additional loss of earnings above that recoverable from social security and non-economic losses - each of these is assessed using ordinary common law damages assessment principles.

6.149 The notion of having one appropriate primary source of assistance also underpins the Tasmanian Motor Accident Insurance Board's provision for those injured in motor accidents who have daily care needs. The *Motor Accidents (Liabilities and Compensation) Act 1973* defines a person as considered to require daily care as follows: "the person will need treatment, therapy, nursing services, assistance, supervision, services for rehabilitation or other care for at least two hours a day for an indefinite period"[53]. In such cases, damages cannot be awarded for these costs[54] - instead the person is entitled to ongoing provision of these needs for as long as they are required - often for their lifetime[55].

6.150 Unlike the Scandinavian model, which relies on the general community based programs available to all citizens of those countries, the Tasmanian system provides the future care assistance on a no-fault basis, funded through motorists' premiums. The arrangements are fully funded, using a small amount of premium income set aside each year. If the person dies the payments terminate. Individually tailored arrangements, including those where some of the services are provided by family members, are funded through this system using individual case managers.

6.151 When the transition from using the tort system to meet these costs occurred in the Tasmanian system, more people were able to be covered with no increase in premiums. This was partly because of the administrative and legal savings from removing these costs from the tort system, and partly because of the savings from reserving funds for these future liabilities, rather than paying out large amounts of capital up front. This latter point is how defendants can benefit as well as plaintiffs when a structured settlement is used.

6.152 **The PIR recommends the Government examine the potential for long-term reform of compensation arrangements by removing payments for future care from lump sum payment under the tort system, in exchange for a right to case-managed individual assistance for people with severe disabilities. (Recommendation 88)** This assistance could be funded through a redirection of those costs currently paid by the tort system, through various tax measures or perhaps more appropriately, through a blend of

sources, as discussed above. Should the Government accept the recommendations in Chapter 7 about structured settlements, such a model could co-exist with a structured settlement model, as the structured settlement could be used as the funding mechanism for case management in relevant cases.

Chapter 7: Reforming the Tort System

A. Background

The PIR's work thus far

7.1 In its first discussion paper[1], the PIR outlined the various legal actions that may be possible when a patient suffers an adverse patient outcome. These included possible actions under consumer protection laws, the law of battery and the more frequently used law of negligence. That paper also described briefly a range of possible reform options[2] as well as summarising the operation of various overseas patient compensation schemes[3]. More recently, the Interim Report proposed that, while the current tort arrangements had many problems, the most appropriate direction for reform in Australia in the immediate future was a combination of reforms of community services and tort reforms[4].

7.2 Chapter 6 has looked at improvements in the assistance available through community-based services, particularly those related to people with severe disabilities. This chapter considers possible reform of the tort system to address the most pressing problems, and describes a range of existing initiatives and other reforms likely to impact on this area. Chapter 8, among other things, looks at the operation of the various complaints mechanisms and disciplinary bodies, which form important other elements of the system for ensuring that the incidence and costs of adverse patient outcomes are reduced.

7.3 The PIR proposed a number of reforms to the tort system in its Interim Report, particularly to reduce unnecessary delays and to look at more appropriate payment mechanisms for damages awards in certain circumstances. Submissions were also sought on a range of proposals that are often lumped together as "tort reforms" but that are more accurately described as cost-control mechanisms to assist defendants reduce their potential liabilities for negligence.

Health professional concerns about the tort system

7.4 Over the course of the PIR and particularly more recently, there has been a great deal of concern among doctors and other health professionals about the tort system. They have expressed concerns about what they see as a weakening of the law of negligence, particularly with the shift away from using the practice of other doctors as the basis for the standard of care expected from a doctor, discussed later in this chapter - the so-called *death of Bolam*[5]. As discussed below, the legal developments that have resulted in this shift have been of much longer standing than is generally recognised. They also mirror developments in medicine and health care, where the focus is more and more turning to evidence of efficacy in determining whether care is appropriate.

7.5 There has also been concern that courts always find against doctors. A balanced look across the range of medical negligence cases indicates this is not so. Even in those cases where there is a judge and jury, and where the plaintiff is someone with whom there is a great deal of public sympathy, such as the recent Nadia Maffei case[6], the result is far from certain

for a plaintiff. While comprehensive data on the results of tort cases commenced are not available, a study by one medical defence organisation (MDO) shows that for cases where liability arose in 1985, only around 20% of cases resulted in a payment to the plaintiff, whether by settlement or judgement. Where a case was taken to court (3%), the case was resolved in favour of the defendant 90% of the time[7]. Another MDO recently noted that only five of its cases had gone to court over the past 6 years and all 5 of these had been found in favour of the defendant.[8] It is therefore difficult to perceive that courts are biased against doctors - the evidence indicates the patient faces the greatest hurdles in winning a case which goes to court.

7.6 Doctors have also argued that even if they successfully defend a case, the associated publicity can adversely affect their practice. They argue that there should be no publicity[9]. Yet, if the tort system is to fulfil its goal at all in educating other practitioners, such publicity is surely a necessary evil. The ironic twist of tort publicity is that clearly negligent practitioners will never face the spotlight of publicity because settlements will be made at an early, private stage. However, making the tort process even more secretive puts the private interests of individual doctors above the community's interests in open justice, and increased awareness and knowledge in those areas where tort cases reach trial and are publicised. The recent O'Shea[10] case has resulted in wider interest in improving information about Pap smears to patients, and also reminded doctors very much of their limitations as diagnostic tools, where other symptoms are present. The publicity of cases where plaintiffs are unsuccessful also helps potential plaintiffs to understand the probable difficulties they could face in obtaining damages.

7.7 Health professionals are also right to draw attention to the stresses they face in tort cases and the suffering of their families as the case drags on, often for years[11]. In studies of doctors who have been sued, they have rated it one of their most stressful life events,[12] with significant psychological effects throughout the process.[13] The stresses for the doctor are amplified by the general cultural approach of medicine to error, as discussed in Chapter 5, and a lack of understanding of the legal process and the concept of negligence as discussed below at paragraph 0. While these concerns are very real, it must always be remembered that plaintiffs face these same difficulties, and face the same dilemmas in the adversarial environment of a tort action. In addition, they are often also dealing with the physical, psychological and financial consequences of the adverse patient outcome - sometimes including an impending early death, in cases involving failure to diagnose a fatal condition. They also often face formidable financial barriers and risks in taking legal action, not shared by the defendant, who is generally adequately protected by professional indemnity cover.

7.8 Many doctors also believe that many more patients are suing their doctors, often apparently because of the publicity associated with medical negligence trials, and the selective and sometimes inadequate reporting of cases by the media[14]. The PIR also received frequent complaints about the entrepreneurial efforts of some lawyers seeking potential medical negligence plaintiffs through advertising. There is little evidence at the moment that such advertising is leading to increased claims against doctors. As noted in chapter 2, no reliable data are publicly available to determine whether the number of health care negligence cases per year is increasing, and if so, at what rate, from MDOs, public agencies or the courts themselves.

7.9 As outlined in the Interim Report the number of cases increased significantly from the pre-1970 period until the late 1980s, but the data provided by the medical defence organisations and limited data available from the public sector since then showed claim frequency was relatively static until 1992, when the confidential survey of claims was undertaken by the Australian Bureau of Statistics for the PIR. Information sought since indicates irregular increases in numbers of claims in some States and some MDOs, but the pattern is certainly not one of exponential or even steady rises, as would seem to be indicated by the public concerns expressed by some practitioners.[15] The overall incidence of legal claims still seems to be quite low - with many of the cases being small cases.

7.10 Some MDOs have provided data showing significant increases in health care complaints activity, which would be expected with the increased availability of this avenue of assistance for consumers. This activity results in increased administration costs for MDOs, which can also be reflected in contribution rises. In some jurisdictions where these are only new, the MDOs costs are rising from a zero base, and so the cost increases per year would be significant in this area.

7.11 The limited South Australian closed claims data and the NSW public sector data discussed in Chapter 2 are consistent with the conclusions of the PIR set out above. The South Australian data shows mixed patterns in the number and size of settlements. While there has been an overall upward trend in settlements, there are signs of more recent declines. Similarly the settlement sizes have not shown a consistent growth pattern. Overall the numbers of claims and settlements seem low.

7.12 As discussed in Chapter 5, increased risk management efforts and the heightened awareness of the potential for suit have resulted in more frequent and earlier notification of incidents, but how many of these will actually translate into legal cases commenced is not yet clear. Recent claims by one MDO that their increased frequency of incidents is reflected in their claims data have not been backed up by any evidence, despite several requests[16]. Similarly, the real effect of advertising by lawyers for potential medical negligence litigants on the number of claims lodged and payments made is far from clear. These concerns and the "crisis mentality" that accompanies them are important reasons why publicly available data on the frequency, type and payments made in health care negligence cases must be collected on a national basis as discussed in Chapter 2.

7.13 As well as these direct concerns, there is the apparent widespread misunderstanding among health professionals of the legal concept of negligence and what it means so far as the health professional is concerned. The need for a better understanding between doctors and lawyers about each others' disciplines was discussed in Chapter 2, and recommendations were made to address this. However, part of the misunderstanding also arises from the culture of medicine about error, as discussed in Chapter 5. The consequences of this culture for a doctor when a mistake or negligence occurs is that he or she may feel a moral as well as professional failure, when that is not the purpose of the law of negligence. Many times throughout the course of the PIR, comments have been made about various legal cases by doctors which have said "He/she is a good doctor - they cannot have been negligent." There

is no logical link between these two comments. Good doctors can have a bad day and breach the standard of care they owe to their patient.

7.14 Defences such as anger, denial and grief occur in a health professional, because the claim of negligence is a very confronting action. The process of litigation is 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 claim, 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. In those few cases which go to court, a judge can accept another person's view of events, which can leave the doctor feeling public humiliation even more acutely.[17] Plaintiffs have similar feelings of unhappiness with the evidentiary processes of the courts which can 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. **The PIR recommends that health professional organisations, medical defence organisations, divisions of general practice and health care institutions look at the availability of counselling and other support mechanisms (including a peer mentor, who may have had experience with a similar event) for health professionals who have a negligence claim or complaint made against them. (Recommendation 89)**

Scope of this chapter

7.16 Perhaps because of the nature of these concerns amongst health professionals - that they are being financially "imposed upon" by the present arrangements - most of the solutions to perceived problems proposed by health professionals have been simply designed to cut the costs to them of negligence cases, and further limit the damages available to injured patients. This is certainly so in relation to most of the so-called tort reforms introduced in the US in the 1970s and 1980s.[18]

7.17 The evidence to support the need for reduced assistance to patients injured by health professional negligence is absent. All the evidence available - and the PIR is the first to admit that this is far from comprehensive - indicates that very few people who suffer an adverse patient outcome that probably involved negligence ever sue, and those who do, are much more likely than not to fail in an attempt to receive compensation.

7.18 Many of the "reforms" suggested in the US are not applicable to the Australian situation. Sometimes this is because Australian laws already impose similar restrictions to those suggested by the US reforms. For example existing Australian law on collateral sources of benefits usually prohibits double-dipping from damages and public programs. Another reason is that precedents in Australia have never moved in the same direction as the US. For

example, Australian awards for non-economic losses are much lower than those awarded in the US. In addition, in some areas, such as high level statutory discount rates, Australian damages are additionally depressed, compared to US awards.

7.19 The inadequate social security and health care system in the US also creates a fundamental difference between the US and Australia. There is no need in Australia to sue for financial assistance to meet these basic needs - they are generally available. Where reforms are being made that are not dissimilar to US approaches, for example, the new moves towards contingency fee arrangements, the models proposed are substantially different than those which have given rise to significant cost problems in the US. In some other areas of US reform, relating to the administration of claims, we already have in place many measures to divert cases from court hearings and litigation, ranging from the State-based health complaints bodies to various court-based case flow management and alternative dispute resolution mechanisms. In other areas, where the PIR considers we have lessons to learn from the US, such as in relation to structured settlements, recommendations have been included to pursue these reforms.

7.20 There has been very limited support for more fundamental change and a move towards a less "tort-based" system both from health professionals and consumer groups. The tort system in this area is still considered to be serving a "public good" function, so far as educating health professionals and increasing accountability for negligence is concerned. It is clear there are many problems with the tort system, which have been discussed at length in the PIR's earlier publications. However, unless and until there are improvements in other accountability mechanisms, such as disciplinary proceedings and credentialling, any removal or limitations on access to the tort system would simply serve to remove one of the only forms of public accountability faced by many health professionals.

7.21 The work of the PIR has defined the system problems that exist rather differently from the folk law spread by the purveyors of the "tort crisis" message. If there is any crisis, it would appear rather to be in the chronic lack of access to legal remedies by health consumers injured through negligent care or who are not adequately informed of the risks of possible treatments before care is provided. This "diagnosis of the problem" guides the content of this Chapter. It focuses on a relatively small number of issues - access to the tort system, administrative concerns (particularly delays), the size of awards and payment arrangements, proving entitlement to damages, and evidence in negligence actions.

7.22 Any general moves away from the tort system in health care negligence cases in the future would need to be contingent on broader system changes, which protected the interests of health care consumers much more strongly than any existing mechanisms do. With the number of people having adverse patient outcomes - even highly preventable ones - being as significant as it is, there are also very large additional cost implications, where even non-economic loss compensation to be provided to all who suffer significant disability from an adverse patient outcome. The PIR's conclusion is that the rehabilitation and on-going assistance required by those with severe disabilities, whatever the cause, are significantly higher priorities for community assistance, where additional funds available, than any separate so-called "no-fault", cause based health care compensation scheme. For these

reasons, **the PIR does not support the further development of a separate no-fault health care injury compensation scheme at this time. (Recommendation 90)**

7.23 Whether such a system (for example, to provide additional compensation for loss of earnings above the level of income support and non-economic loss) will be appropriate at some future date is something for later consideration. However, the PIR believes there are many higher priorities than this, if we are to minimise the human and financial costs associated with adverse patient outcomes, as well as to ensure we do have the high quality health care we are told should be available.

B. Access to the tort system

Introduction

7.24 As discussed above, there are significant problems in accessing the legal system for those who seek damages for alleged health care negligence. These include the significant costs associated with taking such action, difficulties in accessing lawyers with appropriate experience and problems in obtaining expert advice and sometimes even treatment, where a person is suing another health professional.

Access to Justice Report

7.25 Many of the access difficulties faced by patients who are claiming that their adverse outcomes arose from negligence are shared by others seeking damages. In 1993, the Commonwealth Attorney-General and the Minister for Justice commissioned the Access to Justice Advisory Committee "to advise on the range of measures that the Commonwealth could take, either alone or in cooperation with other levels of government and legal institutions, to improve access to justice"[19]. This Committee provided a comprehensive report to the Government in May 1994[20], and in combination with responses to other related reports, the Government responded in May 1995 with its *Justice Statement.*[21]

7.26 The importance of access to the justice system is set out in the statement:

> The justice system underlies the myriad of private and commercial transactions that take place in our daily lives. While we may not always come into direct contact with the justice system, we are empowered by the knowledge that the laws and institutions that form the basis of that system uphold the rights and enforce the responsibilities of every member of our community. The certainty of that foundation must not be compromised by the cost or complexity of the system placing it beyond the reach of any section of the community.
>
> As an essential part of our lives, the justice system must be accessible. It must also respond and adapt to changes in our community to ensure that it remains relevant to contemporary life.
>
> Our nation is built on concepts of fairness and justice. These ideals must be realities for all Australians, in access to justice as much as other essentials of community life

such as health care and education. The Justice Statement is directed to achieving that reality.

> The Government is committed to bringing down barriers that restrict access to justice for all those who need it. Justice, and the means to enforce it, should be available equally across State boundaries, regardless of means, and without discrimination.[22]

7.27 Some of the reforms in the Justice Statement that are of specific relevance to the health care negligence area are:

- requirements in relation to information for lawyers' clients (discussed in the next section);
- the national introduction of "up-lift" based contingency fees;
- $10.5m over 3 years for the establishment of a national disbursements fund;
- an additional $16.8m to legal aid commissions over the next four years for increased access to legal aid in civil and family matters; and
- an additional $6.9m over the next four years to enable legal aid commissions to provide more people with legal advice that is not means-tested.

7.28 The national introduction of contingency fees, not based on the US model of percentage of verdict, but rather on the model of a higher scale fee as already exists in NSW, is an important reform that improves access to justice.[23] Some submissions to the PIR opposed contingency fees, for fear that they would promote further litigation[24]. The statement addressed concerns that have been raised about the likelihood that contingency fees will result in more litigation. The implication of this is that more non-meritorious cases would be pursued. The Justice Statement quite rightly concludes that:

> 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.[25]

7.29 As noted earlier, the plaintiff's chance of succeeding in a health care negligence case is probably far less than even[26], given the difficulties of proving both causation and fault in these complex cases. As indicated in the Interim Report[27], whether the combination of contingency fees and the "risky" nature of this kind of business will result in increased access by potential plaintiffs is not clear. Certainly, it could help those cases where causation is clear - but in these cases access is already likely to exist through speculative arrangements, not involving any up-lift. The downside of this proposal in health care negligence cases could be increased costs in the "easy" cases, and no better access for those whose cases may not succeed. To overcome the first concern, the Justice Statement proposes that lawyers be

required "before proposing a contingency fee arrangement, to assess the risks of winning or losing the case, advise the client in writing of that assessment, and be able to defend the imposition of a contingency fee on the basis of those risks."[28]

7.30 **With the above reservations about the need to monitor whether access in these cases is actually being improved through contingency fee arrangements, the PIR supports the expansion of the kind of up-lift contingency fee arrangements proposed in the Justice Statement as one way of potentially addressing the problems faced by people seeking redress for alleged health care negligence. (Recommendation 91)**

7.31 In jurisdictions, where speculative and up-lift contingency arrangements already exist, particularly where class action methods are being used, the PIR has been informed of problems that need also be addressed as part of any national implementation of contingency fees. In some cases, the "no-win, no-fee" situation, has resulted in plaintiffs being pushed to continue a case, where they wish to pull out for various other reasons - while copies of the particular legal service contracts were not sighted, the PIR was told of some people being told they would have to pay the legal costs incurred to the date of their withdrawal, if they pulled out. If this were being used as a threat by the legal adviser, the PIR believes the conduct to be unethical, and if the contract in fact contained such a clause, the PIR believes it to be an unfair and inappropriate provision.

7.32 Similarly, the PIR was told of people who had commenced actions on a "no-win, no-fee" basis, who were unhappy with their lawyer's work and had sought to change lawyers. In this case, the contract clearly indicated that if this occurred the firm had a right to payment for costs carried by them to the date of termination, before handing over material relating to the case. While it is accepted that the first firm has an economic interest in the work it has already undertaken, and the second firm can unfairly benefit from this unless there is some division of fees, it seems inappropriate to require the often significant costs to be met at that time by the plaintiff. One option would be to allow adjudication of the fee (if any) between the various lawyers by the relevant professional body. **The PIR recommends that these problems experienced with contingency fee arrangements, where a plaintiff wants to cease an action or change lawyers, be considered by the Law Council of Australia and the Standing Committee of Attorneys-General, when they are making the contingency fee recommendations of the Justice Statement operational. (Recommendation 92)**

7.33 The establishment of the National Disbursements Fund is central to the success in improving patient access in health care negligence cases. Currently, even where a lawyer agrees to take on a health care negligence case on a speculative or contingency basis, most require the payment of costs for such things as medical reports and expert evidence "up front" or as required. In a complex health care negligence case, such costs can be very significant, and a real disincentive to proceeding. In addition, some health care practitioners charge exorbitant fees for such reports, allegedly because "the market will bear it" and because of their own perceived inconvenience, possibly in having to later go to court. The content and standard of such reports is often inadequate, and there is little guidance for a health professional about what should be in the report. **The PIR considers that the National Disbursements Fund to be established by the Commonwealth has significant potential to improve patient access to the tort system, and recommends that the establishment of**

standards and fair and appropriate fees for such things as medico-legal reports should form an early part of its work. (Recommendation 93)

Legal advice and patient assistance

7.34 In its interim report the PIR suggested that the option of specialist accreditation in health care negligence be explored. Some lawyers have supported this and others not. However, the prevailing view appears to be that the area of the market is too small to justify such accreditation. Those States that have accreditation, sometimes have accreditation in personal injury litigation, and this is considered by the legal profession generally to be specific enough. The PIR still believes from its work that there are quantum differences between other forms of personal injury litigation and health care negligence cases, and that experience in personal injury law is not sufficient to guarantee an effectively run case for a plaintiff. Accordingly, **the PIR recommends that accreditation or experience rating of lawyers specifically for health care negligence cases be developed in Australia to ensure that injured patients get the best, most appropriate advice at an early stage in their cases. (Recommendation 94)**

7.35 The complex and specialised nature of health care negligence cases also creates the need for specialised legal advice. This is available always to hospitals, doctors and some other health professionals, whose MDOs or insurers have specialised legal advice "on tap". The power imbalance between health professionals and patients is equally reflected in the absence of places to seek specialised advice from the perspective of a health care consumer.

7.36 So far as lodging a complaint is concerned, there are various mechanisms in place, as discussed in Chapter 8, including the independent health care complaints commissions. The role of these bodies so far as the tort system is concerned varies between the States, with those whose key focus is currently the conciliation and resolution of individual complaints playing an honest broker role in the settlement of appropriate cases, as well as providing advice to health care consumers about how to find out what happened to them. Others have little involvement in the tort process, though the findings of an investigation may well be useful evidence in a subsequent tort action. However, an important issue for these bodies is their impartiality which prevents them exercising a role as patient advocate. Chapter 8 discusses the potential role of patient advocates in the resolution of complaints and helping people find out what happened to them.

7.37 None of these models provides a real "one-stop shop" for a person who has had something go wrong, and who is not sure what they should do. None of them can advise a person whether or not the pursuit of a tort action is even feasible. In England, a body called the Action for Victims of Medical Accidents (AVMA) was formed in 1982 to assist people in exactly these circumstances.

7.38 AVMA arose from a televised play called "Minor Complications" by Peter Ransley. It depicted the true story of a woman who went into hospital for a laparoscopic sterilisation, during the course of which her bowel was damaged. She suffered severe pain immediately afterwards, and for many days, problems were denied and she was treated as a "difficult patient" by medical and nursing staff alike. Almost a week later, she had become gravely ill,

and was re-operated on. Because of the delay, a large proportion of her intestines had become gangrenous, and had to be removed, leaving her with a significant permanent disability. The film depicted her difficulties in hospital and afterwards in trying to obtain compensation, including problems accessing the legal system and expert advice.

7.39 Following the play's broadcast in 1980, hundreds of other people contacted the playwright with similar stories and he believed he had stumbled onto a real social problem requiring attention. A steering committee was formed to seek funding in 1981, initially without success. In 1982, the Greater London Council provided a grant of 25 thousand pounds for an initial 18-month period. The organisation has grown steadily since then, becoming a company limited by guarantee in 1988, with a staff of nineteen. Its funding comes from a combination of grants from various councils, hospitals, government and legal bodies, as well as public donations, training courses and publications.

7.40 AVMA aims are two-fold: firstly individual case work for people who have been or think they have been victims of a medical accident (including omissions), and secondly advocacy for changed attitudes and actions by health professionals about medical accidents. The casework element includes non-legal and legal help; AVMA sees itself as "primarily a charity concerned with health, not with law". Some of its non-legal assistance parallels the work of the various complaints commissions, though its role is clearly to represent the interests of the patient. For example, it helps people to find out what happened, and to refer cases to appropriate boards and disciplinary processes, as well as providing moral and physical support in that period. Where a person wants to seek compensation, and their case is assessed by AVMA to be an appropriate one, a referral is provided to a panel of solicitors who have experience and are competent in medical negligence work. The role of AVMA in casework is, in one sense, to address the imbalance described earlier between a doctor supported by an MDO and a plaintiff alone.

7.41 AVMA also set up a Lawyers Support Group, where lawyers doing this kind of work meet to discuss developments and problems of mutual concern, and a Resource Service, to provide lawyers with information, advice and the names of medical experts who are prepared to give evidence in medical negligence cases. This latter issue is also a matter of serious concern in Australia as discussed below. Lawyers pay an annual subscription for these services.

7.42 AVMA contributes the injured patient's perspective into government inquiries of different kinds. It also seeks to alter the attitude of the medical establishment to the issue of medical accidents, through producing articles, speaking to doctors in groups and individually and organising seminars. By these means it says that it "is seeking to persuade the medical establishment to take education about medical accidents seriously."

7.43 The PIR understands that a body of this kind is seeking to become established in Australia, to address many of these same problems. **The PIR considers a body to represent the interests of patients in the manner described above for the English Action for Victims of Medical Accidents (AVMA) to be an option worthy of the support of government. (Recommendation 95)**

The barrier of expert advice

7.44 Throughout the work of the PIR, we have been told of the difficulties patients face in obtaining expert evidence to determine whether or not their adverse outcome arose from negligence. There are practical and attitudinal barriers that make it very difficult for patients. Many doctors are uncomfortable alleging a professional colleague was negligent - partly because of the wide variety of actions that 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[29]. There have been a number of stories told to the PIR that indicate doctors are concerned that they will be sent to professional Coventry, if they speak out against one of their colleagues, particularly if the case goes to court.

7.45 Such an attitude displays a profound ignorance of the core elements of the public duty of a professional of any kind. The public accords these groups their particular status as professionals because of their stated goals should ensure their conduct fulfils the highest standards of honesty and probity towards those for whom they provide professional services. Notions of "protecting their own", which are implicit in the difficulties patients have in obtaining expert advice even in cases of clear negligence, is strongly against the notion of public responsibility inherent in the status of 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.

7.46 **The PIR recommends the development of a national professional standard through the Australian Medical Council and other national or State-based professional bodies to define the discrimination or other negative treatment of those who provide evidence in tort cases, disciplinary processes or any other legally sanctioned investigations (such as royal commissions and coronial inquiries) as professional misconduct, with strong sanctions in such cases. This should also cover similar offences under the various different State health complaints acts, relating to discouraging complaints being made or investigated, or disadvantaging those who participate in a complaint. In all cases it should cover negative treatment against another person of the same health profession, a different health professional, a patient or anyone else. (Recommendation 96)**

7.47 The PIR was also made aware of a number of times where patients were informed that they could not access a particular institution or health service, because they "had lodged a complaint and were a trouble-maker". While formal complaints legislation makes such discrimination an offence, there are substantial difficulties sometimes in proving such cases and it only applies where the complaint has been lodged through that process. If, for example, the injured person goes straight to a tort action, people involved in the court case would not be protected by these provisions. There are also a number of States that do not provide such legislative protection. **The PIR recommends that similar legislative protection should also be provided for those who provide evidence in tort cases, disciplinary processes or any other legally sanctioned investigations (such as royal commissions and coronial**

inquiries) from discriminatory or negative acts perpetuated at an institutional level, with appropriate enforcement mechanisms for breach of this legislation, for example fines and damages for losses caused to the victim of the negative acts or discrimination. (Recommendation 97)

7.48 There is a need, in fact, for professional bodies, such as colleges and others to recognise the important public service that can be provided by encouraging the best and most appropriate practitioners to provide the courts with high quality, up-to-date evidence, not just for defendants but also for plaintiffs. **The PIR recommends that AHMAC and the various colleges work together to determine ways of encouraging health professionals to recognise their public responsibilities to provide expert evidence in tort cases, disciplinary procedures and other related processes, so that decision-makers have access to the best evidence available. (Recommendation 98)** In some overseas jurisdictions, the culture within the health professions is such that the best people are nominated to serve on a panel of experts for provision of such information to decision-making bodies, such as courts and tribunals, and this is considered a sign of professional excellence[30].

7.49 **The PIR also recommends the development of a model like AVMA to address the problems plaintiffs currently face in obtaining expert advice. (Recommendation 99)** The importance of such sources of advice cannot be overestimated. AVMA considers that this role was initially one of the most important in its legal work. The need for a consumer-focussed body to gather information about experts who are willing to provide such medico-legal advice, and ensure that this information is available for lawyers who require such advice for their clients' cases to be successful or even to determine if any case exists, is a fundamental issue in achieving access to justice.

C. Delay in tort cases

Introduction

7.50 One of the most significant administrative and practical problems with the tort system is delays. In the medical negligence area, these can be very significant, as outlined in the Interim Report, where almost 60% of cases were not finalised within 7 years of an occurrence[31]. These delays arise partly from problems with obtaining evidence as outlined above and partly from the need to make a once-and-for-all assessment of the damages necessary to provide for someone who may have injury-related needs arising over a very long period of time. These effect of these delays will only be partially ameliorated by moving to structured settlements as discussed below - the element of delay can only be significantly reduced by an early determination of liability, when partial payments of compensation are made pending finalisation, as currently occurs under some tort-based motor vehicle accident arrangements. They arise partly from slow and cumbersome processing of the claim either through the courts or by the lawyers involved. They are also said to arise because of delays in commencement of claims. This section of Chapter 7 deals with these last two concerns.

Court based initiatives to reduce delays

7.51 Delay in the court process can be defined as "the amount of time between the commencement and the conclusion of court proceedings that exceeds the time necessarily spent in the preparation of a case for trial, the conduct of its hearing and the determination of its final outcome."[32]

7.52 The Interim Report recommended that research be undertaken into court-based case management reforms with a view to recommending measures to reduce the delays in medical negligence litigation.[33] These initiatives involve the judges and senior court administrators taking a more active role in managing the case flow before the courts. It involves processes to speed up the resolution of cases once they are commenced, by imposing time limits on the different processes, by requiring early production of evidence, by requiring an early definition of the areas of dispute, by greater use of court-linked mediation and pre-trial conferences, and by cost penalties and other "encouragement" to early resolution in appropriate cases.

7.53 Some submissions spoke directly in support of these initiatives. For example, case flow management initiatives in South Australia and New South Wales were supported by a correspondent who stated that the success of changes in those States was well-known. The correspondent urged the PIR to recommend that the Commonwealth Attorney-General encourage other States and Territories to implement similar changes.[34] One correspondent commented on the New South Wales' initiatives that, "... there is no doubt that case flow management procedures can significantly reduce delay in litigation."[35] This correspondent recommended the New South Wales' differential case management scheme be introduced in other jurisdictions. Another correspondent wrote to the PIR pointing out that significant work was being undertaken in Victoria to reduce court delays.[36] The Commonwealth's Justice Statement referred to above also strongly supports such initiatives, and describes how these methods are to be implemented in various federal courts and tribunals[37].

7.54 Delay in the courts were once simply viewed as a function of a lack of resources. If more judges could not be obtained to minimise delays then rules or procedures could be adopted to improve the productivity or decrease the workload of judges. It was assumed that by adjusting the level of resources or altering procedures or rules, the pace of litigation could be controlled.[38] It is now widely acknowledged that while resources, rules and procedures can have a significant impact on court operations, informal relationships, norms and practices of court practitioners are equally important in determining the efficiency of courts and the effectiveness of delay reduction activities.

7.55 Two major United States studies[39] have found that the case processing time of a court cannot simply be attributed to its size, caseload or the presence of speedy trial rules. "Rather, ... both speed and backlog are determined in large part by established expectations, practices and informal rules of behaviour of judges and attorneys." Unless practitioners and litigants expect that rules and procedures will be enforced by the court there will be little incentive for them to change established behaviour. They will most likely continue to enter into informal arrangements, which may be to their personal advantage but to the detriment of the efficient operation of the court.

7.56 Since the mid-1980's, Australian courts have taken significant steps to improve their administration of civil actions and to facilitate the speedy resolution of litigation, including:

- using case flow management to control the progression of cases brought before them;
- increasing their emphasis on alternative dispute resolution;
- enhancing court control of interlocutory steps; and
- encouraging earlier pre-trial disclosure of information.

Court-based reforms designed to reduce delay are fully detailed in Appendix G.

7.57 The basic premise of case flow management and many of these reforms is that courts are not merely neutral adjudicators. Rather, they have a responsibility for the efficient and timely disposal of cases by managing the progression of cases from filing to disposition. In contrast to rule and procedural changes, case flow management allows courts to influence all aspects of case progress through direct intervention. This forces a change in informal procedures and will eventually affect expectations and norms. Case flow management also provides a mechanism for ensuring that procedural rules are adhered to. Most discussions of case flow management refer to the following as important features of a successful case flow management system[40]:

- 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.

7.58 There is considerable variation in implementation of such changes across Australia, probably at least partly because of the different volume of court activity in different jurisdictions. In Tasmania for example, the volume of civil court activity particularly in the area of personal injury is quite low and does not fully occupy the assigned judges. For this reason Tasmania has not considered restructuring existing arrangements as a high priority.

The streamlined operation of its no-fault motor accident scheme probably contributes to this low volume, diverting all but the long-term cases away from the tort system. The Commonwealth and States are currently jointly developing performance "benchmarks", to help courts measure their effectiveness and efficiency. This exercise was agreed to by the Council of Australian Governments in July 1993, and seems likely to encourage the spread of active case flow management to all levels of the court system across Australia[41]. The possibility of National Case Disposition Guidelines is also discussed in Appendix G.

7.59 Most of these managements and procedural changes are designed:

- to set firm time frames, which must be met by the parties;

- to encourage the earliest possible settlement through open exchange of information and determination of matters in dispute;

- to minimise the need for and opportunity to bring up matters at the last minute (sometimes colloquially called *trial by ambush*) ;

- to provide lower cost forums and mechanisms to resolve cases without going to court hearing, such as pre-trial conferences, early neutral evaluations, mediation and arbitration;

- to reduce time-consuming legal formalities and paperwork to the minimum required for justice to be done; and

- to provide cost penalties and penalties such as striking out an action if unnecessary delays and complexity are being caused by either party or its lawyers.

7.60 Case flow management initiatives and other delay reduction strategies detailed below have been very effective in reducing court delays. For example, in NSW, the number of matters on hand (matters where a notice to set down for hearing has been filed) in the Common Law Division of the Supreme Court has dropped substantially in the period June 1990 to March 1994 - from 7419 to 4329.[42] The estimated time to dispose of matters on hand fell from 3.9 years in 1989 to 1.5 years in March 1994. Other performance information available is summarised in Appendix G.

7.61 There are also some legislative initiatives that attempt to avoid the commencement of legal proceedings at all. One of these was introduced into the South Australian District Court for motor vehicle accident cases, but it may also be useful in the area of health care negligence. In South Australia, a plaintiff must notify the defendant insurer of a potential claim 3 months prior to lodgement of the initiating documents in a court process. If the plaintiff's lawyer does not do this, then there are cost penalties. This allows the defendant insurer to make an offer of settlement in appropriate cases even before any costs of the court process have been incurred. In motor vehicle accident matters the District Court requires the plaintiff to give the insurer 3 months notice before issuing proceedings. This is designed to encourage settlement negotiations before the matter becomes the subject of court processes.

7.62 The better management of cases by courts imposes disciplines about preparation and timing on practitioners. Prior to these initiatives, there have been considered to be in-built incentives for lawyers to delay resolution, because with existing fee arrangements, the more steps they take, the greater their level of remuneration. Also, if a case has been run over an extended period of time, it is more likely that a client will accept a larger bill, than if the matter was disposed of quickly.

7.63 This attitude was described to the PIR as one that used to exist in South Australia, and which initially led to significant resistance among some lawyers to the tightly managed processes before the Courts there. However, after an adjustment period, lawyers noticed that their income came in faster, and they could in fact manage more cases over the longer time period. In turn these benefited plaintiffs and defendants, because their costs were lower and the cases were finalised faster. For a defendant, this led to earlier finalisation of any liability as well as a shorter period of worry about the litigation process itself. For plaintiffs, it meant knowing whether or not they were entitled to compensation faster, and earlier payment if they were.

7.64 **The PIR strongly supports current court-based delay reduction reform initiatives as detailed in Appendix G. (Recommendation 100). Given the complexity associated with many health care negligence cases, however, the PIR considers that it would be worthwhile monitoring the effects of such initiatives, to see if in fact they are settling more quickly. The PIR recommends that the Department of Human Services and Health liaise with an appropriate body, such as the Australian Institute of Health, Law and Ethics, to undertake such a study and to liaise with court registries to ensure health care negligence cases can be identified for tracking purposes. Such a study should also include liaison with the Australian Institute for Judicial Administration about any special needs there may be to streamline these cases even further. (Recommendation 101)**

An Australia-wide statute of limitations

7.65 In the Interim Report, the PIR recommended that an Australia-wide statute of limitations, generally of three years, be considered.[43] While noting an exception could be made for cases where the harm is latent, the PIR suggested a three-year statute of limitations could help overcome some of the extensive delays and costs associated with the tort system. To counter possible adverse effects on health care consumers' rights to bring a tort action, the PIR recommended development of guidelines for patients on how to find out information and be more aware of their rights, in the event of an adverse patient outcome.[44]

7.66 The option of an Australia-wide Statute for Limitations for medical negligence cases was discussed by several correspondents. This option sought to address the extensive delays which are experienced in health care negligence cases because of the legal assessment of "competence" and the latent nature of some health care interventions where the disability or illness does not become apparent until a long period after the incidence.[45]

7.67 From the perspective of professional medical colleges, one correspondent supported a statue of limitations of three years for medical negligence cases. This correspondent also

supported an absolute limit of six years from the date of injury for the commencement of legal action for people without legal competence, for example, a child with a brain injury. The medical defence organisations supported a shortened Statute of Limitations although recognising that such a strategy would only be effective if judicial discretion to waive the Statute was either removed or markedly constrained.[46]

7.68 However, most correspondents who discussed this issue rejected the option of an absolute Statute of Limitations for medical negligence, noting that was inconsistent with a needs-based approach to compensation and the focus on prevention and prompt rehabilitation. For example, one correspondent did not think that it was possible to judge the level of disability of an individual at a particular age. This correspondent expressed concern that, "the rights of children injured at birth will be limited compared to other members of the community".[47] Another correspondent felt that the case for limiting medical negligence actions to three years was not substantiated[48]. Another comment was that a sufficient case had yet to be made for reducing the time limit for lodging claims particularly in respect of the issue of denial of natural justice for those where the injury does not become evident until many years after the event, for example, Creutzfeld-Jakob Disease.[49]

7.69 One correspondent strongly opposed any reduction to limitations periods, noting that patients' rights should be paramount. This correspondent's work in the field of psychiatric abuse revealed that the patient is often so brutally abused (physically and mentally) that he or she can not protest against the abuse until long after the assault has occurred.[50] A number of correspondents also commented on problems that result in substantial delays in the lodgement of cases. An example is the difficulty of establishing the relevant standard of care and the delay between establishing causation and accessing rehabilitation and other assistance services.

7.70 **The PIR accepts that a shortened statute of limitations in health care negligence cases should, at this time, be rejected. The current lack of accessibility to the tort system for health care consumers, the difficulties they face in finding out what occurred, and their difficulties in getting access to their health records are all good reasons not to attempt to shorten the period of the statute of limitations at present. (Recommendation 102)** The PIR originally proposed consideration of a shorter statute of limitations to enable the funders of occurrence-based products to be able to determine their liability with greater certainty. However, with the system operating as it does, this certainty would probably be at the cost of making invalid legitimate claims, which have already faced formidable practical difficulties. The PIR does not think that this would be a fair outcome for health care consumers - the certainty for medical defence organisations and other funders of defendants (including governments) would come at too high a price.

7.71 However, national consistency in relation to the length and potential for extension of the statutes of limitations in all States would be desirable. The PIR views the NSW statute of limitations as offering a reasonable balance between the interests of both parties to litigation. **The PIR recommends that the Standing Committee of Attorneys-General establish a model statute of limitations which could be adopted nationally to ensure equity of access to the courts to all Australian citizens. (Recommendation 103)**

7.72 There are very good practical reasons to encourage early disclosure of potential claims (as discussed in Chapter 5) and for patient who suffer a potentially negligent adverse patient outcome to be made aware of this at an early stage. Similarly, where a case cannot be resolved informally, it would be desirable to ensure prompt commencement of legal proceedings. Both benefits can be achieved without at this time seeking to shorten the statute of limitations. For example, early definitions of liability can be obtained by creating a more open system, where patients are made aware when an adverse event has occurred, particularly where it could have involved negligence. A more open system is also encouraged from the potential defendants side through improved risk management and adverse event notification processes. In both cases, the obtaining of fresh evidence and documentation enhances the likelihood of successful suit or successful defence. Many of the PIR's other recommendations are designed to achieve these ends.

D. Damages assessment and payment

Submissions on limitations on damages

7.73 The Interim Report discussed in considerable detail in Chapter 4 the various kinds of damages available to compensate a person who can establish that their disability arose from the negligent act of a health professional or health institution. It suggested a range of ways that damages awards could be limited, while also indicating the arguments against many of them. Many of these themes were picked up in submissions.

7.74 One correspondent rejected many of the PIR's options for limiting the amounts of compensation, noting the tort system is a force for quality in health care.[51] The correspondent said that an award for non-economic loss (pain and suffering) was integral to the remedy provided to the injured patient and an essential deterrent to negligent care. The correspondent went on to note there is a precedent for the award of exemplary damages in medical negligence. Capping compensation and limiting the operation of the earnings-related principle were both said to be inimical to the principle of justice embodied in the tort system. According to the correspondent, the tort system is entirely capable of making assessments of future care costs and required no change.

7.75 Another correspondent who rejected capping compensation thought the major problem was under-compensation.[52] The use of tables for assessment for non-economic loss was also rejected as tables were seen as inflexible, that is, they do not take into account the effect of an injury on an individual basis. Similar comments were made by a correspondent who wrote that an accurate estimation of the plaintiff's loss is rarely possible, with some being over-compensated, but a much larger group being under-compensated. Capping of damages was opposed as it would not result in fairer compensation.[53]

7.76 A correspondent pointed out, "... damages is not only compensation it is punishment for the provider and probably even more so `the system' to give it `a hard kick in the wallet' which is the only place that hurts it."[54] It was noted by another correspondent that the issue of caps on damages had been raised in non-medical areas, such as accountancy.[55] It was said to be a complex area in which the social and financial implications of measures to control costs must be considered carefully by the PIR.

7.77 Capping awards for general damages and transferring the costs of future care to the needs-based welfare system were seen by some as appropriate measures to help reduce the financial uncertainties and total costs of professional indemnity.[56] A time limit to the operation of the earnings-related principle, and then moving to a flat-rate, was seen as a fair principle by another correspondent.[57] It was felt this would encourage health and independence where possible and provide fair support where full health and independence could not be regained.

Limits on damages - the policy issues

7.78 The general policy of the law is that damages for personal injuries should only be limited when there are other overriding policy reasons for so doing. One of the main reasons for such limits being imposed in Australia has been the replacement or supplementation with no-fault system benefits, such as has occurred in motor vehicle and workers' compensation arenas. In some other areas, the reasons have been mainly financial and political - to limit premium increases, such as occurred in NSW in relation to motor vehicle accidents, where such increases are seen as politically unacceptable. It is not clear that these same policy, financial and political concerns arise in relation to health care negligence.

7.79 While some health professionals, particularly doctors, can be seen as politically influential, the PIR does not consider that there is strong evidence of need for reductions in damages. The overall amount paid out (except in very large cases, which are considered separately below) does not appear to be particularly large, the premium payers are generally high earners, the law of negligence still operates in a traditional manner in most of these cases, and the number of cases where payment is made under the tort system appears to be low in absolute terms.

7.80 Once better data is available, it may be possible to determine whether there are other areas of cost-containment that are appropriate, but there is currently insufficient evidence for the PIR to recommend any such special limits. If the issue of cost-containment were to become a pressing issue in the future, the options would be to consider cutting costs overall or in either large cases or small. Simply cutting costs overall could further disadvantage those who are most seriously disabled, and shift larger costs onto community services and the families of those with severe disabilities.

7.81 If cuts were to be targeted to particular types of claims, it is necessary to know the pattern of claims to accurately predict any impact. While it is difficult to be certain, the data that is available indicates a pattern of claims in this area that is not very different from other areas of personal injury litigation - that is, there are a large number of small claims and a small number of large claims. Various measures discussed relate to large claims. Many of these are likely to contain costs, but are important reforms for other reasons. On equity grounds, the PIR would argue they should be implemented, even if the overall costs to the tort system were greater.

7.82 Various measures to contain the costs of small claims have been implemented in NSW under motor accident legislation. Most of these measures require compensation for any

economic losses (such as lost earnings and medical and rehabilitation costs), but limit recovery for non-economic loss to more serious cases, with no non-economic loss payable when the amount assessed is below a specified floor[58]. It is arguable that such measures provide an appropriate balance between cost containment and equity. Recent changes in NSW have tightened the floor that applies in these cases to further contain costs.[59] The impact of these changes can be quite significant, depending upon the pattern of claims - in NSW motor vehicle accident claims, the package of changes is estimated to stop a compulsory third party premium rise of 70%.[60]

Large damages awards - the policy considerations

7.83 Damages awards in the health care negligence area have, over the past year or two, caught up with the levels payable in other forms of personal injury litigation - a recent Victorian settlement involving a permanently severely disabled young adult being said to exceed $6m[61] and a 1994 South Australian Supreme Court judgement involving a severely brain damaged infant being for around $5m.[62]

7.84 Such damages awards have led to cries from some for the capping of damages awards. There is often a misunderstanding about what such large amounts are for, which adds enthusiasm for the capping proposal. The vast bulk of very large damages awards in Australia - sometimes up to 90% - is for the person's costs of care. A very large award in the several million dollar category, generally means the person needs constant care and attention.

7.85 To limit to total size of a damages award would result in a person with very high-level care needs arising from their injury being unable to meet these costs from their award. As already occurs in cases where the award or settlement has proved inadequate, the person would be thrust back onto community-based assistance as soon as their award ran out. Other capping regimes operating overseas, particularly in the United States, cap the amount payable for non-economic loss. Both overseas and in Australia among some health professional groups, there was strong support for the so-called Californian cap. This caps non-economic losses at around $250,000. In California and some other US states, this significantly reduces the total amount of a damages award. However, that is because the non-economic loss component of verdicts in the US can itself be in the millions. In Australia, this component of damages rarely exceeds the Californian cap. Therefore it is unlikely to reduce the amount of damages payable, except for a small handful of cases which may include a marginally higher sum.

7.86 The only way to significantly reduce the actual size of large damages awards in a manner which does not simply disadvantage those with the greatest needs is to look at alternatives to the single lump payment for future care costs. This section briefly considers structured settlements. The main other option of removal of costs from the tort system with provision of these needs through a no-fault or community based arrangement were discussed in Chapter 6.

Structured settlements - an introduction

7.87 The PIR has dealt with the issues of the disadvantages for those with long-term support needs of a single lump sum payment for future care costs both in the Interim Report[63] and its separate discussion paper on structured settlements[64]. This discussion paper provided a number of case studies based on the records of real cases before the Administrative Appeals Tribunal, where often very large lump sum awards have proved to be inadequate, and people are seeking access to social security payments because they are now destitute.

7.88 These issues have been widely discussed both in Australia[65] and overseas[66] over many years. Many overseas jurisdictions have moved to address the problems by encouraging the use of structured settlements. Structured settlements are financial arrangements that provide a combination of periodic payments and occasional lump sums, where the timing and size of the payments are tailored to meet the needs of the recipient. They can also make provision for the claimant's dependants in the event of the claimant's death. While the term structured settlements usually refers to private contractual arrangements entered into as part of a settlement, many of the same arguments can be made in relation to court judgments that achieve the same end. Unless otherwise indicated, the PIR refers in the following discussion to both these mechanisms, when discussing structured settlements.

7.89 The PIR received many submissionswhich commented on the introduction of structured settlements. One correspondent supported the greater use of structured settlements because, "... serial payments are more likely to provide adequate and continuous care and maintenance for their recipients without them having to return to the welfare system".[67] With respect to examining tax law amendments to maximise incentives for structured settlements, another correspondent commented on the advantage to insurers of being able to cover their liabilities at a lower cost since they would not have to find the lump sum "up front".[68] The concept of structured settlements was also supported on the grounds of equity and lower costs and it was advocated all liability cease in the event of a patient dying.

7.90 Offering a different viewpoint, another correspondent noted that although generally simpler and easier to administer, lump sums should not be paid to the person or persons involved. The correspondent advocated that the money be held in trust with the compensable person applying for tax-free disbursements when required and on production of evidence of need.[69]

7.91 One correspondent said incentives to take lump sums related to the greater attractiveness of being paid a large sum as opposed to being "doled out an amount each fortnight".[70] The activities of insurance companies who employ invasive surveillance tactics in an attempt to limit their on-going liability were also cited as a disincentive to periodic payments. Further problems raised were the lack of understanding on the part of the claimant of the disadvantages of lump sums and the claimants' solicitors' personal financial interest in securing a lump sum for their clients. This correspondent noted experience shows claimants often receive incomplete or incorrect advice about social security law.

7.92 Periodic compensation payments were supported by a correspondent who observed it was desirable to have payments available over a lifetime from the point of view of security of

care and service.[71] For this correspondent lump sum payments were still an important option, for one-off payments for expensive or large equipment. Comments about combining lump sum and periodic payments were made in several submissions: For example, "[l]ump sum payments are useful and in many cases essential in enabling lifestyle choice to be made ... but lump sums of themselves do not provide adequate compensation. Continuity of payments is also important. We argue for flexibility in the payment of compensation and the ability to take a combination of lump sum and periodic payments".[72]

7.93 Another submission addressed the deficiencies of lump sum settlements.[73] The correspondents went on to support the introduction of structured settlements, noting that they had extensive experience of negotiating such settlements in relation to diseases caused by asbestos. These settlements, the correspondents said, could be structured to provide an initial payment based on loss that can be said to be virtually certain to occur at the time of settlement, with additional payments linked to specified contingencies.

7.94 Addressing provision, cost and uncertainties associated with medical indemnity, one correspondent wrote giving in principle support for structured settlements, provided, "... the fund's liability can be fully and finally discharged by the purchase of an appropriate annuity, or the capital sum reverts on the death of a patient".[74] This view was supported by other commentators.[75] Structured settlements, it was said, protect the community from the cost that arise when the welfare system is relied upon to meet the needs compensation was awarded for after compensation has been spent on matters it was not awarded for.

Barriers to the broader use of structured settlements in Australia

7.95 While court-based structured settlements require legislative changes to allow the court to make such an award, any plaintiff can enter a contractual arrangement of this kind at the present time. However, there are very few of these in place in Australia, even though there is considerable evidence from overseas that both plaintiffs and defendants can benefit from them. Given this, the PIR concentrated its efforts on the identification of the barriers to broader use of structured settlements, and ways of encouraging their use.

7.96 It also looked at the availability of lump sum compensation across the tort system (ie not just medical negligence). It was estimated that over 65,000 people receive a lump sum payment of compensation for personal injury each year in Australia. Of these, fewer than 3,300 people receive money for future income and of these fewer than 500 people receive money for future care needs. However, these 3,300 people, representing fewer than 5% of lump sum recipients, receive more than half of the total money paid in lump sums. Accordingly, the money received totals approximately $1,474 million per year, of which at least half and probably more is paid for future care and income requirements.[76]

7.97 One of the greatest barriers to the broader use of structured settlements in Australia has been traditionally considered to be the current taxation regime, so the PIR sought expert advice in this area. A separate report of that consultancy[77], undertaken by Coopers and Lybrand on behalf of the PIR, is available. The structured settlements discussion paper includes a brief discussion of the current tax law and other barriers to the broader use of these arrangements.

7.98 In summary, the conclusion of the work is that under current tax rulings structured settlements may well be able to be paid in a similar manner to that used overseas (that is, the periodic income is tax free) though there is considerable uncertainty about how the tax office may deal with any individual arrangement. Tax rulings indicate that the important issue is the nature of the payment - whether it is capital or income. However, the ruling says the person cannot choose the nature of the payment by simply calling it, for example, compensation for loss of earning capacity (which is generally believed to be capital in nature), rather than compensation for lost earnings (which is income). The Taxation Office can look at how the payment is made, and where it is paid periodically, it may well be considered to be income. In the case of care costs, reimbursement arrangements are not likely to be taxable, but income to buy the services may well be.

7.99 This complexity and uncertainty - about whether the periodic payments received for loss of earning capacity or injury-related care needs will be taxable - lead to an understandable reluctance on the part of a plaintiff to accept such an arrangement. **For structured settlements to be more widely used in Australia, the PIR considers that a clear ruling about the existing law covering the tax treatment and characteristics of the structured settlement products covered by the ruling is a necessary first step to any broader use of structured settlements. The PIR recommends that the Taxation Office finalise such a ruling as soon as possible. (Recommendation 104)** It is only once this ruling is made that it will be known if any legislative changes are necessary to encourage the use of structured settlements.

7.100 **If such a ruling is not consistent with the encouragement of the use of structured settlements, the PIR recommends the Commonwealth Government take urgent action to amend the tax law to encourage the use of structured settlements. (Recommendation 105)** The Coopers and Lybrand Report indicated that encouraging the use of structured settlements was in the financial interests of the Commonwealth Government, even where any income derived from such a product was tax-free. However, there were concerns raised with the PIR about possible "flow on" effects if structured settlement payments were ruled not to be taxable, principally to workers' compensation and other periodic compensation schemes, and the possible costs implications of this.

7.101 The concern is that generally in Australia, workers' compensation weekly payments are taxable, which differs from some overseas jurisdictions, such as the US, where such payments are net of tax and therefore not taxable in the hands of the recipient. These payments are considered here to be for lost earnings, and so in the nature of income, not capital. Any change in the tax status of these payments would involve a considerable loss of revenue to the Commonwealth. It would also seem to be stretching the bounds of credibility to try to argue that payments for a week's absence from a work injury involved provision for loss of earning capacity. Such a position would undercut the conceptual essence of current arrangements.

Broader tax reform options to encourage the use of structured settlements

7.102 An option is needed that addresses these concerns about loss of revenue and recognises the importance of the differences between capital and income under Australian tax law, while at the same time providing encouragement for people with long-term compensation needs to use a structured settlement and providing certainty and predictability for all about the treatment of particular payments. One possible option would involve two elements:

- periodic compensation relating to earnings could be defined as income for a certain period after injury (say, for example 2 years) and thereafter be defined as capital; and

- income received to meet care costs would not be taxable up to an appropriate annual indexed limit prescribed in the appropriate legislation, so long as proper receipts showing expenditure up to that level were retained .

7.103 There would undoubtedly need to be limits on the payments under such products and other safeguards to ensure that they were not used as tax minimisation mechanisms, but this model at least seems to address the key concerns mentioned above. However, the first component is already implicit in current tax office treatment of periodic payments under the Victorian no-fault motor accidents scheme and long-term benefits post two years in the South Australian workers' compensation scheme. What is required for broader use of such arrangements is certainty. **The PIR recommends the Government consider an amendment to the tax law to define a period after which compensation periodic payments would be considered to be periodic provision for loss of the capital asset of capacity to earn. (Recommendation 106) Further, the PIR recommends that the Government consider an arrangement to allow periodic receipt of income for injury-related care costs in a tax-free manner, up to a statutory limit and subject to proof of expenditure on such costs. (Recommendation 107)**

7.104 The PIR does not favour a model where all damages awards are obliged to be paid periodically in every case. Structured settlements should be available to all, but they should not generally be mandatory. In many cases, the damages recipient has minimal on-going care needs and the most cost-effective and appropriate option is likely to be a single lump sum payment. However, in the case of very large awards in the millions of dollars, where the person must have very significant on-going care needs, the PIR considers that there is a strong argument that the use of structured settlements for the future care component of such an award should be mandatory. **If the Government accepts the PIR's recommendation about the desirability and practicality of encouraging the use of structured settlements, the PIR recommends the Commonwealth Government further considers whether it should be mandatory in very large damages awards (for example those over $1 million) for the future care costs component to be taken as a structured payment arrangement - whether by settlement or judgment. (Recommendation 108)**

7.105 If a mandatory arrangement were considered to be the best approach for the future care component in very large damages cases, a person would still be able to take all the other

parts of their damages as a lump sum. For those who believe they may require periodic larger sums, for example to replace expensive equipment, this can also be included in a structured settlement, in addition to the initial lump sum at finalisation.

7.106 If there are difficulties in getting State Governments to amend legislation to allow courts to award damages through structured payments, then the Commonwealth should consider allowing a roll-over period after judgment to allow a recipient of a damages award to purchase an appropriate structured payment product and still obtain any preferential tax benefit.

7.107 The PIR expressed some concerns in its discussion paper about the availability of a range of suitable products to meet these needs. Some possible products were described in that paper. Judging from the interest in the insurance industry in the discussion paper and consultations held by the PIR, there appears to be growing industry interest in this area. It is therefore highly likely that appropriate products will be made available, if they are not currently there, as interest from all parties increase.

E. Proving entitlement to compensation

Views from submissions

7.108 In the Interim Report, the PIR rejected establishment of a separate system of compensation for any special groups. In particular, it recommended against establishment of single lump sum, single purpose compensation schemes for special groups as has occurred overseas, for example for immunisation-related injuries.[78] The PIR's recommendation was based on the view that special purpose schemes:

- do not help achieve the goal of simplifying and standardising compensation arrangements and their relationship with community-based assistance;

- militate against equity between compensable and non-compensable people with similar needs; and

- usually entail complex eligibility requirements related to the cause of the injury or harm, such that for many applicants eligibility is as difficult to demonstrate as it is to demonstrate negligence in the tort system.

7.109 Correspondents offered a range of opinions, some approving the recommendation,[79] others advocating particular groups that should be considered for no-fault compensation, or in favour of no-fault compensation generally.[80]

7.110 Some of those correspondents who were in favour of the recommendation commented on the difficulties associated with no-fault compensation. For example,

> [w]hile supporting in principle the no-fault compensation system, I believe that their [sic] has been only limited experience in other countries which to judge the benefits and adverse effects of this system. These examples would need to be fully studied and assessed before any consideration was given to change. There is no evidence that

> national compensation schemes introduced in other countries have been totally successful. In fact, new reforms have produced new negative effects.[81]

7.111 Some correspondents approved the recommendation because they believed no-fault compensation that covered all health care injuries would, "... run the risk of increasing costs and possibly the incidence of vexatious claims".[82]

7.112 Other correspondents approached the recommendation by contrasting no-fault compensation with the tort system and found the tort system preferable:

> [T]he tort system is a powerful device for delivering justice and remedy to those injured by the negligence of others ... By comparison, a no-fault compensation scheme stagnates legal thinking ... and is subject to the risk of cost saving changes being made by non-accountable bureaucrats which will substantially jeopardise the rights of innocent victims.[83] The desirability of the tort system as an incentive to good practice and deterrent to poor practice was also singled out in submissions.[84]

7.113 Turning to those correspondents who disagreed with the PIR's views on compensation schemes for special groups, the issues identified included those where there is a known but relatively small risk of a patient suffering harm, which is thought to be outweighed by the public health benefits flowing from the health treatment concerned. Another problem highlighted was that without access to no-fault compensation, those harmed have to seek compensation in the civil courts by alleging negligence. This is not only costly and stressful for all concerned, but if large awards of damages result, this could deter the relevant manufacturers and/or health care professionals from continued participation in that area of health care, thus reducing the availability of an effective public health measure.

7.114 One correspondent argued, in relation to harm which occasionally results following some vaccinations:

7.115

> [i]t is known that a small proportion of recipients of vaccines may suffer adverse reactions of varying degrees of severity. These are statistically expected and although every effort is made to eliminate such risks, it is impossible to eliminate them entirely ... However to defray costs of treatment or to compensate for prolonged disability, the only recourse a plaintiff has is to charge with negligence, those agencies involved in the provision of the vaccine.[85]

This correspondent continued by drawing attention to vaccine manufacturers' concern about increasing litigation and to suggest a no-fault indemnity system to ensure, "... the continuing availability of life saving vaccines and [that] the industry can continue with vaccine development without the threat of resources being diverted by costly, inappropriate and inefficient litigation.[86]

7.115 The effect of litigation on obstetrics management was highlighted by a correspondent advocating that those suffering from cerebral palsy be treated as a special group.[87] A number of correspondents focussed on screening programs to discuss their concerns, including those about indemnity and compensation.[88]

7.116 Concerned about colorectal cancer in particular, one correspondent argued that: screening is carried out on "well" people; professional liability for procedures involving well people is greater than for those involving patients; no screening process completely eliminates the risk of cancer; and, given colorectal screening can detect up to 60% of cancers, it has the potential to reduce the mortality rate of the disease by some 50%.[89] As one of the reasons for failures to detect cancer in the screening process is human error, one cost of the program is that the health care professionals face litigation. The correspondent underlined this as a major barrier for the program. "If there is no change to compensation, it is likely that screening for colorectal cancer will not be introduced and the current ad hoc screening will increase."[90]

7.117 With respect to cervical cancer screening and litigation alleging failure to diagnose, another correspondent noted the error rate in examining and reporting Pap smear slides can be minimised but not eliminated.[91] This correspondent estimated that the cost of litigation from women who develop cancer after a Pap smear with no reported abnormalities could exceed Commonwealth Government funding via Medicare and health program grants for early detection of cervical cancer. Suggested possible solutions were: Commonwealth indemnity for accredited laboratories; no-fault compensation for women who develop squamous cervical cancer within three years of a negative smear, if the review of the original slide shows missed abnormalities; use of medical panels or court experts; and alternative dispute resolution processes.

7.118 The correspondent said the effect of the threat of litigation could result in: a rise in the cost of screening; scientists/pathologists moving to other areas of practice; insurers refusing to provide indemnity; and ultimately, the loss of a public health program, should laboratories seek to recover the true costs of reporting Pap smears.[92]

7.119 Continuing the theme of screening for cervical cancer, another correspondent said that the "false-negative" error rate (from Pap smears), whereby a small number of cells amongst many hundreds of thousands of cells on a slide, may be overlooked by cytotechnologists has been variously estimated and may be up to 25% of all slides examined.[93] This correspondent suggested the critical question to ask was, "[i]s it better to have an imperfect technique or test than no test at all?"[94] The benefits of Pap smear testing at a community level outweigh the alternative of no Pap smear testing, according to the correspondent:

> “[T]he whole basis of pathology testing, and indeed large parts of scientific knowledge worldwide, are based on statistical probability, rather than traditional simplistic attitudes of cancer or not cancer, normal or abnormal, high or low ... Therefore, there appears to be a great need for wider understanding of the implications of diagnostic statements and opinions, based on statistical probability.”[95]

Expert medical and legal panels were suggested as one way of determining what constitutes a negligent act in this area as, "[t]he alternative is to rely on individual expert witnesses; in such circumstances, there are many differing opinions and matters of judgment as to what might constitute a negligent act".[96]

7.120 The PIR actively considered all these views. As noted earlier, it concluded that a broad-based, statutory no-fault medical misadventure scheme was not the most appropriate

direction for reform. However, there are options that can increase availability to existing compensation mechanisms and address some of the causation difficulties that arise for people with disabilities arising from adverse patient events. One of those discussed in the Interim Report was the use of accelerated compensable events[97]and the broader use of strict liability[98]. Yet another idea of limited no-fault assistance which has been raised several times with the PIR will also be discussed here.

Accelerated Compensable Events

7.121 Recommendation 8 of the PIR's Interim Report concerned the exploration of the feasibility of using a system of accelerated or designated compensation events in Australia, with the PIR to report on its conclusions in the Final Report.[99] Accelerated Compensation Events (ACEs) are a subset of possible adverse patient events that are judged unlikely to occur where good care is provided. Its United States proponents suggest these could be used to provide a "selective no-fault" scheme, which speeds up access to compensation and improves quality assurance for this subset of possible adverse patient outcomes.

7.122 Because the occurrence of such an outcome suggests a high likelihood (but no certainty) that negligence was involved in the care provided, the PIR does not consider the system to be no-fault based. It is more accurate to call it a method of speeding up and simplifying the proof of fault, or providing an extended basis of strict liability. As such it can be used with equal ease within an ordinary common law damages assessment framework, or an administrative assessment mechanism. Should it be considered desirable by groups of defendants or their compensation payers, such mechanisms could be introduced as guidelines for settlement, without any legislative assistance being required.

7.123 Following its investigations, the PIR has decided that ACEs were not an appropriate option for any of these purposes in Australia at the moment. It is a system which is really in its very early days in the United States, and its operational capabilities and claimed cost benefits have yet to be demonstrated. This does not mean that the PIR believes that ACEs do not have the potential to become a useful concept. It may be that once developed and piloted they could become a useful tool for speeding up the tort system or as a basis for a targeted compensation system, should one be considered desirable in the future. Rather, the PIR's decision reflects the current state of development of ACEs

7.124 The main proponents, Tancredi and Bovbjerg[100] also note that further work on ACEs is required in four areas:

- an extension and refinement of the existing ACE lists, and of their database on avoidable adverse outcomes;

- additional statistical studies:
  - establishing the incidence and prevalence of ACEs in selected health care institutions;
  - comparing the pervasiveness of ACEs with other quality measures; and
  - establishing the inter-rater reliability of those who will use the lists to establish the occurrence of an ACE.

- "shadow" implementation where data and results are gathered, but are not actually used; and

- implementation on a field test basis at a health care facility.

7.125 The PIR concluded that the above list represents a considerable body of work. While there is some interest in the work in the US[101], it has still got a long way to go before it achieves any of its claimed benefits for compensation or quality of care. Were such a system to be considered appropriate in Australia, it would ideally accompany the development of guidelines and performance measures - that is, it could be the reverse side of these processes where clinicians defined unsatisfactory outcomes, particularly those which could be avoided. As such **the PIR considers that it is not appropriate to recommend the adoption of any system based upon accelerated compensable events for Australia at this time, though their continued development in the United States should be watched with interest. (Recommendation 109)**

Strict liability

7.126 One of the difficulties faced by a patient in taking legal action is the need to demonstrate fault in each case. As noted above, it may be possible to increase access to the tort system by accepting that a particular outcome probably indicates negligence, without a patient having to prove it in each case. This is one of the concepts that underpins the ACE system.

7.127 It may be possible, as part of the current guideline development processes and other quality of care initiatives, to determine some areas where a particular result in most cases will mean an inference of sub-standard care was appropriate. In such cases, the proof of the particular outcome itself could enable the patient to obtain compensation, without proving fault in the individual case.

7.128 **The PIR recommends that the Taskforce on Quality in Australian Health Care, the National Health and Medical Research Council (as part of its guideline development work) and those who are developing performance measures for health professionals consider whether there are certain outcomes which should prima facie be considered likely to result from substandard care. (Recommendation 110) Where such circumstances can be identified, the PIR recommends that the Department of Human Services and Health investigate the possibility of such outcomes attracting strict liability in any tort action seeking damages, either through Commonwealth or State legislation. (Recommendation 111)** Similarly, defendants and their insurers could determine whether such outcomes should be used to provide faster and less costly resolution of appropriate cases, even if no legislation were to be introduced.

Limited no-fault assistance

7.129 As was noted above the PIR does not favour either a general health care injury no-fault system or a "special cause" one, as the most appropriate direction for reform in Australia

for all the reasons set out in the Interim Report[102] and section A above. However, there have been repeated calls for such arrangements over the course of the PIR's work, particularly in the area of side effects from immunisations, which are part of the National Immunisation Strategy.

7.130 Such options are often attractive in these areas because it is claimed there would be very few cases and "the community would like it". The PIR continues to reject the option of the creation of single purpose, lump sum schemes, as have arisen in the area in other jurisdiction, as a desirable direction for reform for all the reasons set out in the Interim Report.

7.131 However, were a government to decide to provide such assistance, it is the view of the PIR that such a lump sum should be consciously seen not as compensation in the full sense, but rather as a non-economic loss payment. In that sense any such payment would be for something that other government sources do not provide. Once a person had received such a lump sum, their entitlement to all other programs of assistance, such as social security, Medicare or other care assistance should be unaffected.

F. Evidence in negligence actions

The Bolam principle and Australian developments

7.132 The so-called Bolam principle came from an instruction to the jury in the English case of *Bolam v. Friern Hospital Management Committee*[103]. It states that a doctor is not generally negligent if "he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice".[104] Under English law the standard of care is a matter for medical judgment, not legal judgment. Despite the many articles claiming that the Bolam principle has a long history of application in Australian law, for at least the last decade, its status as anything more than an informal rule of evidence in Australia has been under question.

7.133 As early as 1983, superior courts in Australia had questioned its application, at least so far as the provision of information to patients by doctors is concerned. *F v R*[105] involved a doctor's failure to warn a female patient about the failure rate of tubal ligation, when she had had such a procedure and subsequently fallen pregnant. Chief Justice King of the South Australian Supreme Court had said in 1983 that:

> 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.[106]

7.134 The ordinary rule adopted by Australian courts in judging whether an action is negligent where the person carrying out the action has special skill or competence is the standard of the ordinary skilled person exercising and professing to have that special skill.

The relevant 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",[107] as was reinforced in the 1992 High Court judgement in *Rogers v. Whitaker* discussed in Chapter 4. This decision confirmed that the so-called Bolam principle could at best be considered an evidentiary rule of thumb in relation to treatment and diagnosis decisions but was not relevant at all so far as a doctor's duty to disclose risks were concerned. It was the role of the court to determine the standard of care appropriate to a medical practitioner, using all available evidence, not just the practice of peers.

7.135 Courts are therefore required to undertake a very detailed examination of the evidence of practice, the state of scientific knowledge, the state of the particular doctor's knowledge and that of his or her peers, in determining what the standard of care was and whether it was breached. This is in addition to the complex analysis sometimes required to determine whether the injury was foreseeable. For example, in a recent case *Woods v Lowns & Others*, Justice Badgery-Parker of the NSW Supreme Court[108]was asked to consider, among other things, whether a specialist doctor had been negligent in not informing the mother of a child who had epilepsy about the use of a particular emergency treatment (rectal diazepam). The judge described the tasks of the court as:

> to determine whether there was a foreseeable risk that the plaintiff might experience an epileptic seizure in circumstances where the duration of the fit was unknown to those having the care of him or in circumstances where there might not be sufficiently rapid access to medical care, and if so to determine in the light of all the circumstances (including the evidence of accepted medical practice) what was required as a reasonable response on the part of the defendant to that risk.... The relevant circumstances must necessarily include, in the present case, the state of knowledge of the availability, reliability and safety of rectal diazepam as an emergency treatment for epileptic seizures which ought from time to time during the relevant period be attributed to the ordinary skilled person exercising and professing to have the special skill claimed by the defendant.[109]

7.136 He also considered that in determining whether or not a failure to inform of a particular emergency action was negligent, the issues of the seriousness of the consequences of not taking the action, the ease of the action and any risks of harm from the intervention needed to be considered together.[110] In this case, the judge carefully looked at all the evidence available from controlled scientific studies, medical literature, practitioner anecdotes and experiences in coming to his conclusions[111].

Tort and evidence based health care

7.137 The law covering standard of care in health care is essentially evidence-based in Australia. This is consistent with the direction that health care itself is moving and the PIR considers that this is the right way for the law and health care to develop. It imposes a duty on health professionals - particularly specialists - to keep up to date in their field, and to not simply automatically rely on the practice of their colleagues as things change.

7.138 There have been several examples provided in earlier chapters about apparently widespread practices that are nonetheless not good practice. While it is not clear whether the English Bolam principle would protect such practices it is clear that the evidentiary route used by Australian courts to establish the standard of care would not tolerate them, even where a very substantial body of doctors practiced that way. For example, in the earlier example of the study[112] of gynaecologists where 41% were taking interventionist action before confirming the presence of abnormal cells cytologically, Australian courts would be likely to find such practices substandard in 1993 when the study was done, given all the evidence of the need to confirm the abnormality before intervening.

7.139 Once the practice of health care becomes more strongly based on evidence, as is currently happening, and as recommended strongly in this Report, there will be fewer conflicts between the judicial process and health care practice, as both will be evidence-based. Any attempt to legislatively impose a Bolam-like standard in health care negligence action would be a negative step, against the best interests of patients and the Australian community.

Clinical guidelines and the negligence action

7.140 The development of clinical practice guidelines both here and overseas was discussed in detail in Chapter 3. The role of such guidelines in tort actions, so far as proving or disproving negligence is concerned, has been much debated in the United States.

7.141 Guidelines are likely to be used to help establish the standard of care in a case in the United States, and in the future in Australia. They may well also form part of the suit of evidence considered by the court in determining the appropriate standard of care. Although it is unlikely they will be considered the standard of care, they could be used by defendants and plaintiffs to establish the relevant standard of care to be applied in a particular case. The weight the court gives to guidelines will depend on their purpose, whether they represent officially sanctioned practice by the profession, the specificity of the guideline to the case in question, the validity of the scientific evidence for the recommendations in the guidelines and the methods used for developing, disseminating, evaluating and updating the guidelines.

7.142 There are claimed to be a number of benefits for the tort system with the broader use of clinical practice guidelines. For example, thecould reduce the cost of medical malpractice legislation and reduce the number of actions initiated. They could improve the quality of care by reducing patient injuries and by improving patients' understanding of treatment options, risks and outcomes expected. Lawyers could use the guidelines to better evaluate whether there is a potentially successful claim, thereby reducing the overall caseload by eliminating doubtful cases. It is possible the use of expert witnesses would decline, together with the practice of defensive medicine, which would further reduce costs.[113]

7.143 The impact of clinical practice guidelines in court to establish the relevant standard of care will be greatest for those based on valid, scientific evidence, and those which are intended to establish professional "best practice". Guidelines could also help solve problems of determining causation by clarifying the relationship between improper practices and harm

to patients, for example by detailing the adverse consequences of failing to carry out recommended procedures.

7.144 For guidelines to become legally binding they would need to be incorporated in legislation as the required standard of care or they could be included in a contract between a doctor and a patient, in which the doctor agrees to comply with the guidelines in treating the patient. Neither of these options appears likely at this time, though they more form part of future developments in this area.

7.145 One recent US study examined the use of clinical practice guidelines in malpractice litigation.[114] A sample of open and closed claims from two insurers was studied and a survey was mailed to a sample of attorneys involved in medical malpractice litigation. The results of the study are not definitive, but they indicate that guidelines are used for both exculpatory purposes (to exonerate the doctor) and inculpatory purposes (to imply or demonstrate the doctor's negligence). In the study, the inculpatory use was more frequent but this was balanced by the fact that a doctor's compliance with a guideline deters plaintiff lawyers from bringing a malpractice suit.

7.146 It was noted that there were plans to legislate for the use of clinical practice guidelines in Maine and Minnesota in tort cases as pilots. These relevant guidelines had to be certified and were in a narrow range of areas. In both States, doctors may use guidelines for exculpatory purposes – in Minnesota as an absolute bar to liability – but plaintiffs may not use the guidelines for inculpatory purposes. The authors conclude that this is use of guidelines is at odds with the use as revealed by the study. The authors argue that guidelines should be used for both exculpatory and inculpatory purposes. In this way some of the information and cost difficulties for plaintiffs are overcome, and cases without much merit may be screened out, or dropped early on. The study also showed that the use of expert witnesses does not necessarily decrease with the use of clinical practice guidelines.

7.147 It is noted that clinical practice guidelines are a double-edged weapon. As exculpatory evidence, they could reduce the number of claims, but when doctors fail to comply with them, they could provide strong evidence about the standard of care against which to measure the doctor's performance. This may not be a bad thing, according to the authors, if widespread use of guidelines in litigation leads to greater compliance in the long-term. However, use of the guidelines in an inculpatory way may lead doctors to be reluctant to participate in the development of more specific and prescriptive guidelines.

Chapter 8: The health care partnership

A. Background

8.1 In addition to outlining the elements of an effective health care partnership, this chapter draws together relevant material from the PIR's Interim Report, submissions on the Interim Report and a number of issues examined elsewhere in this Report.

8.2 The PIR's Interim Report discussed a number of issues of concern to consumers in a single chapter. Correspondence to the PIR suggested it would have been more effective to include discussion of consumer issues throughout the Interim Report to emphasise that consumers are, or should be, the central focus for all activities in the health system. One submission maintained that, "[i]t is inappropriate to have a separate chapter for 'Consumer Issues' because it implies that the interests of consumers are marginal rather than central to the health system."[1] The structure and content of this Report acknowledges this concern, and consumer issues have been raised throughout. This chapter summarises relevant issues and focuses on the health care partnership.

8.3 In its Interim Report, the PIR discussed the changing role of health care consumers. The change from a paternalistic approach to a focus on consumers' rights and the consumer as a partner in health care with the health care professional. The context for this discussion included:

- the recent development of the Public Patients' Hospital Charter under the Medicare Agreements;
- the importance of health care professionals disclosing the risks of proposed treatments;
- the need for improved patient access to their health care records;
- increased recognition of the need to improve communication between health care consumers and health care professionals;
- the need for consumers to have greater confidence in boards and complaints bodies to deal effectively with poor quality practitioners; and
- consumers' participation in the health system generally leading to greater openness and a reduction in adverse patient outcomes and consumer complaints.[2]

B. The elements of an effective health care partnership

Introduction

8.4 A health care partnership requires an active recognition by both health care consumers and health care professionals of each other’s rights and responsibilities. A health care consumer is seeking advice and sometimes treatment from a health professional, whom they believe is an expert. To this extent, the health care partnership has an inherent inequality of knowledge between partners. At a different level, the patient also has knowledge, which the health professional requires to exercise their expertise. Some of the signs and symptoms of illness can be readily observable, but the task of diagnosis is enhanced by a patient's ability to describe symptoms accurately. In common law, this is acknowledged in the court's

recognition of a partial defence of contributory negligence for a patient failing to fully inform a doctor of her or his symptoms.[3] At the heart of the partnership is effective communication.

8.5 Traditionally some health care professionals treated the knowledge inequality as the basis for telling patients as little as possible and thus significantly magnified the imbalance of power. This power imbalance and the underlying knowledge differential leads some doctors to argue that any attempt to convey sufficient knowledge to a patient to facilitate decision-making is doomed to failure. Many times through out the work of the PIR, doctors have said, "but if I give my patients all the information, they make the wrong choices!" The corollary of this view is that when patients are not given information, the doctor makes the *right choice* even if it is one the patient would reject with proper information. Such an attitude is an abuse of power and a breach of trust rather than a justifiable use of expertise.

8.6 One submission to the Interim Report from the Committee of Presidents of Medical Colleges described the power relationship in quite a different manner:

> Clearly, the health care consumer is not an equal partner with the health care professional, but, rather has a right of control to accept or reject recommendations made by his/her attending health care professionals ... in the vast majority of circumstances and cases, the patient is clearly the 'controlling partner' in the relationship with the health care provider.[4]

8.7 The PIR considers this to be a misreading of the power dynamic in the health care partnership, and yet this submission recognises fully the underlying consumer-service provider element of the patient-doctor relationship. Where patients are not receiving care which they consider acceptable or where they are not being provided with information in an appropriate manner, it is their right to choose another service provider. The need for patients to recognise their powers and options is one strong argument for patient charters.

8.8 The underlying imbalance of knowledge-based power means that to create a proper partnership, both parties need to acknowledge the imbalance and do their best to overcome the imbalance – this principally occurs through the provision of information by both partners. The knowledge imbalance means a health care professional needs to ensure their communication skills are sufficiently good to convey the necessary information in a manner the patient can understand, and to ask follow-up questions to ensure the patient has understood.

8.9 The nature and scope of the trust relationship between a patient and a doctor was one of the questions to be considered by the High Court in the *Breen v. Williams* case (see 4.72-4.84).

Charters

8.10 Charters can be a vital element in an effective health care partnership through:

- stating the rights of health care consumers;

- outlining fundamental principles and goals governments have a responsibility to pursue; and

- setting standards for health services which reflect the needs and experiences of consumers and against which the performance of services can be assessed.

8.11 At the time the Interim Report was published, the Public Patients' Hospital Charter was being finalised. The Commonwealth Government and a number of States have published charters covering public hospital services and, in some cases, public health services in general.[5]

8.12 Several other patient charters have been proposed, drafted or are being finalised. For example, a national charter of rights for rural and remote health consumers was recommended at the Third National Rural Health Conference in February 1995,[6] a Client Charter of Rights has been developed for the Commonwealth Dental Health Program and Private Patients' Hospital Charter is being developed.

8.13 The Consumers' Health Forum's work on consumers' rights and the importance of a charter of rights for health care consumers was noted in the Interim Report.[7] In July 1994 the Australian Consumers' Council organised for a draft health consumers charter to be prepared by the Public Advocacy Interest Centre. This draft was reviewed at a workshop in Newcastle. Following the workshop, the Australian Consumers' Council has received funds to develop the draft health consumers' charter, which is currently the subject of consultation. It covers a range of issues including: universal access to health care; access to information; the right to refuse treatment; the right to privacy, respect, dignity and confidentiality; the right to complain and effective redress; and the right to participate in health policies and standards.[8]

8.14 The concept of a charter of consumers' rights was supported by some correspondents, who argued for a comprehensive package for health care consumer protection.[9] Health rights, they claimed, should be central to the PIR's recommendations and its support was sought for a national health consumers' charter, such as the charter proposed by consumer groups in conjunction with the Australian Consumers' Council and in particular the Newcastle Declaration for an Australian Health Charter.[10]

8.15 **The PIR strongly supports the development of a national health care consumers' charter to clarify the rights and responsibilities involved in the health care partnership. (Recommendation 112)** This would ensure health care consumers and health care professionals have a clear, mutual understanding of the nature of their relationship. It could also help both parties to reflect on and state their expectations, which could minimise later disputes.

Information and expectations of health care

8.16 The PIR's Interim Report noted that the community may have unrealistically optimistic expectations of health care. There are a number of reasons for this: well publicised successes associated with the latest medical technology; the lack of data available on adverse patient outcomes to health interventions; and health care professionals who may be reluctant

to discuss all the possible risks associated with various treatments. The PIR stated that community expectations need to change.[11] The PIR emphasised this because, on the basis of its research, patients who have a realistic appreciation of probable outcomes to treatment are less likely to complain or pursue litigation in the event of an unexpected result and are more able to reach informed decisions about their health care.

8.17 One correspondent commented that, "[t]he community is overly optimistic about the outcomes of health care. Education about expectations needs to include a recognition that there are no guarantees of perfection and that there are risks associated with health care".[12] Commenting from the perspective of the medical profession, another correspondent said, "[w]e have been hoisted on our own petard, because of the enormous technological advances in medicine, people conclude that an adverse outcome is due to the doctor failing to administer the technology competently."[13] From a non-medical perspective, it was noted that it was common for consumers, "... not to know the risks or side effects of the medical procedures performed, having a lack of information about the options available, with many having difficulties in gaining second opinions".[14]

8.18 The PIR believes realistic appraisals of the effects of health care are another vital element in an effective health care partnership. The importance of health care consumers having information on the performance of health care providers and the strength of the evidence for the effectiveness of various treatments has been discussed in Chapters 3 and 4 of this Report.

Disclosure of risk

8.19 In the Interim Report, the 1992 High Court decision of *Rogers v. Whitaker* was discussed.[15] The principle enunciated in the case was, that doctors should disclose to patients any risks of treatment that a reasonable patient could consider a material risk. Many doctors were concerned about the consequences of this judgment, though the immediate hysteria and terrible predictors of the collapse of the doctor-patient relationship in an unending mire of information-giving appear now to have been somewhat exaggerated. Submissions reflected some of these concerns among health professionals.

8.20 Commenting on the PIR's statement that for a number of reasons patients may have a limited ability to understand or retain information imparted during consultations, one medical practitioner wrote, "Thinking stops while the pain, the nausea and the sheer overwhelming agony take over. This is what happens when we tell a patient (or a parent/child/friend) awful medical news or even unhappy possible diagnoses. Telling a parent that their child has leukaemia, or a woman that she has breast cancer, just stops all their thinking – for days!"[16] This correspondent went on to say that the PIR had seriously minimised significant reasons (such as shock, horror, fear, fever, pain, nausea, vertigo) why patients may have a limited capacity to understand, in addition to the barriers that may be presented by culture and language. The PIR recognises the communication barriers. However, once a health professional is aware of this, then better ways or timing of communicating can be set up. For example, in the case of bad news, a doctor may consider having some simple facts set down on a pamphlet or sheet of paper for the patient to take home at the time of the first visit and then schedule another consultation to answer questions a few days later. None of these barriers are insurmountable.

8.21 Again from a medical perspective, it was said it might be impossible for a doctor to provide all information to a patient about a proposed treatment. The doctor may not know it all. An obscure and unlikely event may have been forgotten. The doctor may wish to avoid frightening a patient if the benefits are deemed to outweigh remote risks. One doctor's beliefs may vary from another's. The correspondent acknowledged it was difficult to define the required level of expertise for informing patients because care is a compromise between complex, inter-related factors. "If our standards are too high and too much information needs to be provided to the patient, many doctors may resign because they could not provide the service without referring to endless texts for every bit of advice they give."[17]

8.22 In Chapter 2 of this Report, the patient's fundamental right to self-determination was outlined. Chapter 3 discusses how consumers can be better informed about the risks and benefits of treatments in the context of clinical practice guidelines. Also in Chapter 3, the health care professional's duty to disclose information in the context of experimental procedures was stressed. Chapter 4 referred to the case of *Rogers v. Whitaker* and the legal standard required of health care professionals in disclosing information about the risks and benefits of treatments. Chapter 4 also examined the duty the PIR argues governments have to provide information about risks, benefits and limitations of the programs they fund and encourage participation in, such as screening and immunisation programs.

8.23 While acknowledging the difficulties this may entail in some cases, the PIR argues that full and frank discussion of the risks and benefits of proposed treatments between patients and providers is basic to an effective health care partnership.

Patients' access to their medical records

8.24 The PIR found there are many difficulties for patients in accessing their health care records in jurisdictions not covered by freedom of information legislation. It is noted that patients do not have a clear common law right of access to their health care records. Correspondence to the PIR from consumers and consumer groups was generally in favour of ensuring that patients can access their medical records. It has been noted that refusal of access to a health care record can be the motivating factor for a patient to initiate legal proceedings.

8.25 The concerns of health care professionals with respect to patients' access to medical records included: what is to be included in the definition of a health care record, for example would it include opinions and test results; whether patients would understand the record; the possibility it would increase litigation; and concerns that patients could be harmed by some information, for example paranoid psychotic patients in psychiatric care.

8.26 Chapter 4 of this Report presented details of the PIR's work in this area, together with details of work by other bodies and the most recent developments in the tort system. The PIR's recommendations concerning patients' access to their health care records and patient held health care records are also in Chapter 4.

8.27 The PIR considers that an effective health care partnership cannot exist where some patients are denied access to their health care records. The PIR considers patient access to

health care records is likely to lead to an improvement in record-keeping, reduced litigation and an improvement in the trust between health care professionals and patients.

Improving communication

8.28 The Interim Report was criticised for failing to treat adequately the patient-doctor relationship and the barriers to patient-doctor communication. Using the analogy of a jigsaw, a correspondent said the health consumer often, "... has grandiose and totally unachievable expectations of their health care provider, expecting them to find all the jigsaw pieces to put them all back into place, with virtually little or no help from that consumer, but the consumer has the expectation that all will be exactly perfect at the finish".[18] This correspondent noted that a consumer may hide one piece of the jigsaw, deliberately, accidentally. The health care provider then, on finding one piece of the jigsaw, spends a long time fitting it into place, while ignoring other pieces that fit quickly and simply, to make the pattern more readily identifiable and the health problem resolvable.

8.29 Turning to the barriers created by the training of medical practitioners, it was noted that some six years is spent learning and using the socially isolating language and technology of medicine and health care which is then applied to the patient. The doctor has learned a different culture which isolates and excludes him or her from the worldly perceptions of the consumer. The correspondent wrote, "... it is as though you have two people speaking totally different languages and neither of them prepared to accept that the other either does or does not understand what is being said."[19] Further submissions on the issue of communication in health professional education and training are discussed in Section B in Chapter 4.

8.30 The PIR's work had shown that one of the crisis areas for communication, even where a good relationship has existed, can be when things go wrong. To address this concern in a practical way, the PIR funded the development of consumer and professional guidelines for what to do when an adverse event occurs. These are set out in full in Appendix D and were discussed briefly in Chapter 4 (4.51,4.52).

8.31 The PIR notes that patient autonomy is increasingly being encouraged and consent to treatment is more likely to be informed where the patient is an active participant in health care. Helping patients to reach decisions is an important part of health care. Sometimes this is not easy as a number of factors can influence a patient – not only their mood and receptiveness, but what they are told and how it is conveyed. A recent study of factors that influenced patient decision-making showed the following:[20]

- People tend to categorise an entity as either "dangerous" or "safe" without recognising that high and low levels of exposure can have different or opposite effects.

- People think that the absolute elimination of a risk is more attractive than a mere reduction of the probability of harm. However, the hope of eliminating risk is often illusory while lessening the odds is the more realistic aim.

- People have little intuitive understanding of the difference between a risk of say 1:20,000 and 1:200,000.

- The interpretation of events depends on the nature of the experience and the manner in which the situation is presented or formed, that is, preferences can be swayed by the choice of one explanation of results rather than another. For example, an experiment showed that surgery appeared less attractive than radiation therapy for lung cancer when the formulations were described using mortality rather than survival statistics. The difference between 10% mortality and 0% mortality is more impressive to most people than the difference between 90% survival and 100% survival.

- When people review past decisions they may highlight data that were consistent with the final outcome and de-emphasise data that were inconsistent or ambiguous.

- People take actual losses more seriously than forgone gains. Losses seem more important than gains in many clinical situations and people may be reluctant to accept a loss in one aspect of life in order to benefit in another.

- People are prone to error when making judgements about long-term consequences because they fail to anticipate how their preferences will change over time.

- People may have irrational concerns or beliefs, which are not usually volunteered. Such beliefs may arise from many sources including misinformation and overconfidence and they may persist despite valid counter-arguments.

- The direct and indirect effects of worry may serve to decrease quality of life without any medical gains instead of motivating health-related behaviours. Further, people may avoid situations and information that would give rise to this unpleasant emotion. For example, some women are reluctant to seek medical attention after detecting a breast lump despite the known medical advantages of early diagnosis and treatment.

8.32 An important new initiative to improve health professional-consumer communication arises from the Cochrane Collaboration. The work of the Cochrane Collaboration was outlined in Chapter 3 of this Report.

8.33 In May 1995 a meeting was convened to explore the feasibility of establishing an international collaborative review group on communicating effectively with consumers. Further details of that meeting are set out in Chapter 5. Briefly, the meeting agreed that health care consumers want evidence-based information about treatment and/or intervention options and to be more of an equal partner in health care interactions.[21] The meeting agreed to begin the process to establish a collaborative review group to look at communicating effectively with consumers. The group is intended to be international, multi-disciplinary and include consumers, clinicians, researchers, sociologists, psychologists, health professionals and policy-makers. The group will review the evidence concerning the effectiveness of interventions and the effectiveness of communicating evidence-based information to consumers.[22] The PIR notes the suggestion from the meeting that the definition of *consumer* should include family, carers, friends and the community in general, and believes this is an appropriate definition. The PIR endorses the establishment of the collaborative review group and the widespread dissemination of its findings.

8.34 The PIR's recommendations concerning effective communication with patients and dissemination of information were presented in Chapters 3 and 4. It is clear that without effective communication there can be no patient-provider health care partnership.

Consumer participation

8.35 The PIR recommended that the Commonwealth Government monitor and encourage implementation of measures to increase participation of health care consumers in health service planning and delivery. The PIR noted that greater recognition of patients' rights would be necessary for their greater participation in the health system. With increased consumer participation and greater recognition of patients' rights, the PIR expects a more open health system to result in fewer adverse outcomes and complaints about health care treatment.

8.36 With respect to consumer participation, one correspondent urged the PIR to recommend:

> "... that the Commonwealth Government use its funding power to provide opportunities for participation through Commonwealth-funded pilots and programs. It should investigate and recommend `best-practice' decision-making processes which favour public participation and actively encourage consumers to participate".[23]

8.37 The issue of consumer participation in quality assurance (QA) and risk management activities was addressed by a number of submissions. Some argued the PIR should suggest the structures through which consumers could have input; that consumers should have input to the way quality is defined; and that consumers are able to complete the quality assurance feedback loop with input based on their experiences.[24]

8.38 A different view was offered by another correspondent who did not agree with the PIR's recommendation for monitoring and encouraging implementation of measures to increase the participation of health care consumers in health service planning and delivery, or with the thought that this would lead to greater consumer confidence in the health system. The recommendation was considered to be too broad and the preferred strategy was to ensure public confidence in the complaints procedures and/or in disciplinary proceedings.[25] How this was to occur without increased participation of consumers in these processes was unclear.

8.39 One correspondent highlighted the role of complaints commissioners in increasing community confidence in health care.[26] Independent investigation, prosecution (where appropriate), and adjudication of serious breaches of health care standards in the public interest were cited. This correspondent also drew the PIR's attention to the value of a national network of Commonwealth and State health complaints agencies able to offer, in addition to the previously mentioned benefits, an alternative dispute resolution forum for health care consumers and professionals, "... which is cheaper, quicker and more accessible than the courts".[27]

8.40 Health care consumers are now gaining representation in many policy development areas of health care, including the processes of Guidelines development and in the Cochrane

Collaboration projects discussed in Chapter 3. Details concerning opportunities for consumer participation in the health system through involvement in quality assurance activities were given in Chapter 5 of this Report. Complaints mechanisms will be addressed below and in Appendix H.

C. Complaints and disciplinary procedures: increasing consumer confidence

Introduction

8.41 In its Interim Report, the PIR examined complaints mechanisms for health care consumers.[28] It was noted that the 1993–98 Medicare Agreements provide for some consistency of approach with respect to complaints mechanisms for public hospital patients by allowing for a complaints body to be established in each State.

8.42 The report detailed the work of the complaints commissions, noting the differences in their legislation and operation. Definitions of alternative dispute resolution (ADR) were outlined and the PIR examined the benefits and flexibility of ADR in resolving complaints, together with criticisms of ADR. Medical registration and disciplinary process were analysed and the differences between disciplinary bodies and complaints bodies noted.

8.43 The PIR's interim recommendations covered: the complaints bodies' provision of initial advice to complainants concerning options for dealing with a complaint; complaints data collection, use and sharing; and co-operative relationships between the complaints bodies and medical registration and disciplinary authorities.[29]

8.44 Following release of its Interim Report, the PIR drafted outcome standards for complaints mechanisms. They represented *best practice*, ascertained from relevant literature and discussions and correspondence with a number of interested parties. After internal department consultation, the draft outcome standards were forwarded to a small group of organisations for comments. This section details developments since release of the Interim Report, and gives an overview of some of the comments received on the draft outcome standards, amended outcome standards, and the PIR's final recommendations in this area. The amended outcome standards for health care complaints mechanisms are presented in Appendix H.

Complaint handling developments

8.45 At the time of writing this Report, no additional complaints body had been established since the Interim Report was published in February 1994, although draft legislation was developed in Western Australia and Tasmania.

8.46 The PIR welcomes the formation of the National Council of Health Complaints Commissioners, comprising the Health Services Commissioner of Victoria, the Health Rights Commissioner of Queensland, the Commissioner for Health Complaints of the Australian Capital Territory and the Health Care Complaints Commissioner of New South Wales. The Commissioners from the four jurisdictions are addressing issues of common concern, including setting national policy benchmarks for their work in complaints handling and

resolution. The PIR endorses the establishment of independent statutory complaints mechanisms in all States as a key element in monitoring and improving the standard of health care services.

8.47 The PIR supports the work being undertaken in Queensland and the Australian Capital Territory to develop codes of health rights and responsibilities as part of the responsibilities of the Health Rights Commission and the Health Complaints Commission respectively. The PIR believes the codes will improve health care services by setting out clearly the rights and legitimate expectations of consumers, as well as their responsibilities. Consumers and health care professionals will understand what is an acceptable standard of care by consulting the codes. The PIR commends the *Health Complaints (Amendment) Act 1994* (ACT),which requires health services to display notices which advise consumers about the action they can take if dissatisfied with the service.[30]

8.48 The PIR believes the proposal to establish an advocacy service within the Health Care Complaints Commission of New South Wales will benefit consumers and should be explored in other jurisdictions. The complaints commissions generally require a complainant to attempt to resolve a grievance with the health care professional concerned, before a commission investigation. The goal is to resolve as many complaints as possible informally at the point of service. Many consumer correspondents to the PIR described the difficulty in approaching a health care professional to express dissatisfaction. Consumers may not be confident in approaching a health care professional perceived to be more knowledgeable and in a position of authority. Many consumers believe the health care professional will not listen or will not respond in a positive way. In some cases, for example where sexual misconduct is alleged, it is inappropriate for the consumer to approach the health care provider. An advocacy service will ensure that a consumer has support in approaching a health care provider and is aware of his or her rights. It is also hoped that the patient and provider guidelines in Appendix D will assist in these circumstances.

8.49 In Victoria, the Health Services Commissioner is undertaking a project to improve the quality of health services through more efficient and effective use of complaints data in acute hospitals. In consultation with 21 hospitals, a database is being developed for the hospitals to record complaints information. In the hospitals, complaints managers and liaison officers prepare regular reports to ensure feedback from consumers informs quality improvement initiatives. The database is maintained and enhanced by the Health Services Commissioner, who provides regular information to hospitals about general trends and emerging issues. Hospital staff receive training in managing complaints and the use of complaints information. A best practice model in complaints management is being developed. The project is to be completed by March 1996. The PIR endorses this initiative and urges wide dissemination of the project's results.

8.50 The Justice Statement, the Commonwealth Government's response to a number of inquiries on aspects of the justice system, discusses the importance of consumer dispute schemes to providing a speedy, independent, affordable way of resolving a wide range of consumer concerns. The Statement notes that both providers and consumers benefit from customer dispute schemes in that they are less complex than courts and vastly improve the public perception of the service providers involved.[31] A key feature of the operation of

dispute 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.[32]

8.51 The statement supports the development of standards for consumer dispute schemes to cover:

- independence and impartiality;
- accessibility and timeliness;
- efficiency and effectiveness;
- openness and accountability;
- consumer participation; and
- data collection and reporting requirements.

8.52 The Justice Statement notes the value to all industries seeking to establish complaints handling and dispute resolution schemes.

Development of draft outcome standards

8.53 The outcome standards drafted by the PIR for complaints mechanisms are intended to serve as a starting point for those responsible for establishing or reviewing complaints mechanisms in the health system. The PIR anticipates they will be of use in the context of the recommendations of the Justice Statement and the work of the Health Services Commissioner of Victoria to develop best practice in this field, noted above. The outcome standards have benefited from input and comments representing many different viewpoints. The PIR recognises they will not be approved in their entirety by all interested parties, and that many of the outcomes described are already achieved in some jurisdictions.

8.54 The PIR believes it is important to resolve of as many complaints as possible outside the court system, and ensure information from consumer complaints is used to improve the quality of health services. This is because the PIR's research shows the court system entails delays, costs and uncertainties for plaintiffs and defendants. However, input from the public reveals many people believe the courts can be the appropriate venue to obtain compensation for an adverse patient outcome involving negligence. Considering this input, the PIR concludes the courts fulfil a role in deterring poor practice on the part of health care professionals, setting legal standards of care and awarding compensation as set out in Chapter 7. The PIR does not suggest that consumers should be dissuaded from taking legal action, but is convinced that responsive complaints mechanisms will be a valid alternative for the majority of health care consumers.

8.55 To be responsive to consumers' needs, health care consumer complaints mechanisms must be able to:

- help the consumer clarify the nature of the complaint and the consumer's preferred outcome from the complaint;

- seek an explanation/response, including an apology where appropriate, for the consumer from the health care professional involved;

- assist with conciliating an agreement between the health care professional and the consumer, if that is what both parties want;

- ensure that any steps necessary to improve health care services and maintain professional standards are taken; and

- recognise when significant issues of public health and safety are implicated and ensure prompt appropriate action or referral is undertaken to protect the public.

8.56 A number of groups wrote to the PIR about this area of its work. The National Council of Health Complaints Commissioners stressed:

- the need for policy co-ordination in respect of establishing complaints bodies in each State, highlighting the use of complaints commissions as an alternative to resolving disputes in the courts;

- the introduction of a complaints mechanism to deal with complaints about private health insurance;

- the importance of public confidence in health care standards and the role of complaints handling; and

- the need to improve health services by analysing information from complaints and using it for quality improvement.

8.57 The Health Conciliation Registry of New South Wales provided comments on the PIR's draft work in relation to conciliation. The Registry points out that in New South Wales registration boards may recommend that a complaint be referred for conciliation by the conciliation unit of the Health Complaints Commission. Should the Commission choose not to so refer, the Commission must investigate the complaint. The Registry comments that while discussions and documents used in conciliation are privileged, they are not necessarily confidential. That is, it is not possible to ensure that parties keep all discussions secret and some documents created prior to conciliation may not necessarily be privileged, that is, exempt from being used in a legal proceeding.[33]

8.58 The discussions the PIR held with the Australian Medical Council assisted in ensuring the draft work on outcome standards for complaints mechanisms was available for consideration by State medical registration boards. Comments from the medical registration boards revealed serious concerns with the draft proposals. The concerns cover such matters as:

- mandatory referral of complaints to an independent commission;
- a commission's power to prosecute health care providers or adjudicate on complaints;
- the appropriateness of the title *health care consumer*, as opposed to *patient*;
- identifying non-compliant health care professionals in annual reports; and
- the inappropriateness of investigating a complaint received orally but not in writing.

8.59 The medical registration boards, which have non-professional members, believe that current board membership works to provide a wider perspective to board operations, although the suggestion that there should be consumer representatives was rejected. One board noted that deep understanding of medical practice and disease processes are necessary to deal with complaints promptly, efficiently and fairly. Those boards in States where there is a complaints commission generally appear to have a co-operative relationship with the commission, with some boards commenting on the usefulness of the independent investigation and review offered by a commission.

8.60 The Consumers' Health Forum of Australia (CHF) expressed concerns that the PIR had addressed neither the means to achieve the desired aims of health complaints mechanisms, nor how the desired outcomes could be measured. The CHF believes the process of dealing with a complaint is likely to be as important to consumers as the outcome. A consumer may be satisfied with the way a complaint is handled, without obtaining the desired or preferred outcome. Consumers should be provided with the most appropriate means to deal with their complaints. Where harm is due to negligence, litigation may be the most appropriate means. The CHF considers that consumers should not be actively discouraged from seeking legal redress in such circumstances, notwithstanding the PIR's emphasis on resolving as many complaints as possible outside the court system. Many complaints are unlikely to proceed to litigation if the onus is on the consumer to directly contact the health care professional. This is seen as an important role for a complaints system by the CHF.

8.61 Comments on the draft outcomes document from within the Department of Human Services and Health suggest attention be paid to development of a nationally consistent data set covering data from MDOs, registration boards and complaints bodies. The data could be collated and included in the publication of the National Health Ministers' Benchmarking Working Group, under the auspices of the Australian Institute of Health and Welfare, to inform policy development and implementation. Concern to ensure complaints bodies are able to refer complaints for further action, for example to an Ombudsman or a registration board, was also shown.

8.62 In addition to thanking the organisations mentioned above, the PIR would like to thank those people and organisations who took part in consultations and teleconferences, and those who wrote to the PIR with comments. Input was often based on personal experiences. The PIR acknowledges that many people with experiences both of the tort process and existing health care complaints mechanisms expressed a sense of injustice as a result of their experiences; this applies to both consumers and health care professionals. The PIR's Interim Report detailed the experiences of consumers as reported in the case study report[34] and noted in particular the dissatisfaction of consumers in New South Wales regarding the way complaints were handled regarding the administration of deep sleep and electro-convulsive therapies at Chelmsford Private Hospital.[35] The outcome standards and other PIR recommendations have attempted to take full regard of concerns expressed to the PIR.

Outcome standards for complaints mechanisms – the PIR's model

8.63 The PIR's outcome standards for complaints mechanisms are set out in Appendix H.

8.64 The outcome standards are grouped to show desired outcomes according to the level of the mechanism being discussed. Outcomes desired of all complaints mechanisms, regardless of formality or level, are outlined first, followed by standards relevant to:

- point of service complaint mechanisms, for example in a general practice or at a hospital;
- referrals from point of service mechanisms;
- complaints commissions, including assessment, investigation, referral and conciliation of complaints; and
- health care professional registration boards.

8.65 In summary, the model advocated by the PIR entails resolution at point of service through appropriate mechanisms and the assistance of advocates or patient complaints officers. If resolution is not possible locally, then the model proposes receipt of a complaint at a State-wide level by either a complaints commission or a registration board, followed by joint consideration of the complaint to determine appropriate action. Where no agreement is reached, the more serious view of the complaint is acted upon. Conciliation is available. Either a commission or a registration board is able to initiate disciplinary proceedings. In the model the term *registration board* is taken to include a tribunal or similar body with adjudication powers as exists in some States.[36] A range of options for disciplinary action is advocated for registration boards. Appeal mechanisms exist for registrants to appeal registration board decisions, and these are not included in the model.

8.66 By proposing that a complaints commission have the power to initiate disciplinary proceedings against a health care professional, the PIR is advocating a model closest to the New South Wales Health Complaints Commission. The other complaints commissions would have to extend their powers, and resources, to undertake this function. The model differs from some States' current practice by envisaging the commissions' receipt of complaints information from health care facilities and registration boards, as well as the exchange of complaints information about registered health care professionals between commissions and registration boards.

8.67 Proper investigation of a complaint for the purposes of disciplinary proceedings is an important one. Currently, many boards do not have adequate resources to investigate matters brought to their attention, and so their role in maintaining standards is significantly compromised. Similarly, there are also difficulties with having a board, which has to determine whether or not disciplinary action should be taken, also being the investigatory body. Using independent complaints bodies to fulfil this role addresses the separation of investigation and prosecution from adjudication. So long as a complaints body is adequately resourced to investigate cases for both resolution and action, economies can be gained from such a model.

8.68 Consumer input is envisaged via advisory bodies to the complaints commissions. The model provides for lay representation on registration boards, and for open hearings wherever possible, as a first step to more open operations. This is currently the practice in some States.

8.69 Standard complaints data definitions, collection and analysis are recommended, with a view to protecting public health and safety and improving the quality of health services. The model provides for protection of public health and safety and procedural fairness to the health care professional and the consumer/complainant.

8.70 The PIR's model envisages a process whereby:

- which complaints data it is useful to collect is determined, together with ways of disseminating the information to those sectors of the health system able to act on the data to improve services;

- a survey of current data collections in the health complaints commissions is carried out to determine the extent and compatibility of current collections in the light of the determination of which data should be collected;

- discussions with relevant parties are held to examine the feasibility of collating a national data set of health care complaints information; and

- appropriate reporting and interpretation of the data are carried out.

8.71 Specific recommendations regarding complaints and complaints data are presented at the end of this chapter. The PIR concludes that the establishment of complaints mechanisms at the point of service, that is, in health care facilities and individual practices, can be effective in improving the quality of health care. Encouraging complaints as an opportunity to improve service should be seen as an essential part of a quality assurance program. As noted in the PIR's Interim Report, it is important to close the quality assurance feedback loop for quality assurance activity to be fully effective. Complaints must be used to assess and modify care, and the modifications monitored to gauge their effect on the quality of the care.[37] Consumer confidence in the health system can be increased if complaints are treated in this way.

8.72 Health care complaints mechanisms must be responsive to individual complaints as well as protective of public health and safety. Occasionally public health and safety concerns may be greater than an individual health care consumer's interest in having a complaint conciliated. The PIR believes these cases should not undermine the confidence of individual consumers in responsive complaints mechanisms.

8.73 **The PIR recommends the establishment of consumer complaints mechanisms at the point of service throughout the health system as part of regular quality assurance processes. (Recommendation 113)**

8.74 The PIR concludes that State-wide complaints mechanisms are required in each State to: protect public health and safety; provide consumers with an impartial avenue for

addressing complaints which cannot be addressed at the point of service; and ensure complaints information is used to improve the quality of health services. Complaints commissions established in accordance with the model proposed by the PIR will be able to perform these functions. In respect of using complaints information to improve the quality of health services, the commissions would be repositories of complaints information from the public and private State health systems and State disciplinary authorities. This information could be collated both State-wide and nationally.

8.75 **The PIR recommends that independent complaints commissions be established as a matter of priority in all States to receive, assess, investigate, refer and conciliate consumer complaints. (Recommendation 114) The PIR also recommends that complaints commissions be able to initiate disciplinary proceedings as a result of investigating a complaint. (Recommendation 115)**

8.76 For maximum effectiveness in improving health care quality, complaints data should be collated and analysed nationally. To fulfil the purpose of improving the quality of health services, the PIR notes that the issue of which data are collected, and their interpretation and dissemination to relevant managers and others in the health system, is critical. **The PIR recommends that the Australian Health Ministers' Advisory Council (AHMAC) provide funding to the Australian Institute of Health and Welfare and the National Council of Health Complaints Commissioners to hold a workshop to determine: which complaints data should be collected and collated nationally to inform quality assurance activities, and appropriate ways of disseminating the information to all relevant levels in the Australian health system. Results of the workshop should be reported to AHMAC. (Recommendation 116)** The workshop, should include participants from health consumers' groups, health care professional registration boards, the Australian Council on Health Care Standards, MDO's, the police and coroners, and AHMAC (and possibly from the National Health Ministers' Benchmarking Working Group).

8.77 Following the workshop, **the PIR recommends that the AHMAC initiate a study of complaints data collections in each State, with a view to recommending standard definitions, collection and electronic collation, based on the results of the workshop mentioned above. The study of complaints data collections should involve the Australian Institute of Health and Welfare and the National Council of Health Complaints Commissioners, with funding provided by AHMAC. The aim of the study is to produce a national data set of health care complaints information from complaints commissions in all States. (Recommendation 117)**

8.78 These recommendations should also build on the recommendations in Chapter 2 relating to data collection by MDOs and the relevant national Benchmarking work.

8.79 **The PIR recommends the National Council of Health Complaints Commissioners, presents an annual report on complaints data to AHMAC and to the Australian Health Ministers' Conference together with its conclusions and recommendations drawn from information in the report. (Recommendation 118)**

D. Sexual abuse in the therapeutic relationship: a case study

8.80 In the course of community consultations on its Interim Report, the PIR was made aware of the problem of sexual abuse of patients by health care professionals. Allegations of sexual misconduct and the way these are dealt with by health care professional disciplinary bodies illustrate many of the issues of general concern about the largely self-regulation model of health care professional disciplinary processes. It also reflected a growing community awareness of sexual abuse by those in positions of trust.[38]

8.81 The PIR researched a number of issues including:

- whether or not sexual abuse is included in definitions of professional misconduct by registration boards;
- why some victims choose not to report sexual misconduct;
- which avenues of complaint are accessed by people alleging sexual misconduct; and
- experiences with disciplinary and complaints processes.[39]

8.82 There is no generally accepted definition of sexual misconduct. Notwithstanding definitional variations, the prevalence and type of complaints of sexual misconduct in Australia is cause for grave concern. Sexual misconduct on the part of health care professionals mainly, but not exclusively, concerns male health care professionals and female patients. The female patients tend be vulnerable through youth and inexperience or they are emotionally vulnerable, during counselling for example. Many patients are, for a time, dependent on the health care professional. Sexual misconduct may not be reported because patients feel they will not be believed as health care professionals are seen as a power group and generally credible. Patients may be embarrassed, feel ashamed and powerless. Many may not complain because the police, complaints commissions or registration authorities may be perceived as being in favour of the professionals, and the system as working against a person who alleges sexual misconduct or abuse. In addition, many women and children who have been sexually abused appear to learn secrecy and not to talk about their experiences.

8.83 **The PIR recommends that an agreed definition of sexual misconduct by a health professional be developed by the National Council of Health Complaints Commissioners to enable uniform data collection, analysis and reporting of such misconduct. Further research may also be needed to determine the nature and extent of the problem. (Recommendation 119)**

8.84 Generally codes of ethics for health care professionals consider sexual contact with a patient unethical and the issue of consent irrelevant, that is, consent by a patient cannot legitimise an unethical act by a health care professional. In this sense, the professional codes of ethics and discipline could be seen as stronger than the criminal law. In criminal law, the principles which appear in relevant judgements include:

- admitting misconduct does not avert a hearing;

- an attitude of contrition may be relevant to the likelihood of repeated misconduct but a medical tribunal or court must be satisfied it is genuine;

- the onus of proof lies with the complainant;

- a practitioner advancing a claim of mental illness in mitigation bears the onus to demonstrate this sufficiently to overturn a decision; and

- distortions of truth and personal misrepresentation in other areas of a health care professional's life influenced medical tribunal or court to reject uncorroborated evidence from the professional.

8.85 Complainants are likely to report negative experiences in attempting to pursue a complaint of sexual misconduct, whether it be through the police, complaints bodies or registration boards. Such experiences include:

- cover up by the health care professional and his or her fellow professionals;

- attempts to discredit the complainant personally and to focus on the complainant's conduct, rather than the professional's conduct; and

- dissatisfaction with action taken where a health care professional is found guilty of sexual misconduct, the penalties are generally seen as far too lenient in comparison with the suffering of the victim.

8.86 The concerns discussed earlier about the professional registration body investigating the case as well as taking action is amplified in cases of sexual abuse. For an abused person, the independence of the investigator from the profession concerned may be very important if he or she is to feel justice has been done. **The PIR recommends that complaints involving sexual contact between a patient and a health care professional are assessed, and investigated where appropriate, by the independent health care complaints commissions. (Recommendation 120)**

8.87 **In addition, to promote greater consistency and co-operation between the police, complaints commissions and health care professional registration boards, the PIR recommends an agreed protocol be developed by the three parties for receiving complaints from people who allege sexual abuse by a health care professional. The protocol should cover information giving to the complainant about all avenues for complaint and support, including any health care advocacy service and the sexual assault counselling services available. (Recommendation 121)**

8.88 An effective health care partnership is dependent upon the ability of the patient to have absolute trust in the professional and sexual misconduct is an abuse of this trust. **The PIR recommends that the National Council of Health Complaints Commissioners develop a national program for informing health care consumers of their rights, and the sanctions and prohibitions against sexual misconduct between patients and health care professionals, for example in professional codes of conduct. (Recommendation 122)** In

developing the national program, the National Council should consult widely with professional and consumer groups and government bodies such as AHMAC and the Office for the Status of Women. Such a national program targets all health care professionals, registered and unregistered.

8.89 It was also clear from the PIR's research that, in the case of some health care professionals, many discriminatory attitudes existed in relation to sexual misconduct, with some of the same ignorant, sexist comments still being made that were once made about women in other circumstances of abuse. Equally, there was evidence that the support mechanisms that may have assisted doctors who needed them in stopping such abuse were also missing. **The PIR therefore recommends that professional associations:**

(a) include information and education on gender relations and sexism in their continuing education, recertification and accreditation programs;

(b) assist members to recognise common situations in which health care professionals sexually abuse patients, understand that this is always inappropriate and provide readily accessible counselling and debriefing for health care professionals; and

(c) as part of professional support to members, ensure that support and assistance are available for members who believe their personal circumstances may adversely affect their professional practice. (Recommendation 123)

8.90 **The PIR also recommends that undergraduate and postgraduate health care professional training and education include information on gender relations, sexism and ethical practice, that emphasises the seriousness of sexual misconduct in professional practice, including information on the adverse impact on patients who are subject to sexual misconduct. The possible adverse impacts on health care professionals, such as shame, loss of reputation, de-registration or restrictions on practice, fines or litigation, should also be stressed. (Recommendation 124)**

8.91 The PIR is aware that some medical defence organisations are excluding damages payable for sexual misconduct by the health care professional from their indemnity cover. This is a difficult question given that such conduct is outside a health care provider's proper professional conduct. However, to remove such coverage may well leave a victim of sexual misconduct with no recompense for any personal injury suffered, depending upon the health professional's assets and financial arrangements. A fairer solution may be to exclude any payments of punitive damages but to retain the coverage of compensatory damages. Otherwise the victims of unethical conduct may be further disadvantaged.

8.92 Another issue was whether there was adequate protection for a consumer who made a complaint relating to sexual abuse, or for a health professional who was reporting a colleague or making a complaint in relation to another professional on behalf of one of her or his patients. Where these complaints are made under health complaints commission legislation, the various acts generally have provisions that protect complainants and anyone providing assistance in a complaint process from any direct or indirect disadvantage of any kind.[40] In

fact, attempting by threats, intimidation or inducement to stop a person lodging a complaint or participating in the process is an offence under most of these acts. This is an important protection, which should be included under any new acts which are established. **The PIR recommends that all complaints legislation provide protection for health care professionals who report incidents where a health care professional has used the clinical setting for sexual contact. In those jurisdictions yet to enact complaints legislation, the PIR recommends that any actions taken to discourage a person from lodging or continuing a complaint of sexual abuse or providing evidence in such a case should constitute serious professional misconduct by the person taking such actions. (Recommendation 125)**

E. Health care consumer advocacy

8.93 In examining sexual misconduct by health care professionals and the responsiveness of health care complaints mechanisms generally to individual consumers, the PIR's attention was drawn to the role of consumer advocates.

8.94 The PIR received correspondence from the National Council of Health Complaints Commissioners that emphasised the potential of the New Zealand model of patient advocacy services.[41] The council noted the need in Australia for consumer (patient) advocacy to increase accessibility for consumers of health care to complaints mechanisms, noting that as commissioners are impartial, they are not able to act as patient advocates.[42]

8.95 The PIR also received details from Consumers Health Advocacy, which is an independent, community-based organisation in Queensland.[43] In its submission to the Queensland Health Rights Commission on the Commission's draft code of health rights and responsibilities, Consumers Health Advocacy stated the consumer's right to expect that health care professionals will advocate on the consumer's behalf should not replace the need for independent advocates, as providers may experience a conflict of interest. Consumers Health Advocacy went on to recommend that "the Government should fund independent advocates to assist consumers to make a complaint and thus uphold their rights".[44]

8.96 The Queensland Health Rights Commission reported widespread support for consumers' rights to access advocacy, noting that:

- few submissions thought it useful to distinguish between the rights of special needs groups and consumers in general;
- consumer groups supported the idea of an entitlement to free advocacy services throughout the complaints and legal process;
- advocates should be well resourced to overcome power imbalances between health care professionals and consumers;
- several submissions referred favourably to the New Zealand advocacy model because it involves a degree of autonomy for advocates and the capacity for "more tenacious advocacy where required".[45]

8.97 The 1993–94 Annual Report of the former Complaints Unit of New South Wales reported that the major types of complaints received relate to treatment, professional conduct, and communication, which together account for two-thirds of all complaints.[46] The majority of these complaints do not raise issues of public health and safety, nor are they frivolous or vexatious.

8.98 During consultations on the establishment of a health care complaints commission, a constant theme raised by consumer groups was the need for an advocacy service to assist consumers of health services to access the complaints system so their concerns could be quickly resolved. It was not considered appropriate to have such a service as part of the commission because the commission's primary focus is on the public interest aspects of maintaining standards.

8.99 Many complaints are about private practitioners. In these cases, unlike complaints about public health services and practitioners, there is no administrative structure to handle complaints. The onus for resolution is solely on the complainant and dependent on the goodwill of the practitioner. Even in the public health system, the complainant has to negotiate a complex and sometimes unsympathetic system. Complainants are disadvantaged in terms of exercising any influence on the internal investigation of a complaint. Many barriers exist to frustrate the complainant such as language and literacy barriers, fear, ignorance of where and how to proceed, lack of support and a desire to *get it over with*. These difficulties are often exacerbated because people are also sick, injured or otherwise debilitated.

8.100 To overcome this, the Commission proposes that advocates at the local level are necessary to assist consumers of health services either at the time of the health service, thus preventing a complaint, or during the process of the complaint inquiry and resolution. The advocates would be employed by the Health Care Complaints Commission, with Area Health Services and Districts providing accommodation and administrative support. The advocates' role would be to provide advice, support and information to assist consumers to resolve problems with their health care. In many cases, such services will prevent a formal complaint being made. If a complaint cannot be resolved at the local level, and the complaint is serious, the advocate will assist the complainant to make a complaint to the Commission. It is not proposed that the advocate would have any investigative role.

8.101 The advocates will:

- promote information about complaints and how to resolve them;
- disseminate information about consumers' rights and the Commission;
- network with consumer groups to promote better understanding of the health system;
- cater for the needs of specific groups such as people with mental illness, the aged, ethnic groups and groups with specific health needs;
- refer consumers where appropriate, including for counselling and legal advice;
- liaise with health care providers and community services;
- provide direct advocacy and mediation; and
- provide advice to the Commission on experiences of complainants at the local level.[47]

8.102 In Chapter 7, a model, that is not based in the government sector, which performs many of these functions, as well as providing legal advice, was discussed. The organisation – Action for Victims of Medical Accidents – provides a different advocacy model that could be explored as well.

8.103 Advocates and advocacy services can also provide important assistance for those who report sexual misconduct by a health care professional, where they are properly trained to deal with such cases.
In another context, it was suggested that criteria for training and hiring staff who may be contacted by people wishing to report sexual misconduct or abuse, should include:

- recognition of society's tendency to blame the victim;
- the nature and extent of sexual misconduct by doctors, the consequences for victims, and issues of race, gender and class which are related to abuse;
- the ways a victim may initiate disclosure and enquiry, and how this may be facilitated and handled in an appropriate, empathetic and supportive manner;
- how to fully explain the complaints and disciplinary processes to potential complainants;
- the options a complainant has to lodge a complaint through the criminal and civil law systems; and
- how to address victims of sexual misconduct and those making enquiries with sensitivity and respect.[48]

8.104 It was further suggested that assistance should be offered to complainants in writing a complaint, and that staff training initiatives for those who investigate sexual misconduct complaints include measures to assist investigators to provide support and counselling throughout the complaints and disciplinary process.[49] The PIR believes these suggestions are appropriate and any health consumer advocacy service should include these points to ensure that people who allege sexual misconduct on the part of a health care professional are assisted appropriately. The PIR notes the New South Wales Complaints Commission employs a complaints liaison officer who supports complainants through the complaints process, particularly in cases involving sexual misconduct and is also developing a pamphlet for consumers of health services concerning sexual misconduct.[50]

8.105 The PIR considers that the assistance health consumer advocates and advocacy services provide to consumers can promote an effective health care partnership and can improve the efficacy of other systems for dealing with complaints. **The PIR recommends the advocacy service to be established by the New South Wales Health Care Complaints Commission, and any advocacy service model based on the United Kingdom Action for Victims of Medical Accidents established in Australia, be closely examined by AHMAC as potential models for adoption in other states. (Recommendation 126) The PIR recommends that the advocacy service maintain close links with community advocates**

who advocate on behalf of people who are disadvantaged due to age, or physical or mental disability. (Recommendation 127)[51]

F. Making the health care partnership a reality

8.106 The PIR believes that to become a reality for all health care consumers, an effective health care partnership requires significant change in the health system. There are, however, many changes under way which will facilitate such a partnership. This Report has discussed some of these changes in detail. The PIR would argue that a health care partnership is a necessary step towards ensuring the health system is accountable and focused on achieving quality outcomes.

8.107 An effective health care partnership has a number of advantages. First, health care consumers often note that debate about the health system centres on the concerns of health care professionals and bureaucrats. A health care partnership in which health care consumers are informed and able to participate at many levels in the health system, would ensure that the health and welfare of all health care consumers, that is the Australian population, is placed at the forefront of any debate.

8.108 Second, patients will be empowered to participate in treatment decisions with health care professionals. This Report has set out in detail why this is important for patient autonomy.

8.109 Third, a patient who has a complaint or grievance will be more likely to attempt to resolve it with the health care professional, rather than having to change health care professionals, or pursuing the complaint through a third party. The PIR notes that for many consumers, the option of changing doctors, for example, may be difficult in rural or remote areas where there is only one doctor, or where few doctors bulk bill.

8.110 Fourth, health care professionals can take advantage of the non-medical knowledge of various groups and individuals to improve their own care. Many health care professionals are working with support groups who have experience of the special needs of various groups, with respect to differing cultural perspectives on health and complementary therapies, or in supporting patients with a particular disease.

8.111 Fifth, health care professionals are less likely to be blamed for less than optimum outcomes to treatment where the patient has been informed of risks and benefits and made his or her own decision about treatment.

8.112 Sixth, health care professionals should feel less constrained in discussing possible or actual adverse outcomes. Acknowledging mistakes can happen allows health professionals to focus openly on preventing as many adverse outcomes as possible and minimising the harm from those which cannot be prevented.

8.113 Lastly, and perhaps most importantly, both health care consumers and health care professionals are likely to benefit from more satisfying personal interactions where there is an improved and more open relationship. The PIR notes that little attention has been paid to health professionals' satisfaction as an indicator of quality of care. For example, occupational

stress for doctors can arise from dissatisfaction with consultations, concerns about the transmission of information between doctor and patient, doctor frustration with patients, including not understanding why they had come for a consultation and resultant feelings of helplessness about being unable to achieve improvements in health.[52] The doctor-patient interaction during a consultation can also influence post-consultation compliance with treatment and decisions about changes in the patient's life-style. It is important to note that many patients may chose a health care professional as much on the basis of their empathy and perceived genuine interest as on the basis of clinical competence. Factors that encourage trust and confidence between doctors and patients have been described elsewhere and include the doctor being sensitive to the needs of an individual patient.[53]

8.114 Implementation of the recommendations throughout this Report will enable an effective health care partnership to exist at many levels. In summary, the PIR's recommendations promote a health care system that:

- enables effective communication;
- focuses on scientific evidence for the efficacy and safety of interventions;
- has vigorous quality assurance and risk management procedures;
- has effective consumer complaints mechanisms linked to improving services;
- offers opportunity for consumer input at a variety of levels; and
- offers prompt and effective redress for complaints.

8.115 Such a health care system would enable consumers to be partners rather than recipients of health care services.

Chapter 9: Health professional indemnity reform

A. Introduction

9.1 A major focus of the work of the PIR has been developing a proper understanding of the indemnity arrangements that cover health professionals for negligence in the performance of their work. These are complex and diverse in Australia, and surrounded by a surprising degree of secrecy. The PIR faced considerable difficulties in getting a full picture for any part of the health sector. This was particularly so with the medical defence organisations (MDOs) - even a survey undertaken by the Australian Bureau of Statistics (ABS) of the financial and administrative arrangements raised more questions than it answered[1]. The Interim Report provided a general outline of the arrangements[2]. A separate consultant's report on the medical defence industry, which accessed the ABS survey and is summarised later in this chapter, provided more detailed analysis of that sector[3]. This chapter does not repeat the detail set out in either of these publications, but rather attempts to build on the information provided there, on the views expressed in submissions and on the PIR's other research.

9.2 Health professionals and health care institutions have two choices in relation to the costs associated with negligence actions, which are in fact quite rare events - they can carry the risk themselves or they can seek to spread the risk among others who have similar risks. This chapter deals with how these risks are borne and the costs funded, and what safeguards the PIR considers necessary to protect the interests of health professionals, health care consumers and taxpayers.

Some basic terms

9.3 Discussion of this complex topic requires a general understanding of the terms, used in this chapter. Firstly, we will define insurance, discretionary cover, self-insurance and reinsurance, so far as they relate to health professional liability. Secondly, we will outline various indemnity product descriptions, such as claims incurred cover, incurred but not reported (IBNR) liability, claims made cover, run-off cover, and capped and uncapped liability. Lastly we will describe full funding and pay-as-you-go funding. Other concepts such as mutuality and risk-rating of premiums will be defined at the appropriate points. These definitions do not include the debate about the relative benefits and problems with the different options, which are discussed later in this chapter.

9.4 *Insurance* in this Report is used to describe a commercial arrangement, where a health professional enters a contract with a licensed insurer (regulated under the *Insurance Act 1973* by the Insurance and Superannuation Commission) to indemnify the costs of negligence actions relating to their professional activities in exchange for a premium. An insurer can operate for profit or on a mutual non-profit basis. It can provide other services to its policy-holders. The nature of the cover offered to the health professional is specified in the contract, as are any exclusions.

9.5 *Discretionary cover* describes the indemnity cover provided by MDOs and a small number of other health care professional discretionary mutuals operating in Australia at the moment. There are no contracts whereby a member is guaranteed payment of their professional

indemnity liabilities, though there appears to be only a few examples where MDOs have exercised their discretion not to cover an individual doctor or group of doctors.[4] Recent statements from one MDO have indicated that they may exercise their discretion adversely against certain kinds of cases such as negligence cases involving sexual impropriety[5]. The nature of this indemnity means the organisations offering it are not insurance companies, and so they operate outside of the regulatory framework covering insurance.

9.6 *Self-insurance* is an arrangement where a body, which has a large pool of financial resources under its control, such as a Health Commission or hospital or medical chain, considers that it has sufficient assets to fund any costs of professional liability from its own resources, without the risk-spreading benefits of insurance, and without becoming insolvent.

9.7 *Reinsurance* is an arrangement where a risk carrier (who may operate as an insurer or a provider of discretionary indemnity) buys insurance for part of their risk, usually with a firm specialising in reinsurance. Sometimes a self-insurer may choose to accept risks up to a certain level, and then insure above that - this is similar in principle to reinsurance.

9.8 *Claims incurred cover* provides indemnity for any claim which arises from an incident that occurs while the health care professional is either a member (in the case of an MDO) or has paid their insurance premium (in the case of an insurer). This variety of cover is sometimes called *occurrence-based* cover, and is the type of cover which applies to the majority of personal injury insurance in Australia - that is, employer's liability and third party motor vehicle personal injury insurance. It is also the product offered by MDOs in Australia.

9.9 *IBNR liability* arises with claims incurred cover. It refers to those claims where an incident has already occurred (that is the liability has been incurred), but the claim has not yet been reported to the risk carrier. Estimates of these are made using historical claims reporting data.

9.10 *Claims made cover* provides cover for previously unreported claims made in the year a premium was paid or membership held. This form of cover is generally provided for economic loss insurance, such as professional indemnity for financial professionals. It is also the kind of cover generally offered by insurers and insurance brokers for health professionals.

9.11 *Run-off cover* arises with claims made products. When health professionals, who have claims made professional indemnity cover, stop practising, they need to buy cover for any new claims which come forward from the period they were in practice.

9.12 *Capped liability* relates to a limit imposed, either by a policy contract or by an exercise of discretion, on the amount of money payable by a risk carrier. It does not limit the amount payable by the person being sued. *Uncapped liability* is the converse: it provides cover to the full extent of damages awarded against a defendant.

9.13 *Full funding* is the ordinary funding principle that applies to commercial insurance. Every year a premium is collected, which is estimated to be sufficient (with any investment income) to meet all the liabilities incurred by the insurer in that year. Full funding is based upon the premise that if an insurer stops writing new business or a policy-holder or member

ceases to make contributions, the money already held by the risk carrier will be sufficient to pay out on all claims relating to the liabilities covered to that time.

9.14 *Pay-as-you-go funding* is the normal funding practice of governments. The money received in each year is sufficient to meet the amount of money needed to be paid out (including legal and administrative costs) to achieve a nil balance at the end of the period.

Funding of health professional indemnity liability in Australia

9.15 Health professional indemnity liability in Australia is currently funded through a range of mechanisms. This section summarises these mechanisms and describes their main characteristics. Overall, it is possible to realise the specialised nature of professional indemnity for health professionals. Unlike professional indemnity for many other professionals, including actuaries, accountants, auditors and lawyers, health professional indemnity usually relates to personal injury compensation, rather than loss of profit or other purely economic losses, and it is based generally in the common law of negligence, rather than breach of contract.

9.16 As such, it shares more elements with motor vehicle and employers' liability insurance than the professional indemnity associated with some of these other professions. Even the record judgements in personal injury claims are not as large as the multimillion dollar professional negligence actions against financial professionals, which arose as a consequence of the various corporate and financial collapses of the late 1980s. In addition, the losses compensated in health professional litigation relate directly to any on-going injury-related needs of a person who has been injured by the negligent conduct of the health professional, rather than the financial losses arising from the advice of financial experts, or property losses in building professional liability cases.

9.17 However, even in the field of personal injury, health care negligence cases are said to have different characteristics. For example, the business is generally said to *have a longer tail* than other forms of personal injury litigation. This means that claims often come in a long time after the original act of negligence. This can be because of the inherent nature of the negligence - for example, a failure to diagnose case may take several years to be detected. It can be because the cases sometimes relate to minors, who have many years before they attain their majority, at which point they have a right to initiate a claim on their own behalf. It can also be because the person is unaware of the negligence until some considerable time later, because of the difficulties patients have traditionally faced in finding out what occurred and obtaining advice about whether or not there was negligence.

9.18 It is also argued that it health care negligence cases are more unpredictable, because of changes in health care practice and the introduction of new treatments. Given the apparent paucity of available data, the PIR considers it is likely that part of its so-called unpredictability arises from inadequate analysis by health professional indemnity carriers of past cases and claims patterns, and inadequate monitoring of new incidents as they are notified. For example, few MDOs appear to monitor the outcomes of claims arising from particular years in any systematic fashion, and none were readily able to provide data on the frequency of the those very long tail cases, which are alleged to give rise to the unpredictability.

9.19 The analysis by MDOs of patterns of claimants and of what had happened in cases appeared to be generally haphazard and only done on an ad hoc basis. While some of this appearance no doubt arose from a reluctance to reveal information to the PIR, the surprise that was frequently expressed at the results when analysis was undertaken led us to believe that such analysis was not systematically undertaken as part of their management processes. Some degree of the unpredictability is likely to have arisen from this. Those who have undertaken better data collection and analysis are more likely to be able to predict their claims patterns and costs accurately, which in turn makes their premium collection more accurate.

Medical defence organisations and other discretionary funders

9.20 The Interim Report noted that there were 10 MDOs operating in Australia, offering medical practitioners (primarily) discretionary indemnity on a claims-incurred basis.[6] This situation remains unchanged, though there appears to have been some preliminary exploration of merger, and one organisation has recently changed its operating name.[7] While most of their members are doctors, some also cover dentists[8] and a range of other self-employed and even employed health professionals. A separate mutual also exists for pharmacists.

9.21 MDOs provide discretionary indemnity cover for their members, which is uncapped and offered on a claims incurred basis. They operate on a not-for-profit mutual basis. Their membership contributions are now based different risk measures, and vary by specialty and in some cases income levels. There does not appear to be any individualised claims experience loading used in determining membership rates. However, membership of certain high-record risk individuals may not be renewed in rare cases. In other cases, where the member has a bad claims record, continued membership may have practice conditions imposed upon it, relating to the areas of high risk.

9.22 MDOs also provide a range of other services to their members, which can be quite costly, for example health complaints representation and assistance in disciplinary processes. This is generally known as *non-claim business* and is not covered by the same policy concerns in relation to ensuring adequacy of funding. Some MDOs in states where complaints bodies exist have identified a significant growth in their administration costs related to this non-claims business. As all States are required to establish such mechanisms, and as disciplinary processes become more open, it is likely that these cost areas will continue to increase, and thus result in rises in membership contribution costs, whatever occurs in relation to claim-based costs.

9.23 MDOs are not insurance companies and would not currently meet the providential requirements of the Insurance and Superannuation Commission (ISC), principally because of underfunding of their IBNR liability, but also because of the relatively small capital base of some, and the lack of separation of the overseas and Australian components of the businesses of the larger overseas-based MDOs[9]. These issues are discussed further in section D below.

9.24 Three Australian-based MDOs have a *captive insurer*, which is a wholly owned licensed insurer covering part of their liability[10]. In these cases, the MDOs offer their members claims incurred cover, while passing on those claims which have been made to their solely owned insurer. MDO contributions are passed to the captive insurer on a claims made basis.

Thus, while funding of their known claims is scrutinised by the ISC, the extent of coverage of their IBNR liability is not included in this scrutiny.

Commercial insurance

9.25 The commercial insurance sector provides cover to various health care institutions, different health professional groups and some State Governments, as well as reinsurance to insurers, MDOs and self-insurers. Some insurers made minor attempts to enter the medical market in the last 1980s but these insurers have now withdrawn from the market.

9.26 Commercial insurance for health professional indemnity provides contract-based, claims made cover, usually with a cap on liability. The nature of the products vary considerably. Some offer run-off cover and some do not. Some require a health professional to have a policy at the time of the incident occurring as well as at the time of a claim being made, while others provide cover for any new claims that were not previously known about, so long as the claim becomes known and notified in the policy period. The definition of when a claim is made, for example at the time an incident is notified by the health professional, at the time of contact by the potential plaintiff or at the time legal process is issued, can also vary. Sometimes an insurer has a right to refuse renewal in any circumstances - other contracts can give a policy holder a right to renew in certain circumstances.

9.27 The policies sighted by the PIR often included extensive exclusion clauses, the effect of which did not seem to be well understood by policy-holders. Verbal reassurances about the scope of such clauses were sometimes sought by policy-holders from brokers who had established the contracts often with overseas insurers. Advice seemed to be received quite frequently that there was nothing to worry about, and they were "quite safe", when the policies' written contents gave no such reassurance.

9.28 The impact of plain English drafting in this area seems to have been minimal, leading to a lack of awareness by many policy holders about the exact nature of the policy until they have need to call upon it. At this point, many had indicated that its scope and coverage had fallen considerably short of what they had expected and, in some cases, had been led to believe by the sellers of the products. If there were evidence of misleading conduct by insurance brokers or other sellers, it would tell against them, but in the case of oral advice proof may well be difficult to obtain.

9.29 The relationship of large organisations like State Governments with insurers was apparently quite different. It was on a far more equal footing, and the customer started from a far more powerful and informed bargaining position.

Self-insurance

9.30 Insurance and MDO cover is designed to protect those who incur risks from large pay-outs, which may otherwise cause them financial disaster. In the case of organisations and individuals with very large financial reserves, a sensible commercial decision may be made to carry any such costs themselves. This means that the organisation or individual holds onto

those funds they would have otherwise paid out as premiums or contributions, but in the event of negligence, they will be obliged to pay out themselves.

9.31 In other areas of personal injury where insurance cover is compulsory (such as motor vehicle compulsory third party and workers' compensation), it is generally only very large companies and Governments who are allowed to be self-insurers. Private businesses that wish to self-insure are generally required to demonstrate that they have assets sufficient to meet their potential liabilities under the particular compulsory scheme. This is to protect the rights of those who may be injured in compensable circumstances.

9.32 While it seems likely that very few health professional individually choose to self-insure their professional liability risks, there has been anecdotal evidence given to the PIR of a small number of doctors who have chosen to not seek cover for their liabilities and have *gone bare*. The evidence came from lawyers who were representing parties in medical negligence litigation where the risks had materialised for these doctors and they were going to be obliged to sell their homes and other assets, if a judgment was handed down in the plaintiff's favour. There also some examples given where cover had been refused by MDOs, because of a poor claims history, but the doctor was still practising. In one sense these doctors have chosen to self-insure and bear the consequences of that decision.

9.33 There was much broader evidence of self-insurance in other parts of the health sector, such as government agencies or commercial health providers, including pathology businesses and private hospitals. There are few if any requirements on such businesses to carry any cover or to demonstrate their financial viability to carry even modest risks. Confidential information was also provided to the PIR of private bodies that required their full-time employed staff to carry their own cover, allegedly so the private bodies did not have to carry their own cover. The existence of an independent institutional duty of care, discussed at some length in the Interim Report[11], as well as the principles of vicarious liability make this a risky financial strategy for the employing body, particular if its capital base is not large, or is all tied into assets unavailable for liquidation without destroying its business, for example, the hospital buildings and facilities of a private hospital.

Catastrophe cover

9.34 A health professional or institution can also choose to self-insure up to a certain level and then seek to insure the higher level risks. Similar theories underlie most reinsurance arrangements. The principles of risk spreading which underlie both practices are quite clear. Insurance and like arrangements are based on paying someone else to carry a risk - the more likely the risk is to occur, the higher is the likely charge payable to transfer it.

9.35 The concept of risk here is not the same as that which was discussed earlier in the section on risk management. There we were broadly talking about the risk of injury to a patient or the risk of errors occurring, which could potentially harm a patient. In the business of indemnity provision, the only really relevant risk is that of having to pay out money. While this financial risk can be affected by reducing these other risks, they are essentially irrelevant to the concept of risk-spreading that underlies insurance, unless they are indicative of likely increases

in payouts. The most important issue for a person who is looking at how much to charge to take on someone else's risks is the likelihood of a payment needing to be made.

9.36 The pattern of health care negligence actions is like most other risk patterns - there is a higher frequency of low-level claims and very low frequency of high-level claims. This is illustrated clearly by the South Australian data described in Chapter 2, where 60% of cases were settled for less than $60,000, and less than 2% were for amounts over $500,000. The greater frequency of smaller claims makes them relatively more expensive to transfer - the likelihood of the financial risk eventuating is greater even though the likely individual cost is smaller.

9.37 This leads to various risk-sharing options, ranging from the imposition of claims excesses, where an insurer refuses to cover, say, the first $500 in any one claim (as often applies in property loss policies) to catastrophe arrangements, where a policy holder agrees to accept all risks up to a level specified in the contract, with any excess above this being met by the insurer.

9.38 Generally, such limits are expressed as a limit on each individual claim or on the aggregated costs of all claims in a particular period, or both. For example, a health care institution may agree to meet all claims below $100,000, up to a total in any one year of $3 million from its budget, with catastrophe insurance to cover any liability above this. This would result in the insurer having to pay out the difference in individual claims in excess of $100,000, until the aggregate payments from all the smaller claims reached $3 million, after which all claims costs would rest with the insurer. Sometimes the catastrophe cover specifies upper limits on the insurer or reinsurer's liability as well.

9.39 It is argued by some that such risk-sharing deters poor performance and encourages increased attention to safety. The theory is that a person will seek to actively avoid the smaller losses they are directly liable for through implementation of safe systems, and that this will consequently further reduce the likelihood of one of the higher cost events occurring. Data comparing the relative safety of different risk-sharing options in practice is scarce. The relative rarity of health care negligence cases where any payment is made is also likely to diminish any potential behavioural effect between different risk-sharing practices on their own.

Is cover really necessary?

9.40 Notwithstanding all the current press focus on to health care negligence, successful health care negligence actions are rare, compared to the number of health services provided each year, the number of adverse patient outcomes that occur and any estimates of actual negligence. Very large payments are correspondingly extremely rare. For example, in 1992-93, there were about 172 million individual health care services funded by Medicare[12] and 4.4 million hospital admissions - around 3 million in public hospitals[13]. The Quality in Australian Hospital Care Study estimated that around 340,000 public hospital admissions[14] were associated with an adverse patient outcome, with 12,700 resulting in permanent disability greater than 50 %. Around half of these were considered strongly preventable. These figures compare to the consultant's estimate of 1,500 claims incurred annually by the MDO industry in

Australia[15], only a small proportion of which would be expected to result in payments greater than $1 million.

9.41 Given this apparently small risk, preliminary question must be asked about whether cover for the risk is really necessary, and whether there are sound public policy reasons for governments having an interest in health professional indemnity and its funding. This could especially be argued, in cases where a health professional is earning substantial income, which may make the payment of liabilities easier.

9.42 There are three key public policy concerns for government relating to health care professional indemnity. They are underpinned by the currently accepted notion of justice in our society, which says that where someone is injured by the negligence of another, the negligent person should bear the costs of the injury, rather than the community or the injured person.

9.43 Firstly, there is 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 compensated. This view was supported in a number of submissions to the PIR from health professional bodies.[16] This is the same interest which has led to the requirements for compulsory insurance in third party motor vehicle personal injury and workers' compensation.

9.44 Further, it is arguable that a consumer needs to know weather a health care professional has adequate professional indemnity cover (either in their own right or through their employer). If a patient is properly informed of the risks associated with properly performed treatment, and they decide to go ahead, then it is arguable that they are accepting that risk of harm and the costs associated with it themselves. However, if harmful consequences arise from the negligent performance of a treatment or negligent inaction, then justice, common sense and the law currently assume that the possibility of having to pay the costs arising from the negligence was not accepted by the injured patient. Public policy should be to ensure that in these circumstances, there are mechanisms in place to ensure the costs arising from the negligent acts are met and will not have to be borne by the patient.

9.45 There were also isolated anecdotes of doctors *going bare* (having no cover) and telling potential plaintiffs that they had structured their affairs so their own assets were not able to be touched, and their practice was structured in such a fashion that recovery against it was also unlikely. Sometimes this was used to discourage the person from pursuing their claim at all, and in other cases, it has been used as a tactic to get a plaintiff to accept a compromise much less than the likely value of the claim for fear of otherwise getting nothing.

9.46 Secondly, there is a public financial and policy interest in ensuring the otherwise compensable costs are not shifted onto government support and assistance programs through inadequate or non-existent compensation, as was discussed at length in Chapter 6. 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.

9.47 Even high-income earning health professionals are unlikely to be able to meet a significant payment from their own resources, and if there are a number of cases in a particular period the likelihood of being able to do so even with modest and small claims reduces as well. As noted earlier, the PIR was provided with some evidence of cases where a doctor had been refused MDO cover, or it had been revoked following repeated claims, and the doctor was continuing to work and cause harm. In one case brought to the PIR's attention, the doctor had fled the jurisdiction and the patient's chances of recovery of the costs of the negligence were minimal. In all these cases, the costs would be transferred to the injured person and the government. This in turn perversely affects the commercial competitiveness of different health care providers, because those who are socially irresponsible gain an on-going competitive cost advantage (by not paying their professional indemnity contributions or negligence awards) over those who are socially responsible and purchase such cover or otherwise meet the costs. It is essentially an unfair competitive advantage gained by cost shifting to governments and injured patients and their families.

9.48 Thirdly, the government has a policy concern to ensure 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. This has recently occurred in South Australia, where a small private hospital serving a country town, had very inadequate indemnity insurance of only $2 million[17], and an award was made for $4.8 million.[18] The case involved negligence by hospital employees at the birth of a child, that resulted in severe brain damage, including spastic quadriplegia and cerebral palsy. Liability was admitted, with the Court simply being asked to assess damages. The hospital went into voluntary liquidation, and it seems likely that it will need to be sold to pay the award - possibly leaving the community without a hospital facility.

9.49 **On balance the PIR considers that there are strong public policy reasons to support government legislation requiring all health professionals to have adequate professional indemnity cover as a condition of practice. (Recommendation 128) Similarly, the PIR recommends that all health care businesses, including private hospitals, day surgery facilities, pathology services and health centres, have adequate professional indemnity cover or be required to demonstrate sufficient financial reserves to be able to meet any probable maximum loss arising from negligence in service provision. A combination of self-insurance and catastrophe cover could also be suitable, where financial reserves were sufficient. (Recommendation 129)**

B. General principles of adequacy for health professional indemnity

Contractually defined cover

9.50 **The PIR is strongly of the view that adequate health professional indemnity must be contractually based, not discretionary, and fully funded from premiums collected for this purpose (that is there should be no cross-subsidisation by other forms of insurance business). (Recommendation 130)** By definition, a discretionary based product does not provide either health consumers or health professionals with assured and clearly defined

protection in the event of negligence. While cases where the discretion of MDOs have been used in an adverse manner are rare, they do exist and this is not considered satisfactory.

9.51 The capacity of MDOs to alter their coverage retrospectively is particularly unsatisfactory for a health care consumer who may find the doctor's assets inadequate to meet claims. This occurred in the Chelmsford cases, relating to the coverage of Dr Harry Bailey by the NSW Medical Defence Union (now United Medical Defence). The attempt to refuse to cover Dr Bailey posthumously for damages incurred by the various Chelmsford patients has been the subject of much litigation[19]. His estate was declared insolvent some years ago. Thus, notwithstanding the findings of the Royal Commission in relation to the practices at Chelmsford Hospital, many of the patients feel rightly that the system has generally failed to deliver them a just result.[20] The discretionary nature of MDO cover is only a relatively small part of their concerns, but it is one of the many which the PIR considers should be addressed through this reform process.

9.52 MDOs have argued that the discretion is generally there to be exercised benevolently - that is, in favour of a doctor. While this may well be the case, there is nothing to stop the exercise of a positive discretion under a contract of insurance. The contract essentially specifies the minimum obligation of the insurer. It also must specify any exclusions, with no capacity for the insurer to unilaterally change the exclusions or conditions.

9.53 Perhaps most importantly, the existence of a contract will of itself redefine the MDOs as insurers, requiring licensing under the *Insurance Act 1973*, and bringing them under the supervision of the Insurance and Superannuation Commission. The financial solvency of licensed insurers is supervised by the Insurance and Superannuation Commissioner, who has various reporting requirements and financial pre-conditions for licensing which are designed to ensure the financial security of the insurance industry. The importance of this in ensuring the proper funding of health professional indemnity over the long term is discussed in detail in section D below. Briefly, it would no longer be possible for MDOs to assert that they did not need to be fully funded, because they have the discretion to not pay claims, as was asserted earlier in the work of the PIR. There was support in some submissions for the notion that all providers of professional indemnity to health care professionals be required to be licensed under the *Insurance Act 1973*.[21] Equally, the prohibition on cross-subsidisation is included to prevent insurers with a wide range of products cross-subsidising the professional indemnity premiums at an artificially low level.

9.54 **The PIR recommends that all health professional indemnity insurance contracts should be expressed, as clearly as possible, using the plain English methods now used by other sectors of the insurance industry. (Recommendation 131)** Many existing insurance policies are of poor quality, and can be misleading about the nature of the cover provided. This is equally unsatisfactory for consumers and health professionals, as the health professional may pay for their cover for a long period, and then find themselves not adequately protected when an unfortunate event occurs.

Compulsory cover

9.55 The Interim Report recommended, in principle, that professional indemnity cover should be compulsory for all health professionals, either through vicarious liability or through their own cover.[22] There were mixed opinions in submissions on whether indemnity cover should be compulsory. Some professional groups considered that while it was desirable and advisable, holding adequate professional indemnity cover should not be compulsory[23], while others considered compulsory cover necessary and desirable[24]. The main concern expressed by MDOs (in the Birthing Issues Sub-committee forum rather than in their submissions) was whether making indemnity cover compulsory led to insurers and MDOs becoming de facto regulators of standards, because if they refused cover (because someone had proved to be a *bad risk*), this could prevent the health professional from practising.

9.56 The strong public policy arguments in favour of requiring professional indemnity cover for all health professional and health care institutions were outlined above. The questions are: what advantages there are to making it compulsory (rather than simply a good idea), and weather making indemnity cover obligatory for practice changes the role of the professional registration boards. The advantage of obliging a health professional or a health facility to carry adequate insurance as a condition of practice (or licensing in the case of health facilities) is that a potential patient can be certain that the health practitioner or the health facility has cover.

9.57 What would the situation be if an insurer considered a health professional to be such a bad risk that it is not happy to offer cover? If this is the case, the registration board itself should investigate the practitioner to determine whether he or she should still be practising. Legislation requiring notification of any personal injury payments to the registration boards of all health professions in all States (like that which operates in South Australia in relation to medical practitioners) as recommended in Chapter 7 would enable the registration boards to play a more active role in these cases.

9.58 One option for linking the two mechanisms to ensure the primacy of the registration boards in determining who should practice health care would be to require all insurers to provide cover at a fair price if a health professional was registered, but to allow the insurer to set the price, having due regard to the practitioner's risk history. If the premium wee considered unfair by the practitioner (compared to his or her peers), then they could appeal to the registration board to investigate the premium charged. The registration board could use this as a trigger to determine whether the person's claims history indicates weather they should be registered, or practising under conditions, or dealt with in some other fashion, or whether the premium sought to be charged was too high and the person should be paying a lower premium.

9.59 This option "compromises" the freedom of the insurers to set individual premiums at whatever level they may consider reasonable to cover the risks incurred, but it overcomes their concerns about becoming a de facto registration board. It would be important to ensure that any such legislation be limited to investigating the size of risk loadings, rather than giving the board any broader power to investigate premium setting practices, where they do not have a role, and which is the core of MDO and insurer business.

9.60 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 to which the Commonwealth contributed. 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. A national approach would avoid the potential problem that all those who were unable to get cover because of poor claims history might gravitate to States without such legislation.

9.61 **The PIR recommends that the Commonwealth and States, through Australian Health Ministers' Advisory Council (AHMAC), develop an agreed strategy for making professional indemnity cover (with a defined minimum set of characteristics) compulsory for all health professionals, either through their own cover or through adequate cover by their employer, in the case of vicarious liability. (Recommendation 132)** These options will be discussed further below. Further **the PIR further recommends that this strategy should aim primarily at developing nationally consistent legislation to be passed in all States, but that if this does not seem likely to occur, the Commonwealth should use the full scope of its constitutional powers to ensure that professional indemnity cover is a requirement for all health professionals in Australia. (Recommendation 133) In the interim, the PIR recommends that the Commonwealth introduce administrative requirements, for example as conditions on grants, as part of accreditation processes and through any other similar devices, that the health professionals or health care businesses provide proof of adequate professional indemnity cover. (Recommendation 134)**

Who should be covered?

9.62 The PIR noted there is no broadly accepted definition of health care professional. In the Interim Report, a number of possible defining characteristics were discussed for determining which groups should be classed as health care professionals in the context of compulsory professional indemnity, and submissions were sought on whether registration should be a necessary characteristic.

9.63 While the PIR suggested that the Health Industry Council of the Australian Council of Trade Unions may have been an appropriate forum for determining a useful, this Council fell into abeyance between the issuing of the Interim Report and this report, and so did not prove to be a useful forum. Some submissions suggested that they would be happy to participate in a forum to develop working definitions and professional indemnity arrangements for health care professionals[25], but, the PIR ran out of time and resources to undertake this work. The Final Report therefore has used submissions received on the Interim Report in casting its final recommendations.

9.64 Some submissions argued that compulsory professional indemnity should be limited to registered health professionals[26], while others argued that any person holding themselves out to be a health professional should be required to hold adequate professional indemnity cover.

> There are many unregistered health care providers, ranging from the well-organised and reasonably cohesive (eg osteopaths, naturopaths) to the diffuse and ill-defined ('counsellors', 'spiritual healers'). The MDOs believe that all those who hold themselves out to be health care providers should be required to hold adequate personal/public liability protection.[27]

9.65 Another correspondent also suggested that the discussion should include all health care workers, not just those traditionally considered to be health professionals, as many of these carried out activities which could give rise to liabilities identical with those of traditional "health care professionals"[28]. Similar points were raised by those who considered themselves to be health professionals but who were not subject to registration such as dietitians[29] and ambulance officers[30]. Other submissions mentioned other health workers who had the potential to cause harm to patients and others - such as traditional birthing attendants[31] and hospital engineers[32].

9.66 The PIR was impressed with the logic of the submissions suggesting as broad as possible an inclusion of health providers who should be required to have professional indemnity cover. While there is an attraction to linking the requirement to registration because of the ease of administration and enforcement, such an option would clearly leave a proportion of health care consumers without protection in the case of negligence by their chosen health care provider.

9.67 While some of these groups may be employed and so covered by vicarious liability, a number of others will not be. With the increased contracting out of various health services (for example, ambulance services in Victoria), there are also likely to be more self-employed, non-government providers of health care services. The need to ensure patients are adequately protected from the negligent acts of health care providers must encompass these changes. It is also clear that, while the incidence of harm to patients can be lower in less invasive forms of health care, this is not automatically so, particularly in cases of failure to diagnose what turns out to be significant disease, and the adequate disclosure of risks and provision of advice to patients.

9.68 The use of qualifications or registration status to determine who should have adequate coverage ignores the reality of modern health care, where there are many people with different qualifications sometimes carrying out similar work. The PIR suggested earlier (Chapter 5) that it was important that credentialling be based on the proper exercise of skills, if it was not to be used simply as a restrictive trade practice. The notion of exercising particular skills (or holding yourself out as exercising those skills) whatever the qualifications held would seem to be a more appropriate test of the need for cover. Such a test would also ensure that where there was more than one health carer (for example, a self-employed midwife and a private obstetrician, as well as hospital staff) operating in a health care situation that all would be covered and therefore, if negligence occurred, all involved could be required to contribute in proportion to their negligence.

9.69 This issue was raised in the Interim Report[33], where the view had been put to the PIR that the rules of joint and several liability should be changed in medical negligence cases, so that a doctor would only have to pay for the proportion of the results of the negligence for which she or he was responsible. This was based upon a view that the current law was unfair to doctors who had a "deeper pocket" than some other health professionals (particularly those whose professional indemnity policies were capped). The current law says that a plaintiff could sue any one of those who were negligent and recover all damages from that person, who can then seek recovery against the other negligent parties. However, such recovery may not be possible or may only be partial if the other defendants have no insurance, inadequate insurance, no assets or have gone into liquidation. The general policy behind the law of joint and several liability in the personal injury area is to ensure that the negligently injured plaintiff is not left without a remedy.

9.70 A recent report to the Commonwealth and NSW Attorneys-General has looked at the issue of joint and several liability in professional negligence, so far as it relates to negligence actions relating to property damage or purely economic loss. The terms of reference precluded the examination of the operation of such laws in relation to personal injury[34], and the report clearly states this precluded them from considering the position of professional negligence for nurses and doctors[35]. This report suggested the law be amended for cases of property damage or purely economic loss to provide for proportional liability, where the liability of a defendant is limited by their degree of fault[36]. This means the plaintiff, rather than all solvent defendants, bears the risk of an impecunious defendant. The conclusions were that "if the plaintiff's claim relates to property damage or economic loss, the argument for provision of full compensation should be subordinated to the dictates of fairness in the allocation of responsibility."[37]

9.71 While personal injury was outside the report's terms of reference, in its analysis of the law, it draws clear distinctions of public policy between compensation for personal injury and compensation for purely economic losses, so far as the fairness of a plaintiff rather than one or more defendants having to bare the losses is concerned:

> ...the principal aim of the law of torts is to provide full compensation (wherever possible) to one who has been injured by the fault of another. No-one can doubt that this is an accurate statement when applied to a plaintiff who has suffered personal injury. Their interest in bodily integrity is rightly accorded a high priority.[38]

While this concept has been overridden in some areas, a better way of achieving fairness between defendants, in a manner which will not compromise the plaintiff's right to recover full damages, would be to ensure that all health care providers have adequate cover.

9.72 **The PIR recommends that compulsory professional indemnity apply not only to registered health care professionals, but also all health care providers and those who hold themselves out as providing health care, because in all health care cases there is the potential for negligent care to result in significant harm to patients (either through treatment, omission to treat, failure to diagnose or provision of advice). (Recommendation 135)**

9.73 The most direct ways of achieving this end would probably be: to make it an offence to provide health care without adequate professional indemnity cover, in the case of self-employed people; to clarify the laws in relation to vicarious liability for employed health professionals; and to clarify the law in relation to assistance in an emergency, as discussed below. This could be achieved through a single model piece of legislation, replicated in each State, through the process described above in paragraph 0. The role of the registration bodies would them be simply to check that these separate statutory obligations had been fulfilled by their professionals and then remind their professionals of their obligations in this regard.

9.74 Where there is no registration body, there would need to be some other agency with the power to prosecute a health professional who did not have cover. This power could be delegated to a body like the health care complaints commissions. For ease of discussion in this Report, the terms *health professional* and *health professional indemnity* will be used to include the broader range of health care providers referred to in paragraph 0.

Capped v uncapped liability cover

9.75 In section A, the diverse professional indemnity arrangements that apply in health care were outlined. The protection offered to health care consumers and health professionals by these arrangements differs significantly between the different types of products. For example, where liability is capped, the cover is limited to the amount specified and if damages awards are higher than this, the health care consumer can have no recourse except to require the health professional to personally meet the costs, or to accept the lesser inadequate sum.

9.76 The degree of inadequacy also varies according to the date on which the cap is determined. For example, the cap can be applied at the date of occurrence, the date of reporting or the date of payment. In long tail business like health care negligence, a cap which relates to the policy limit at the date of occurrence or at the date of notification of a potential claim by a health professional can end up covering only a small portion of the damages. In turn this can lead a health professional to delay early notification of a potential claim, to maximise the cap which would apply to the case (and thus minimise their personal exposure to loss).

9.77 From a practical perspective, the imposition of caps on cover serves to shift costs onto the government sector and onto injured people and their families, since often the effort of seeking recovery from an individual health professional or institution beyond the cap may be considered too difficult or expensive. Not only do caps leave the health professional financially vulnerable, they also shift costs away from the negligence system.

9.78 Insurers argue that caps are necessary to ensure adequate funding of their liabilities, and they can be indexed in such a way as to better cover liabilities while still providing certainty for the insurer. These arguments ignore the hardships arising in those rare cases of significant damage that exceed the caps. While there have been exceptions to this pattern, the upper limits of damages in personal injury cases tends to increase in a gradual manner. The patterns of increases can be monitored and adjustments made - as they are regularly in other personal injury premium arenas. Caps need to either be set at the top end of expectations or at some lower level, which is much more likely to end up inadequate.

9.79 In the end, the total amount available to meet a damages award is the capital base of the insurer. However, individual personal injury cases do not reach levels that could endanger this base, and claims patterns generally do not show that even in aggregate such an event is likely. The insurance sector already uses the concept of maximum probable loss in determining the adequacy of reserves for aggregates of all liability estimates. The process of estimating liabilities where there in no contractual limit is no different from the estimation process undertaken both in cases less than the cap and in determining maximum probable losses for reinsurance and similar purposes. The estimate includes predictions on the amount payable in particular cases, the likelihood of success for a plaintiff in any individual case, the likely level of claims inflation and the time taken to settle a case. Such predictions are the stuff of insurance business - and while sometimes they will be wrong, their businesses run on being right more often than not. Most insurers are conservative in these estimates to ensure that they do collect sufficient premium, and they balance this conservatism against their need to have a premium or product which is more attractive to potential policy-holders than those of their competitors.

9.80 The PIR therefore does not accept that the arguments for capping of policy payments outweigh the strong arguments against them. Accordingly, **the PIR recommends that all health professional and health care business indemnity cover be uncapped. (Recommendation 136)**

Claims made v claims incurred cover

9.81 Claims made policies can lead to uncertainty for health care professionals about whether they will have cover when they need it. If a health professional has claims incurred cover every year they are in practice, then they know that, so long as the insurer's policies are fully funded, they will have cover for a claim, even if it arises after they have ceased practising and paying their premiums, because the premiums collected when they were practising included a component for these costs. This would also be the case with insurance for health care businesses - claims incurred cover would mean that even if they later ceased operations, the insurer who collected the premiums would be in a position to pay out the claims arising from their period of operation.

9.82 However, in the case of claims made cover, the cover for past events only exists while premiums continue to be paid. It would never be possible to be sure at the time of consultation or treatment whether the health professional would have cover at the time of a claim being made, because the cover relates to the year the claim is made, not whether the person had a valid policy at the time of the treatment. This can be a particular problem where an insurer stops writing such business. Those insurers, who entered the medical indemnity market in the late 1980s and then withdrew from it, have left those who bought their products with significant uncovered risks for claims where the incident occurred during the policy period, but the claim was made after the insurer withdrew from the market.

9.83 Situations were reported to the PIR where a health professional had purchased policies over long period, and when a claim was lodged, the insurer refused the renew the person's policy the next year. In both of these cases, when a patient attended the professional, they would have appeared to be covered, but in reality if a claim was made even a short while after

in the next premium year, the injured person would be left without financial recourse, except against the personal resources of the health professional.

9.84 In consultations with those in the insurance sector,[39] the view was put that claims made cover should be the favoured approach because it gave the insurer greater financial certainty. In essence, at the end of every year, the insurer knows with certainty what liabilities they had arising from that year. The PIR is strongly of the view that the certainty of an insurer in knowing their liabilities in any one year is a secondary concern to the certainty of cover for both patients and health professionals.

9.85 The view was also put that almost all professional indemnity cover in Australia was arranged on a claims made basis, and it is also widely used overseas. However, in the health care sector at the moment (rather than the broader professional indemnity insurance market), probably the biggest component is handled through a claims incurred product. While the MDOs certainly have had some problems, the PIR believes that these can be remedied without changing the nature of the product currently provided. The basic nature of the product - an uncapped, claims incurred product - is best for both patients and health professionals. As discussed earlier, the PIR sees this part of the market as having more in common with other insurance for funding the costs of personal injuries, such as motor vehicle personal injury and employer's liability cover, than professional indemnity for groups such as accountants and actuaries, where the losses being compensated are purely economic[40].

9.86 These personal injury insurance products are required by legislation to be uncapped, and where fully funded, they are a claims incurred product. If a motor vehicle owner no longer owns a vehicle when the plaintiff takes legal action, the plaintiff is still covered by the previous insurance of the owner when the accident occurred. Similarly, with work accidents and illness, if an employer ceases operation, and an illness from that earlier period becomes obvious, the employer is still covered by the earlier policy.

9.87 To improve the assessment of the costs of claims incurred, there is an obligation on the vehicle owner and employer to notify their insurer of any accident, which could involve personal injury as soon as possible after the event occurs. This could also be an obligation imposed upon health professionals by their insurance contracts. This not only helps determine liabilities at an earlier time, but it allows an insurer to become active earlier in managing the claims and ensuring prompt compensation in appropriate cases. There has been considerable effort by MDOs over the recent past to ensure early notification of potential claims - the increase in claims notified has probably arisen partly from this effort. This should mean that fewer "surprise claims" arise, and allow more accurate assessment of the costs of claims incurred.

9.88 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. 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 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 PIR concludes, however, that once adjustments are made to make the protection of claims made cover as certain as claims incurred cover, the same uncertainties that make some insurers reluctant to issue claims incurred policies arise again.

9.89 Finally insurers argue that many international reinsurers will not offer claims incurred reinsurance, and that the nature of reinsurance should be same as the primary product, so therefore policies must be claims made. At one time this matching of reinsurance and primary insurance was a requirement of the Insurance and Superannuation Commission (ISC) as well. However, changes in the international reinsurance market have required the ISC to reconsider its position in relation to both motor vehicle compulsory third party and workers' compensation. Advice from the ISC[41] to the PIR is that they will in future be requiring proof of adequate reinsurance for the maximum probable loss, rather than matching the nature of the cover.

9.90 **The PIR recommends that the professional indemnity cover for all health professionals and health care businesses be required to be on a claims incurred basis. (Recommendation 137)**

9.91 The combined recommendations of uncapped, claims incurred cover based on an insurance contract will require changes in the cover provided to many health professionals both by insurers and MDOs, as well as considerably expanding the number of people who may require cover. **The PIR recommends a transition period of 2 years to enable these developments in health care professional and health care business indemnity to occur in an orderly fashion. (Recommendation 138)**

Emergency voluntary assistance and indemnity

9.92 The issue of professional indemnity cover where a health professional provides voluntary emergency assistance was discussed in the Interim Report[42]. In that report, the common law and various statutory extensions of it were discussed. While there are very few cases in this area, there has been a recent judgment in NSW extending the common law duty of a doctor to provide assistance when asked in some circumstances, even if there was no pre-existing doctor/patient relationship[43].

9.93 There are clearly strong public policy reasons to encourage the provision of assistance in emergencies by those who have relevant training. This includes health professionals, but it can also include trained volunteers such as the St Johns Ambulance Brigade. There are two issues; coverage for those who are otherwise health professionals who provide emergency voluntary assistance, and coverage for those who are volunteers, rendering emergency first aid assistance, who are not otherwise health care providers.

9.94 Given the PIR's recommendations about professional indemnity cover of all health care providers, either through vicarious liability or individual cover for self-employed people, what should be the position in relation to volunteers or their organisations, delivering first aid? Should they be required to carry indemnity cover, in the case of negligence? While there have been a very small number of allegations made against first aiders, the St Johns Ambulance

submission indicated that there has not been any successful actions over the past 10 years involving their members[44].

9.95 Whether or not there is a need for cover depends on whether it is considered appropriate that a person being rescued should have a right to recover against their rescuer in any circumstances. The apparent rarity of any actions probably indicates that it is unlikely that, even if they suffer injuries as a result of being rescued, most people will seek to take action against a rescuer. The recent NSW case referred to above of *Woods v. Lowns and Ors* in New South Wales involved a finding of liability in negligence for failure to provide assistance. As noted in the Interim Report[45], there are a range of statutes which impose obligations on health professionals and others to render assistance in various emergencies.

9.96 The evidence would seem to indicate that public policy favours the encouragement of good Samaritan acts, and while the possibility of a negligence action is very unlikely, it could act as a deterrent to someone providing such assistance in an emergency. This argument is even stronger in cases where there is a statutory requirement to assist.

9.97 On balance, **the PIR recommends that legislation should be introduced to preclude a recovery in negligence against a rescuer or voluntary provider of first aid for services rendered in an emergency. (Recommendation 139)** Where there is no emergency, or the person is being paid to provide health care assistance, then the ordinary rules relating to negligence and indemnity cover discussed earlier should apply.

Data reporting

9.98 Chapter 2 included a detailed discussion and recommendations on the aggregated national information on health care negligence cases, which would form a useful data-base for the development of preventive actions, provide important policy information about rises and falls in claims incidence and costs, and give useful data to insurers and others about claims experience across Australia. Chapters 2 and 7 also included recommendations for information reporting by health professionals and their registration boards, where claims against them were paid out, either through a settlement or judgment.

9.99 In addition to this aggregated information, members of individual MDOs or purchasers of insurance products need sufficient information about the operation of their individual MDO or insurer, such as the overall numbers and costs of claims received and paid by the organisation, the estimated liability for claims incurred but not reported and how subscriptions or premiums are calculated. They need to know what exactly the subscription or premium is paying for, and why it is increasing, decreasing or remaining steady.

9.100 Perhaps more than any other major sector of personal injury cover, health care professional indemnity products have been shrouded in secrecy and misinformation. It would be impossible currently, for example, for an existing member or potential member of an MDO to make an informative comparison of the various MDOs and their products and services. This is due to differing terminology and definitions used[46] and of unsubstantiated or inaccurate claims about MDOs, often by one MDO about a competitor. The lack of publicly available, consistent data makes it impossible for members or policy holders to fairly assess claims about

the financial position of an MDO or the reasons for any rises in subscription rates. The only reporting obligations on MDOs at the moment are under the general corporations law[47].

9.101 The recommendations that MDOs become insurers will mean that they must use the same terminology and definitions as other insurers. The accounting standards and concept statements included in AASB 1023, which covers the financial reporting of general insurance activities, will apply to MDOs. Compliance with these standards is compulsory for all insurance companies preparing financial statements under the Corporations Law[48]. In addition to these data requirements, once MDOs are authorised insurers, they would also have to comply with ISC reporting requirements[49]. These obligations are significantly greater than their existing obligations under the general corporations law. For example, not only are these standards important for the measurement of the liability for outstanding claims, but they impose "considerable disclosure requirements aimed at providing a reader of the financial statements with an understanding of the entity's results and financial position"[50].

9.102 The MDO consultancy found that MDOs generally do not have adequate information data bases to enable them to perform the calculations. While the position of some of the MDOs is likely to have improved in this regard, since the completion of the research for the MDO consultancy report, it seems highly likely that the MDOs have some way to go to position themselves for the data requirements of being insurers. It is important, however, to realise that this information will also allow them to operate more effectively. Their members could also be better informed. If all adopt the use of the AASB 1023 requirements, health professionals will be able to make better comparisons between different product providers.

9.103 The main difficulty with the MDOs providing this data is the extremely competitive nature of their operations. The MDO consultancy report noted the protective approach the MDOs had to what they regard as confidential information:

> It appears that the MDOs regard virtually all of their information as commercially sensitive, including the following: membership rates; subscription rates; structure of subscription rates across medical specialties; claims experience; assets and liabilities; reinsurance arrangements; and corporate structure.

9.104 This was certainly true at the beginning of the PIR's work. One MDO even refused to provide the PIR with its fax number. However, there have also been considerable change in this secretive as the PIR proceeded. It may be that, prior to any action by government on the requirement for cover of health professionals to be through an insurance-based product, the MDO sector is mature enough to start down that road itself.

9.105 **The PIR recommends that the MDOs and health professional indemnity insurance sectors standardise definitions of basic terms and calculations and commence to use the AASB 1023 reporting standards to report to their members. This should provide sufficient information for existing and potential members and policy holders to assess the relative financial strength and products offered by the organisation in a fair and accurate way. (Recommendation 140)**

9.106 While MDOs have indicated they do not consider self-regulation a viable option[51], improved cooperation within the industry through the establishment of an industry council, could assist in the development of greater trust within the industry and the capacity of organisations to learn from each other during the current reform process. Such an industry council might be able to set a date by which all its members will commence using these standards, and could act as a forum for the development of plain english policies. The PIR is encouraged to see an apparent increase in the positive interactions between the various MDOs - including the MDO consensus submission to the PIR[52] - and hopes that such an industry body will develop in the short term.

9.107 A highly competitive, unregulated market, about which it is difficult to obtain public information, offers temptations to provide false or misleading claims about the product or the degree of financial security involved. The PIR is aware of some of these in both the MDO and insurance sector. The various sectors have an even stronger moral and ethical duty not to mislead because their members or policy holders are unable to check the veracity of their statements. **The PIR recommends that, where false or misleading claims are made by insurers or MDOs about their products, the matters should be referred to the appropriate body such as the Insurance and Superannuation Commission or Trade Practices Commission. (Recommendation 141)**

C. Who should carry the cover?

Interim Report and submissions

9.108 The Interim Report expressed concerns that there was both over-insurance and under-insurance in the sphere of health care professional indemnity. Some full-time employees were taking out such cover, when the risk was already being insured by their employer under the principles of vicarious liability and as part of their independent institutional duty of care. In other cases, people who should have had cover were not aware of the need for it and so carried an uninsured risk.

9.109 The Interim Report suggested the following solutions :

- the statutory clarification of vicarious liability to remove the possibility of an employer seeking to recover damages paid for their employee's negligence in relation to their work, as already exists in NSW, South Australia and the Northern Territory[53];

- the development of products which did not provide indemnity cover for employees but rather provided them with assistance to obtain independent legal assistance, as may be required for disciplinary proceedings, coronial inquiries and tort actions, where their conduct is brought under scrutiny[54]; and

- the development of a set of model contracts for health professionals, which would clarify the nature of their relationship to the facility where they worked, and clarify their position in relation to professional indemnity[55].

9.110 A number of correspondents to the PIR addressed these issues. Some favoured retention and possibly reintroduction of the common law rules of recovery in vicarious liability situations. For example, one submission indicated that the situation in relation to vicarious liability was unclear for many health care professionals, but rather than modifying the rules of recovery in vicarious liability situations, all health care professionals should carry their own individual professional indemnity, according to their level of risk and exposure, with the question of payment of the premium for such cover being a matter for industrial negotiation.[56] This could apply to the public and private health systems and to employed and self-employed professionals, including non-medical professionals. Under this option all health providers would have to carry their own cover.

9.111 Another correspondent, from a State Government health region, noted all doctors were encouraged to be members of an MDO, although, in general, they were indemnified when working within hospital guidelines, policies and procedures.[57] This correspondent endorsed the PIR's recommendation that other health care professionals not covered by vicarious liability be required to maintain their own indemnity cover. One organisation comprising broad representation of rural interests wrote that clarification of vicarious liability, and how it applies to health care professionals working in rural and remote areas, was of great importance to some of its members.[58] The PIR's attention was drawn to possible double insurance where professionals carry their own indemnity and are also covered by vicarious liability; concern where rural professionals act outside the normal codes of practice; and uncertainty regarding some groups who may or may not be seen as health care professionals.

9.112 Some employing agencies considered they benefited from the uncertainty surrounding vicarious liability, because it "frightened" their staff into purchasing cover, which allowed the employing agency the real possibility of seeking recovery. There was also a lack of enthusiasm for tackling the issue among some bodies representing employees, because they saw their offering of professional indemnity cover for their members as being a big incentive for staff to join their organisation.

9.113 Initial discussions were held with the secretariat of the Standing Committee of Attorneys-General (SCAG), which was happy to consider a joint working group on this and other issues with the Australian Health Minister's Advisory Council (AHMAC). Preliminary work was commenced by the PIR, with a working group of State and Commonwealth representatives, to determine action on a range of the recommendations in the Interim Report, which involved the need for State action or combined Commonwealth-State action. At a meeting towards the end of 1994, AHMAC determined not to act on the recommendations of that group, and not to act with the SCAG, despite recent endorsement of action by SCAG. This left the PIR with no option but to proceed to its Final Report without having made significant progress on these important issues.

9.114 Similarly, with the apparent abeyance of the Health Industry Council of the Australian Council of Trade Unions, coordinated efforts by unions on some of these issues were not forthcoming, nor was it possible to obtain assistance from either forum in the preparation of model contracts. The PIR simply proceeded with these on its own, in the hope that action will proceed once the Final Report is considered.

Vicarious liability and independent legal advice

9.115 Notwithstanding the apparent lack of enthusiasm for clarifying the law in this area, the PIR considers its original recommendations in relation to vicarious liability and the need for a separate product for funding independent legal advice (but not providing indemnity) are the most appropriate reforms to prevent double insurance, to minimise the costs of professional indemnity, and to ensure that those who control workplaces have the maximum incentive to encourage safe work practices to minimise the incidence of adverse patient outcomes. Individual cover of all employees would be likely to lead to higher costs because of the lesser bargaining power of individual health care providers compared to their employers, and the greater administrative costs associated with individual policies.

9.116 Those employers who argue that individual cover is more consistent with the health professionals individual responsibility to their patient ignores the widespread evidence that while human error is responsible for many adverse patient events, there are many system-related safeguards which can be introduced by an employer and many system-related failures which result in often quite simple errors resulting in significant harm to patients. Such employers appear to abrogate their responsibility for overall safe practices and safe systems. Individual accountability can be maintained in any system where the employer funds the cost of negligence through other much more direct sanctions, including counselling, discipline and, in the end, termination of employment.

9.117 Accordingly, **the PIR recommends that the Minister for Human Services and Health propose to the Commonwealth Attorney-General that a clarification of the law of vicarious liability in all States (in a manner similar the *Employees Liability Act 1991* (NSW) and similar legislation in South Australia and Northern Territory) be referred to the Standing Committee of Attorneys-General for coordinated national action. The legislative amendment should be as broad as possible, and cover negligence in activities arising out of or in the course of employment. (Recommendation 142)**

9.118 **If a national approach cannot be achieved through the Standing Committee of Attorneys-General, the PIR recommends that health unions seek to have similar arrangements included in industrial awards or enterprise bargains. Because the issue of vicarious liability reform is of relevance to other providers, the PIR further recommends that the Executive of the Australian Council of Trade Unions examine the need for coordinated national action. (Recommendation 143)**

9.119 The PIR continues its support for the provision of independent legal assistance to employed health professionals in relation to their health care work. **The PIR recommends that all employed health professional have access to independent legal advice and assistance, where their actions are the subject of judicial or other inquiry, for example complaints authority investigation, disciplinary processes or in coronial inquiry. This could be through the negotiation of employer funding through awards or enterprise bargaining arrangements; through the combined purchasing power of their unions and professional associations to enable purchase of inexpensive legal costs insurance, self-insurance or some direct funding arrangements with the legal profession; or through the availability of**

specific products from insurers and MDOs that do not include a professional indemnity component in their contract. (Recommendation 144)

Model contracts

9.120 One of the uncertainties surrounding the scope of vicarious liability that was identified in the Interim Report[59] was determining whether some health care professionals are employees or independent contractors. The PIR therefore recommended development of model contracts, with clauses to clarify whether the contract is one of employment or one for services.[60]

9.121 Some submissions were received on the issue of model contacts. The recommendation regarding model contracts was seen as naive or over-optimistic in one submission[61]. It was seen as impossible to develop a set of model contracts to cover every contingency of employment, direct and contractual. Another correspondent noted that private hospitals would like to participate in development of the model contracts to ensure that the activity was representative of both public and private health care establishments.[62] One correspondent commented that if a health care professional were a sub-contractor, then he or she should have to demonstrate that the appropriate professional indemnity was held, and if he or she were an employee, then the employer should be responsible for the cover.[63] A submission drew attention to a potentially difficult situation for pathologists working for private pathology practices, where the pathologist could be seen to be an employee for taxation purposes, but was treated as an independent contractor for indemnity purposes.[64]

9.122 Submissions also argued that there was a need to clarify the employment status of some categories of health care professionals to determine whether or not they are covered by the law of vicarious liability. These categories of providers include student nurses, agency nurses, sessional providers, and honorary medical officers.[65] Submissions to the PIR:

- argued there was a need for a broadening of the definition of employees in the organisation to ensure that providers are covered by vicarious liability where their employment encompasses operating in a specific organisational context[66];

- queried the liability status of student nurses who are not employees, but tertiary students undertaking clinical placement in a health care establishment[67]; and

- raised the question of nurses engaged through an agency, where in terms of vicarious liability, it is not clear whether the health care establishment or the employment agency is the employer.[68]

9.123 The question of employment status remains particularly problematic for visiting medical officers (VMOs). For these medical practitioners the doctor-hospital relationship does not always appear to fit into an employment context, as such doctors are users of the facility, essentially operating as independent contractors to the patient. The problem is worsened where the doctor, "employed" by the patient, uses other professionals to provide assistance who are not themselves employees of the hospital.

9.124 As discussed in the Interim Report, the common law provides that the key issue in determining whether an employee-employer relationship exists, and thus whether vicarious liability arises, is whether the relationship between the health care establishment and the health care professional is a contract of employment or a contract for services. Both the "control" test and the "organisation" test used by the courts for determining whether a contract of employment or a contract for services exists were discussed in the PIR's Interim Report. There were a number of problems with the application of the control test in the health sector, which led to its application being broadened.

9.125 The particular difficulties of applying the control test to the health care setting became apparent in a series of cases where hospitals were found not to be vicariously liable for the conduct of hospital staff.[69] The trend towards more specialised skills and social changes enhancing individual autonomy also led to the development of the organisation test. Under this test, organisations are held liable for the conduct of people who form part of the organisation and are integrated into the discipline and direction,[70] so long as they are not engaged directly by the patient.[71] This test is based upon the concept that the hospital is an organisation providing health care services, rather than a body merely providing facilities in which health care professionals can operate their own businesses. The concept of the institutional non-delegable duty of care discussed in the Interim Report[72] also arose from this philosophical position.

9.126 These complexities are aggravated in the diversity of employment situations in Australian hospitals, particularly in the case of doctors, and the payment arrangements that have arisen from them. The most simple arrangement from a legal liability angle would be that all doctors when working in a hospital were the employees of that hospital, and were paid, either for the hours worked (that is, like casual employees) or on a salaried basis (as permanent part-time or full-time employees). This could allow the development of proper enterprise liability arrangements, as are developing in the United States (discussed below).

9.127 Such an employment arrangement would also recognise that the hospital owns all of the infrastructure and pays all the support staff who service the workplace for many doctors who consider themselves to be "self-employed". Few hospitals require doctors to pay for the use of the hospital facilities for private patients, yet these facilities provide their means of earning a living. The doctor receives income in the case of a private patient from Medicare, the patient and health insurance, and the hospital receives accommodation costs from health insurance and/or the patient. While the accommodation costs of private patients in public hospitals provide some additional income to hospitals, the financial benefits gained by using a hospital facility are significant for a doctor.

9.128 Instead of a straight forward employer-employee arrangement, many hospitals have Visiting Medical Officer (VMO) arrangements, which treat these doctors as self-employed contractors, instead of part-time employees. Self-employed contractors are generally expected to retain their own professional indemnity cover and are not covered by vicarious liability. Often fees are struck which are at a higher rate, because of these additional "practice costs". In the case of private patients, it is easier to consider the relationship as a self-employed one, because the hospital does not pay the doctor directly for treatment (though they may well be remunerated for being on call at the same time). Where a VMO treats public patients, it is

likely to be easier to characterise this as an employment relationship rather than one of an independent contractor, using the organisation test.

9.129 However, for various other reasons, VMOs in some States seek to have themselves engaged as private contractors, even when treating public patients. The complexities are further extended for those who are full-time employees, but who retain a limited right of private practice. In some cases, such employees are allowed to keep all they earn up to a limit, after which any excess goes to the hospital or special purpose funds (such as research or for attendance at conferences and training); in other cases they can keep it all, and in still others the income goes to the hospital, with the employed health professional simply being paid more salary for the extra hours worked.

9.130 The relevance of the doctrine of vicarious liability to the nature of the VMO relationship with hospitals (whether for public or private patients), and for employed staff with rights of private practice is a vexed question. The position also varies from State to State, a situation which, as Government Insurance Office Australia pointed out in its submission to the PIR, is of no assistance to patients who cannot be expected to differentiate between an employed doctor and a private doctor.[73]

9.131 To give some idea of the variety of arrangements, in New South Wales VMOs are defined as independent contractors in that they are not employed by the Department of Health and as such are not indemnified for any liabilities arising within the public hospital system, whether the patients are public or private.[74] The rates paid to VMOs take account of such factors as the costs incurred in taking out their own medical indemnity cover.[75] Similarly, the Commonwealth does not accept responsibility for the conduct of independent contractors, including VMOs, in any Commonwealth hospital. In Victoria, VMOs are considered to be covered by the principles of vicarious liability in the case of public patients. In South Australia, however, both full-time employed doctors and VMOs are included as staff indemnified for medical malpractice, except in rural hospitals.[76]

9.132 The major public policy concern is the cost associated with the uncertainty of whether or not a relationship of vicarious liability exists. For doctors who practice privately will probably hold full indemnity insurance anyway. It may be that the question of "over insurance" does not exist for doctors practising privately and that it is better if they are considered to be independent contractors in all circumstances. Alternatively, it may be that the arrangement should depend upon whether the patient is a private or public patient, with a hospital accepting liability for all public patients as if it were the employer, but only having its own non-delegable duty in relation to the contractor in the case of a private patient. Certainty and clarity in all such situations will minimise difficulties.

9.133 The Interim Report recommended that a working party be established to develop a set of model contracts for use by health care professionals and health care establishments, which includes a specific term of the contract directed to the issue of whether it is a contract of employment or a contract for services. Where the contract is a contract of employment, the PIR recommended that the model contract set out the situation regarding vicarious liability in that State and that, in the absence of legislative protection, the option of a contract of employment providing for appropriate indemnity for the employee be explored. The PIR further

recommended the exploration of ways in which health care providers can readily and accurately be informed about whether they are engaged under a contract of employment or a contract for services and the consequences of this, in cooperation with the Health Industry Council of the Australian Council of Trade Unions.[77] The PIR also considered that specific work should be undertaken to attempt to find a nationally acceptable solution to the employment position of VMOs so far as it relates to indemnity for different "classes" of patient.

9.134 While those involved recognised the difficulties that arise for consumers and health professionals from the current variety of employment arrangements and from the lack of clarity in these arrangements, the PIR found it difficult to have options to address the problems considered in any appropriate forums. Some of these problems were noted above in paragraph 9.113. Instead the PIR developed some model clauses on its own. Because health professionals are currently contracted for employment or for services using a variety of formal and informal contracts and letters, a set of model clauses to be included in contracts by health care professionals and health care establishments were developed. These clauses distinguish a contract of employment from a contract for services.

9.135 The clauses developed are indicative only and seek to have the current arrangements, whatever they are, made more transparent for consumers and health professionals alike. The four sets of clauses include options for dealing with specific issues such as whether State Government legislation precludes the employer, from recovering from an employee, damages paid to a third person. They have been developed to assist institutions to deal with the current circumstances relating to formal and informal contractual arrangements with current employees with and without private practising rights and health professionals hired as independent contractors, as well as to cover circumstances of enterprise liability as discussed below. They are set out in full in Appendix I.

5.1 **The PIR recommends that employer and employee groups and the AHMAC consider the model clauses and seek to have them included in health contracts of employment, to clarify their entitlements and obligations in relation to professional indemnity and related matters. (Recommendation 145)**

Enterprise liability - a different model

5.2 The term *enterprise liability* covers a number of reform initiatives and practices in the United States, where the enterprise in which health care is practised takes over the whole costs of liability for health care services it provides. Enterprise liability also includes insurance channelling arrangements, whereby large hospitals provide their associated doctors with coverage under the institution's own insurance policy[78]. The American Law Institute developed a detailed proposal for this in the early 1990s[79] and it is reported to be being trialled in some states.[80] It is consistent philosophically with the integrated claims and risk management processes run for many public and University health care institutions in California by Professional Risk Management, discussed earlier in Chapter 5.

9.138 In the United States enterprise liability was considered likely to cover around 90 per cent of cases currently giving rise to malpractice claims and payments[81]. Some of its proponents argue that it reduces the administrative complexities when there are multiple

defendants - this occurs in around 25 per cent of US cases.[82] It is also argued to be a useful lever for improved systemic care and patient safety.[83] The major obstacle to its broad adoption is considered to be "the physician's impulse to preserve his or her own autonomy" almost at any cost.[84]

9.139 Such a model could be a useful one for Australia in areas where it is considered that professional indemnity concerns are adversely influencing health care workforce choices, or where hospitals believe that indemnity costs are one of the reasons they are having trouble attracting appropriate staff in certain areas. The most frequently discussed of these is in relation to birthing services. There are concerns for some birthing service providers that adequate products are not readily available, for others that they are very expensive, and that conflicts and uncertainty relating to professional indemnity are causing a breakdown in health services. For example, there was a recent situation in Queensland where self-employed doctors were advised by their MDO not to continue to provide back-up services for self-employed midwives, and where the midwives subsequently had their visiting rights revoked because of the unavailability of back-up.

9.140 Enterprise-based liability could involve all these professionals being employed by the hospital for the purposes of birthing service provision, and the hospital taking over the professional indemnity liability of them all. This could be as part of a salary package or part-time remuneration arrangement. Alternatively, enterprise liability could leave some of the professionals involved as self-employed contractors, who would make a contribution to their indemnity cover to the hospital by way of premium (a form of insurance channelling). While it would potentially shift some costs onto the enterprise, it could solve many of the problems inherent in the existing arrangements. Similarly, if home birth were one of the birthing services options, the birthing service practitioner could operate like a home nursing extension officer of the hospital, with all the back-up automatically built in if referral to hospital were necessary.

9.141 Such a model focuses on the health care consumers, and the service they require, rather than health professional and their professional indemnity needs. It also spreads the costs over a much larger "cost unit", which means that cover is likely to be much more economical overall. This is particularly so if the reimbursement of the costs of professional indemnity subscriptions form part of the pay arrangements of the health professional. The person may end up with the same cover at a lower cost. The enterprise manager is also directly encouraged to take greater responsibility for patient safety. **The PIR recommends that AHMAC and hospital managers consider the possibility of using enterprise liability arrangements in any circumstances where professional indemnity premiums appear to be causing problems in attracting or retaining appropriate health care professionals. (Recommendation 146)** A possible model contract clause to provide this cover to a contractor is also included in Appendix I.

D. Medical defence organisations: some specific issues

Interim Report and submissions

9.142 In the Interim Report, the PIR noted the following:

- the MDOs are mutual organisations and are not regulated as insurance companies;

- a rise in members' subscription rates has taken place over the past few years;

- MDOs are estimated to have considerable unfunded liabilities for claims incurred but not reported; and

- the rise in premiums has not been caused by a medical malpractice crisis, but rather by MDOs seeking to adjust their financial position in the wake of a period when subscription rates were held below the level necessary to fund their liabilities.

The Interim Report discussed possible regulation of MDOs to ensure their long-term financial stability and suggested further discussion should take place with MDOs. This section of deals with the results of these consultations and some specific issues of relevance to MDOs arising out of the problems identified above and the recommendations made earlier in this chapter.

9.143 In response to the Interim Report, the PIR received submissions from several of the MDOs operating within Australia, including a Consensus Statement prepared by: the Medical Defence Union; the Confederation of Australian Medical Defence Organisations; the Medical Defence Society of Queensland; the Medical Protection Association of Australia, and the Medical Protection Society. In addition to these submissions, the MDOs provided the PIR with other information and research material. This material is summarised elsewhere in this Report.

9.144 The MDOs commented on the rising number of negligence actions over the last few decades and the associated rise in the costs of defending such actions and the size of awards and settlements. However, they supported the view of the PIR that Australia is not, at least as yet, experiencing a malpractice crisis as was alleged to be the experience in the United States. The MDOs noted the importance of improving doctor perception of the rapidly increasing costs of medical indemnity, hoping to address the common belief that costs could be recouped through moves in market prices for medical services.

9.145 The Consensus Statement noted the different support within the industry for either claims-made or claims-incurred (occurrence-based) indemnity. Noting this, the MDOs supported several measures aimed at reducing the financial uncertainties and the total cost of professional indemnity, and securing the industry:

- a shorter, absolute Statute of Limitation;
- capping of awards for general damages;
- transferring future care costs from litigation to welfare;
- reform of the administration of tort law; and
- prudential supervision.

9.146 The Medical Protection Association of Australia (MPAA) in its separate correspondence to the PIR supported occurrence-based indemnity noting that it provides the most complete protection for both doctors and patients. By way of example, the MPAA noted that occurrence-based indemnity provides access to indemnity after a doctor has retired from practice or has died.[85] The MDOs noted the role of an external prudential supervisor in ensuring that all organisations offering professional liability protection accurately estimate and

fully fund their liabilities. The MDOs supported, in principle, the adoption of uniform solvency and accounting standards and standardised definitions as the principal components of such external regulation.

9.147 The MDOs supported the need for all practitioners to hold adequate indemnity cover for professional liability, either though enforceable vicarious (employer) liability or personal protection through professional liability insurance or membership of a mutual indemnity fund. The MDOs supported the need for professional indemnity to be affordable, accessible, secure and adequate. The MDOs also supported the notion that proof of adequate indemnity arrangements should be a condition of registration. The MDOs believe that all those who hold themselves out as to be health care providers, including osteopaths, naturopaths, counsellors and spiritual healers, should be required to hold adequate personal/public liability cover.

9.148 The MDOs noted the "rapid" growth in the future-care cost component of awards and settlements, with the MPAA commenting that it was "the largest cost-push element in medical litigation, and hence in subscriptions for the medical protection organisations".[86] The MPAA believed that removing such costs from litigation would remove much of the upward pressure on subscriptions. The MDOs opposed selective no-fault, specified-causation programs, such as the vaccine encephalopathy program in the United Kingdom, explaining how the proposition that such costs should be funded universally and on a "needs" basis was in opposition to selective no-fault compensation.

9.149 The MDOs supported banding subscriptions according to the risk of members. They note this is more logical only substantially on member's capacity to pay, that is, income banding. Some commented that the subscriptions charged by MDOs are not commensurate with the incomes earned within some areas of medical endeavour. A compromise offered by some MDOs is income banding within risk rating. The MDOs explained how a return to full mutuality would only be feasible if all medical indemnity insurers were required to be selective in their recruitment strategies, that is, to avoid any organisation recruiting to only "low-risk" practitioners whereby undercutting the mutual rates charged by organisations accepting all disciplines and risk-groups.

9.150 The MDOs generally supported the introduction of structured settlements. The MDOs noted the concern of the community to ensure that if a plaintiff receives compensation sufficient to meet his or her needs, then that compensation should be applied for the purposes for which it was awarded. Structured settlements thus protect the community from double-dipping. Specific reservations related to the ability of a fund to fully and finally discharge its responsibility upon the purchase of an appropriate annuity and the arrangement for the capital sum to be reverted upon the death of the patient.

Consultancy on professional medical indemnity

9.151 The PIR commissioned a consultant's report on medical professional indemnity.[87] Consultations were held with: the five MDOs that accept liability in their own right; the Australian Medical Association; the Committee of Presidents of Medical Colleges; the Insurance and Superannuation Commission; the Private Health Insurance Council; and a number of individuals with specialised knowledge of the MDO industry.

9.152 There was general acknowledgment that some level of supervision was necessary to conform to current prudential requirements and policy-holder expectations. The greatest challenge to the financial viability of MDOs was seen as the liability for claims incurred but not reported, which was variously estimated to be between 50% – 100% of known MDO liabilities. Various reasons were offered to account for the escalation in the liability. None of the MDOs claimed to be solvent, that is, assets in excess of liabilities, including the liability for claims incurred but not reported, although all said they were solvent with the liability for IBNR claims excluded.

9.153 All MDOs claimed to set subscription rates at a level sufficient to generate income to meet all claims incurred in the underwriting year. That is, they operate on a fully-funded, claims-incurred basis. Opinion was divided on the question of whether cover should be provided on a claims-made or claims-incurred basis. Those advocating claims-made cover cited ease of administration, consistency with reinsurance arrangements and greater links between subscription payment dates and the state of medical practice and technology and community expectations, as reasons for favouring this form of cover. The comprehensiveness of cover from the members' (doctors') and the patients' perspective and the obviation of the need for run-off cover, were cited by those favouring claims-incurred cover.

9.154 Many of the consulted believed self-regulation was not a viable option for the MDO industry. A fear of over-regulation was expressed during discussions. The Insurance and Superannuation Commission was favoured as a supervisory body rather than the a special, separate regulatory agency. There was general agreement on the need for consistency of accounting and reporting standards. In respect of a national data base on claims to provide information on the number and type of adverse patient outcomes involving negligence and to inform quality assurance processes, there were doubts regarding its confidentiality and comprehensiveness, as many cases of negligence are not subject to claims, and many claims do not involve negligence. Others thought, in principle, consistent industry data should be available to identify trends and to inform risk and claims management activities.

The move to insurance-based products and its effect on MDOs

9.155 The benefits for health professionals of moving to a contract-based insurance product, which was uncapped and claims incurred in nature, were discussed earlier. The change from discretionary mutuals to mutual insurers will result in a number of changes to the MDO industry.

9.156 Currently, two major MDOs operate as branches of overseas MDOs. In the interim report the PIR suggested that these organisations move to separate accounting for their Australian assets and liabilities and/or separate incorporation in Australia[88]. The purpose of this recommendation was to ensure that the Australian business would be self-funding, and to ensure that there were sufficient assets in Australia to meet the liabilities for Australian claims. Regulation by the ISC will not require the overseas MDOs to be separately incorporated in Australia - a Branch of an overseas incorporated company can be authorised to carry on insurance business in Australia[89].

9.157 However, to grant an authority to carry on insurance business in Australia to any MDO, the Insurance and Superannuation Commissioner must be satisfied of the following:

- where the body corporate has share capital, it must have a paid up capital of not less than $2 million;

- if the body corporate is incorporated in Australia, the value of its assets must exceed its liabilities by not less than $2 million;

- the body corporate must have its reinsurance arrangements approved by the Commissioner under section 34 of the *Insurance Act 1973* or be granted an exemption under that section;

- the body corporate must be, and be likely to continue to be, able to meet its liabilities; and

- the body corporate must be and be likely to continue to be able to comply with the relevant provisions of the Act.[90]

9.158 These requirements will mean all MDOs operating in Australia will have to account for their Australian liabilities separately and hold sufficient assets in Australia. Insurance regulation will require MDOs to properly reserve and fund the product they offer their policyholders. Both Australian and overseas-based MDOs will be required to meet the ISC's solvency margin requirements, which should help avoid the significant financial difficulties experienced in the industry in the late 1980s. Options for dealing with the still unfunded tail from that period are discussed below. The required solvency margin also provides some cushioning for premiums, where unexpected claims arise. The ISC solvency margins are $2 million, or 20% of the insurer's Australian premium income in the previous financial year or 15% of its estimated outstanding Australian claims liabilities, whichever is the greatest. These financial requirements will ensure that MDOs no longer have to rely on their existing power to make a call on members equal to one year’s premium subscription if they get into difficult financial circumstances. While not often used, some MDOs were obliged to make a call on their members in the late 1980s when the financial shortfall from the previous decades underfunding became critical. ISC supervision should ensure such difficulties do not arise again.

9.159 Australia's MDO sector may well need to consolidate some of its arrangements to accommodate the capital requirements of the ISC. Even with the new opportunities for branching out into products for other health professionals, it is unlikely that all 10 organisations would be able to operate as insurers in their own right, just because of the limited size of the Australian market. However, the proposed phase-in of the recommendations in relation to professional indemnity over the next 2 years, (see paragraph 9.91) will allow time for these changes.

Premium setting: issues for MDOs

9.160 As was noted in the Interim Report, medical practitioner professional indemnity subscriptions paid to MDOs rose dramatically between 1988 and 1993. More recently, there

have been some increases and some declines in different specialties and different states. The two main reasons for these increases were:

- the move away from "mutual subscriptions" , which had applied to MDO business over the previous century, whereby all doctors shared the liability for medical negligence actions by paying equal subscriptions to "risk rate subscriptions"; and

- the need to address long-term underfunding of liabilities, which was caused by indemnity subscriptions being held at an artificially low level for some years.

9.161 Concerns about premium setting practices were the subject of some submissions to the PIR. A university department of obstetrics and gynaecology wrote expressing support for the principle of mutuality and cross-subsidisation in medical defence.[91] As a high-risk group of doctors, they were aware that their medical defence subscription rates were among the highest and they argued that this was partly responsible for the alleged decline in doctors practising obstetrics and gynaecology.

9.162 Addressing professional indemnity for dentists, a correspondent wrote that the punitive nature of risk-rating subscriptions was not likely to have a deterrent effect because adverse outcomes were usually related to, "... unforeseen misadventure rather than deliberate negligence".[92] Referring to the deterrent effect on practice in some specialties of high indemnity subscription rates and mutuality and cross-subsidisation in medical professional indemnity, the correspondent said consumers were better served where the nature of cross-subsidisation does not deter specialist practice in high-risk areas.

9.163 Addressing different subscription rates for different classes of doctors, another correspondent said there were two solutions: strict mutuality among all classes of doctors; or differential fees, while dealing with high-risk areas on a special case basis.[93] The latter option was preferred by this correspondent.

9.164 From the perspective of a staff specialists' association, one correspondent pointed out that, for some staff specialists, the subscription for medical indemnity was approximately 60% of private practice income.[94] Also important was the fact that staff specialists' salaries are based on years of experience, with all staff specialists having the same salary base, whereas MDOs set subscription rates according to speciality, among other things. For this correspondent, the principle of mutuality (equal subscription rates) should apply to all staff specialists.

9.165 The PIR has two concerns in this area - the first is to ensure that health professional indemnity is adequately funded and the second is to ensure relatively stable premiums for health professionals. Rapidly increasing indemnity subscriptions have been seen as a key sign that the system is in crisis, and premium instability in the longer term is not really desirable. Increases have particularly affected both specialists and general practitioners who provide birthing services, especially those in rural areas, but is also an issue for many other parts of the medical profession. Many other chapters of this report address ways of reducing the overall costs of the tort system, which will help to stabilise premiums in the future.

9.166 However, the proliferation of very small risk categories could be seen as a recipe for long-term premium instability. Loss spreading and risk sharing are fundamental principles of both mutual funds and insurance. The smaller the number of members or policy holders in any risk category, the more volatile the subscription rates will be and the less capacity there will be to spread the loss. This has been identified as a major issue in the premium costs of various groups in the United States.[95] At its most extreme, such class-based risk-rating could lead to risk groups as small as one or two practitioners, bearing almost directly any losses incurred by either of them. The inevitable consequence of the creation of many small categories of ever decreasing size will be long term subscription instability.

9.167 This has many negative consequences for medical practitioners. It also has the potential to affect medical workforce decisions, which may or may not be consistent with the public good, so far as availability and cost of health services are concerned. A consequence of this in some parts of the United States has been to push all high-risk procedures into the public health system, where the loss can, once more, be spread over a larger population. Such consequences must be borne in mind in determining whether or not unfettered risk-rating is a desirable thing.

9.168 Stable premiums come through a broad spreading of risk across a sufficiently large class to cushion the group against the relatively rare incidence of claims. Obviously the biggest spread would be across all members or policy holders equally. However, there are both practical and philosophical reasons why this may not be a suitable option. Firstly, it would increase the burden on those who had low risks, whether this was as a natural consequence of the kind of health care practiced by them or because of direct efforts to increase patient safety (as has occurred with anaesthetists, whose premiums have declined in some States). It would result in low-earning, low-risk doctors subsidising those with high earnings (and arguably higher risk exposure) and high risks.

9.169 A few years after risk-rating had commenced, the PIR noted a rapid increase in the number of risk categories. While many MDOs seem to be moving back from the large proliferation of risk categories of that time to larger groupings, there are still some groups which are being subdivided in ways which affect the composition of the health care workforce. This is particularly so in the case of general practitioners, where some MDOs have 3 or 4 categories, the highest of which involve obstetrics and other procedures, many of which are required of rural general practitioners.

9.170 There are four ways that MDOs or governments could act to increase the sharing and spreading of risks among doctors, and thus, move back towards a more mutual base.

- legislation could be introduced to require any organisation that provides professional indemnity cover for medical practitioners, do so without differentiating by specialty or type of practice, while at the same time allowing differentiation of subscriptions by income level, for example, by percentage of income or by flat rates applied to income bands. These options are arguably the most equitable form of "mutuality" and if income level relates to service level, it could be argued to involve some correlation between exposure to risk and subscription level in a general sense. Most MDOs currently offer a limited range of subscription bandings based on income, for example, for income less

than $15,000 or $40,000. It is probably the broadest form of mutuality, which still overcomes the inequities implicit in having one single rate for all doctors or one for all general practitioners (GPs) and one for all specialists.

- legislation could require that there is no differentiation between different classes of general practitioners, but still allow specialist subscriptions to be risk-rated according to their specialty. This will address the disincentives associated with general practitioners providing birthing services and other procedures, and allow them a full range of practice options without affecting their indemnity subscriptions. It will particularly benefit rural general practitioners, whose practices require them to provide a diverse range of services. However, it will not assist specialists in areas that are perceived to be high risk.

- legislation or MDO administrations could provide for, say four or five broad risk bandings, into which the various groups of practitioners could be placed, and different subscriptions could be applied to the different groups. These subscriptions could be based on different flat rates or different proportions of income.

- legislation could provide for specialty-based risk-rating of claims below a certain financial level and then pooling of all claims above that. This would take account of the rare and relatively arbitrary incidence of high claims, while recognising the benefits of encouraging prevention by difference classes of doctors or other health professionals through risk-rating on small claims experience

9.171 Were any of these premium setting options considered appropriate, there should still be provision to allow differentiation in subscription rates between different States. Many of the reforms which can influence subscription costs will need to be implemented by State Governments, so this differentiation will provide Governments and doctors with a significant incentive to vigorously pursue the cost containment options discussed in this Report.

9.172 One existing problem with risk-rating by class of practitioner is the lack of publicly available data to justify the various subscription classification decisions and the apparent arbitrary divisions and sub-divisions of classes of practitioners. As discussed many times before in this Report, there is no publicly available data on claims rates and costs by groupings, and individual organisations refuse to provide such information because it is seen as commercially sensitive. Until such information is available to all MDO members, risk-rating may be seen as an arbitrary and capricious exercise. While it may be an inaccurate impression, some doctors have claimed that current subscription levels appear to be more based on what an MDO thinks a certain category of practitioner will pay, rather than on claims costs. The prompt implementation of the PIR's recommendations to do with better aggregated national claims data that is publicly available should address these concerns.

9.173 Once better information on risk groups and their claims experience is available, it may be appropriate to look at re-introduction or refinement of risk-rated subscriptions. However, one of the fundamental problems of unfettered class-based risk-rating is the small size of the total risk-spreading pool of all medical practitioners.

9.174 The benefits of risk-rating are argued to be that it focuses practitioners' minds on prevention and risk management to minimise costs and provide safe, high quality services. Individual risk adjustment, for example, a no-claim bonus or claim penalty arrangement can serve this purpose more directly than specialty-based risk-rating. As far as the PIR is aware, this option has not been used by MDOs in Australia to date. However, it could apply to any of the reform models outlined above, and could be allowed under the legislation, with or without any statutory limits upon such a power. One disadvantage of such a model could be the lack of incentive to doctors to then report possible incidents, for fear of the effect upon their subscription rate.

9.175 The regulation of MDOs as insurance companies will not result in any scrutiny of their premium setting practices (except in aggregate). The fundamental question is whether the Commonwealth Government has a role in monitoring premiums, or imposing any limitations on premium setting practices. The only real workforce concerns at the moment seem to be in relation to birthing services providers and GPs. Birthing service provider issues are separately discussed in Chapter 10, but the issue of subdivision of GPs premium categories can work directly against the Government's aim of having GPs play a wider role in health servicing. Whether this works as a disincentive is not clear; even the evidence in relation to birthing service provision is equivocal. **The PIR recommends that the General Practice Branch of the Department of Human Services and Health monitor the indemnity concerns of general practitioners (GPs) to determine whether it is necessary to adopt an appropriate premium setting option to ensure that professional indemnity issues are not discouraging diversification in general practice, or limiting the practice choices of rural GPs. (Recommendation 147)**

9.176 There have been calls for MDO premium increases to be built into the Medicare rebate adjustments. When the indexation arrangements were settled, premiums had remained steady and equal for all doctors. MDO premiums were built into the overall component of "costs of practice". However, premiums have risen exponentially for some groups and very little for others since the late 1980s. The Commonwealth Government indicated that it was willing to look at all these issues as part of an overall review of practice costs, but to date this examination has not occurred.

9.177 If premium increases were directly built into MDO premiums, it could be argued that the Government becomes the funder. This is what led the United Kingdom Government to take over the coverage of all liability costs under crown indemnity. At a minimum, the Commonwealth Government would have a direct interest in premium setting, and ensuring that any increases or decreases were appropriate. This would alter the arguments in favour of Commonwealth control of premiums, which under current arrangements and those proposed above, is not recommended. **In the event of a direct link between MDO premiums and the level of Medicare rebates, the PIR recommends that a regulatory body to scrutinise the level of premiums and justification for movements in them be established by the Commonwealth Department of Human Services and Health. (Recommendation 148)**

Meeting unfunded liabilities

9.178 While most MDOs now appear to be calculating their annual subscriptions on a more appropriate basis than previously, it is apparent from other work of the PIR that there remains a significant "unfunded tail" of business for existing MDOs from the period when subscriptions were too low to fund all liabilities incurred. While all organisations claim to have been seeking to fund this tail through increased subscriptions over the past seven or so years, it appears that previously incurred liabilities to some extent remain unfunded.

9.179 Estimates of the level of unfunded or only partially funded liabilities are difficult to make with certainty, but before subscriptions began to rise they may well have exceeded 100 per cent of known liabilities. Even with the improved position which now exists, national unfunded liabilities in the industry may well be between $100 million and $250 million. Therefore, there is a significant need to ensure that any unfunded liabilities are properly funded. All MDOs claim that they are fully funded for all their known liabilities.

9.180 This matter is complicated by the fact that members have moved around between MDOs to a significant extent over the past few years, when subscriptions have been most volatile. However, the major parts of the unfunded liabilities relate to periods in the 1970s and 1980s, when subscriptions were still being collected on a pay-as-you-go basis by most organisations. Under pay-as-you-go arrangements, companies collect funds needed to meet expenditure during the year in question. The income raised covers only the cost of incidents settled in that particular year. "Liability for 1980 incidents which are not settled in 1980 will have to be paid out of future years' subscription income. This method can be expected to result in lower subscriptions because nothing is put in reserve."[96]

9.181 Current members of particular funds may well have moved away from an MDO which holds many years of their liability, which was inadequately provided for by the doctor and the MDO through low subscription rates. To simply require existing organisations to collect sufficient money from current members to meet the unfunded liabilities of the medical defence industry, for example, through a call on current members, would not necessarily mean the additional funds went to the organisations responsible for the liabilities.

9.182 The subscription instability and membership shifts that have characterised the last few years of operation of the MDO industry epitomise the consequences of offering claims-incurred cover and not fully funding liabilities. According to the recent Coopers and Lybrand Report: “Should MDOs stop operating now, they certainly would not be in a position to meet the expectations of members in respect of future reported claims on past occurrences.”[97]

This means that when an MDO loses a member, the member leaves them with an unfunded liability, which it may be in no position to recover by the normal "emergency" procedure of making a call on members. It may have to use their discretion not to pay such claims, if they were to avoid financial failure. Such an option would seem to be unsatisfactory from the perspective of both doctors and patients.

9.183 There are two options to address the problem of unfunded IBNR liability. The first, which was initially favoured by the MDOs, was to define it away by moving to claims made

cover. There has been detailed discussion of this option earlier in this chapter, and it was rejected for a range of reasons, mainly to do with the inadequacies of the protection offered by claims made policies, particularly where a health professional has time out of the workforce, or retires or dies. It is understood that most MDOs no longer favour this approach for all the reasons indicated.

9.184 A second option for ensuring that the current IBNR liability of the industry is covered is to establish a fund to which all doctors contribute through a small loading on their subscriptions over several years, and from which MDOs can access funds to meet the IBNR liabilities. The MDOs would continue to be responsible for their present liabilities. A clear definition of an IBNR claim would need to be determined and applied equally to all MDOs to ensure that the problems already caused by inconsistent definitions were not perpetuated under this arrangement.

9.185 Such a fund could grow by gradual contributions as the IBNR liabilities changed into known liabilities. This would allow the most gradual recovery from doctors, of adequate funding of already existing liabilities, and it would allow doctors' past unfunded costs to be reduced through improved claims management and various tort reform initiatives. In a recent article, one MDO indicated that the funding of IBNRs through such a fund would probably only involve a small annual surcharge of 1-2% of premium for four to five years[98].

9.186 The adequacy of premiums collected by MDOs has been a matter for much speculation. Claims and counter claims have been made to the PIR that indicated that some doctors had sacrificed fully funded premiums for greater market share. MDOs that have collected their premiums on a fully funded basis for the longest period and who may well have lost members by so doing will gain a competitive advantage under the option out lined above. The reserves they have put aside for IBNRs (for which they will be able to access the separate fund) will allow them to charge lower premiums in the future.

9.187 **The PIR recommends the establishment of an MDO fund to cover the costs of claims incurred but not reported by a specified date. That date should take account of the fact that all MDOs now claim to be setting their contribution rate on a fully-funded claims incurred basis. All providers of cover - whether existing or new MDOs or insurers - would be required to collect the levy from doctors holding membership or a policy with them. (Recommendation 149)**

E. Mutual insurance: an option for some health professionals and institutions

9.188 Concerns were raised with the PIR by some groups that professional indemnity cover and negligence cover for health care businesses and institutions, particularly of the uncapped kind suggested in the PIR's recommendations could be prohibitively expensive if purchased from a commercial insurer. If the agency is too small to self-insure, and there are other risk takers who have similar concerns, one useful option is a mutual insurance arrangement. While they are currently not insurers, MDOs operate on a mutual basis in Australia - the cost of claims are shared across their members on a non-profit basis. The benefits of mutuality are by no means precluded by a shift to an insurance basis. A mutual insurance mechanism spreads

insurance risks among a group of homogeneous members.[99] It also allows the provision of specialised services that specifically meet other needs of the particular homogeneous group.

The Canadian experience

9.189 In Canada, mutual organisations (known as reciprocals) are recognised in most Provincial Insurance Acts. They are unincorporated insurance organisations, regulated like commercial insurers. All members or subscribers share the losses of each in proportion to their premium contribution and each subscriber must be able to fund its share of the losses of the group. Should the premiums charged be inadequate to cover losses and expenses for a particular year, the shortfall is shared proportionately by subscribers. Charging adequate premiums and earning investment income results in surplus funds, which can be refunded to subscribers. The 10 mutual insurance exchanges operating in Canada cover various areas including health care, universities, municipal corporations, school boards, urban transport and professional indemnity for lawyers.

9.190 The Canadian organisation Reciprocal Insurance Management Limited lists the following advantages of a mutual insurance arrangement:

- control rests with a board of directors comprised of subscribers;
- the quality of protection can exceed that of commercial insurers;
- serving subscribers directly eliminates brokers' commissions and expenses; and
- the entire operation will be managed to the advantage of subscribers.[100]

9.191 The Healthcare Insurance Reciprocal of Canada (HIROC) was formed originally as the Hospital Insurance Reciprocal of Ontario in 1987 to overcome the problem of rapidly increasing health care insurance premiums charged by commercial insurers. Hospitals were facing a crisis as their liability insurance premiums rose and one major insurance company withdrew from writing this class of business.[101] Two independent consultant's reports recommended the formation of an insurance mutual exchange to provide a financially secure alternative to commercial insurance.

9.192 The Ontario Hospital Association provided initial funds to establish a reciprocal, based on sharing insurance losses, to provide greater premium stability with profits returned to subscribers, re-examine the appropriateness of the coverage provided and to broaden it where necessary.

9.193 From the beginning, emphasis was placed on initiating a risk management program specifically addressing the requirements of health care establishments, with the formal risk management program introduced in 1989. There were some 50 subscribers provided with a standard limit of liability protection of C$5 million for any one loss, with a voluntary additional limit of C$5 million. Over time, broader coverage was provided with the introduction of environmental impairment liability cover with a limit of C$5 million and employee dishonesty bond protection (crime) with a C$1 million limit. Apart from crime insurance, an optional limit of C$10 million was extended to all cover offered.

9.194 In 1990, an associated company, Reciprocal Insurance Management Limited (RIM), was incorporated to provide management services to HIROC and subsequently all HIROC employees transferred to RIM. RIM is 100% owned by HIROC subscribers. Also in 1990, a stabilisation fund was approved. The stabilisation fund offers subscribers an alternative to paying an assessment directly. With a subscriber's agreement, its portion of the unallocated surplus is transferred to the fund, where it earns investment income for subscribers. Should subscribers be called upon to pay an assessment for any underwriting year, then the subscribers, as a group, have the option of paying the assessment from their stabilisation fund instead of from their operating budgets.

9.195 By specialising in the health care industry, in most instances HIROC's underwriting, claims and risk management personnel are able to address subscribers' questions and concerns immediately. Seventy-seven per cent of beds covered are in facilities with approved risk management strategies. A data base management information system has been developed, integrating accounting, underwriting, claims and risk management information. HIROC is the largest health care liability insurer in Canada with assets of C$50 million. HIROC has refunded C$20 million to subscribers since it began and now has 170 subscribers in four provinces.

9.196 The following services are provided by RIM for subscribers:[102]

- assistance in developing, implementing, monitoring and evaluating risk management programs;

- development of appropriate guidelines, forms and surveys;

- assistance with continuing improvement of risk management programs, including help with training and education programs;

- assistance with implementation of incident reporting systems and reporting procedures and analysis of client incident reports to identify trends and individual incidents with litigation potential; and

- publication of claims and risk management bulletins detailing actual situations that will assist subscribers in their risk management activities.

9.197 HIROC sees claims management as a cornerstone upon which a successful mutual depends. Critical components of HIROC's program include effective adjusting, legal defence representation and production of relevant data.[103] Subscribers are offered:

- comprehensive claims management services, including investigations, medico-legal evaluations and loss reserve establishment;

- periodic reviews of outstanding claims;

- assessment of the adequacy of investigation, examining and reserving practices;

- audits of claims management programs, offering confidential recommendations; and

- design and implementation of claims management services for specialised needs.

Parallels in Australia

9.198 In addition to MDOs, local government mutual insurance schemes operate in Victoria, New South Wales, Queensland and South Australia, as well as a workers' compensation fund in South Australia. The feasibility of a scheme for mutual liability and workers' compensation insurance is under study in Western Australia.[104]

9.199 In Victoria the mutual or self-insurance scheme offers cover for local governments for public liability, products liability and professional indemnity. Funds under management total $11.8 million and 77 out of a possible 78 local governments are members, together with 16 associated authorities. In New South Wales, cover for public liability, products liability and professional indemnity is offered. Funds under management total $12 million, and 113 local governments and associated authorities are members. In Queensland, public liability, products liability and professional indemnity is offered. Funds under management total $4 million, and 108 local governments and associated authorities are members. In South Australia, the scheme offers civil liability with unlimited liability. Funds managed total $8.5 million and 118 (or 100%) of local governments and 60 associated authorities are members. In South Australia, the workers' compensation scheme offers benefits as prescribe by State legislation. All local governments are members and funds total $12.6 million.[105]

9.200 Each scheme offers services including:

- claims management;
- risk management/loss control;
- in-house legal services;
- administrative services;
- statistical analysis and reporting;
- in-house rehabilitation services, where appropriate; and
- investment management.[106]

9.201 At the time of writing this Report, a famous Australian mutual - the National Roads and Motoring Association (NRMA)- was debating whether to remain a mutual or become a public company.[107]

The advantages of a mutual insurance mechanism

9.202 Mutual insurance arrangements that are able to offer advantages to members, could be appropriate for many areas of the health care system, where it is claimed that commercial premiums are too high or appropriate products are not available.

9.203 As noted above, the advantages of a mutual include: elimination of brokers' fees and expenses; management of risks to lower premiums; return of surplus funds to members; and the ability to integrate all aspects of the insurance, claims and risk management processes to the advantage of members. For example:

- a mutual only covers the risks of its members, with reinsurance of catastrophic losses (commercial insurers' rates can be affected by exposure to other forms of liability);

- with the use of stabilisation funds, insurance premiums are stable over the long-term (commercial insurance may see major losses paid through large, sudden increases);

- the mutual is independent of any broker or insurers;

- program management fees are based on work done to add value to hospital management, not on a percentage commission based on premiums; and

- mutual personnel have relevant industry and professional experience and can relate to the broad scope of hospital management objectives.

9.204 **The PIR recommends the concept of a mutual insurance mechanism to any part of the health care sector that considers commercial insurance too costly, and self-insurance too risky. Some possible areas where mutuals might be appropriate could be pathology laboratories, private hospitals and individual groups of health professionals who are otherwise unhappy with the range or cost of available commercial products. (Recommendation 150)**

Chapter 10: Birthing Services: case study of reform

A. Introduction

The Birthing Issues Subcommittee of the PIR

10.1 The PIR conducted extensive research in the area of birthing services, because of the widespread public concern about whether professional indemnity issues were affecting birthing services. In 1993-94 this work was focussed on the Birthing Issues Subcommittee, which was established in August 1993 to address the implications of the rising cost of professional indemnity on the provision of birthing services. The members of the subcommittee[1] included representatives from State Governments and Commonwealth Governments, all relevant professional and industrial groups, consumers, medical defence organisations (MDOs) and the insurance sector.

10.2 Its terms of reference were to examine and report to the PIR on issues relating to:

- the availability and cost of professional indemnity cover for birthing practitioners, including specialist obstetricians, general practitioners and midwives;

- the reasons for the increase in medical indemnity contributions and other professional indemnity cover supply issues;

- the effect, if any, that professional indemnity cover and birthing litigation is having, or will have, on the supply of birthing services; and

• any proposals for change to address these matters."

10.3 The subcommittee met on a number of occasions and two papers - one on general background information[2] and one on rural issues[3] - were prepared by the PIR to assist in its deliberations. These are separately available. While a draft final report from that group was prepared, it proved difficult to get a version that was universally acceptable. In addition, from day to day further information was being made available to the PIR from various sources, which to varying degrees, affected the recommendations. The chair of the PIR determined that the most appropriate course, given these difficulties, was to present the available evidence on various issues in the Final Report, and to consider the application of the recommendations presented in the Final Report to the area of birthing services.

Interim Report and submissions

10.4 In addition to the extensive input of the various groups represented on the Birthing Issues Subcommittee, the PIR received a number of submissions on the Interim Report that dealt principally with birthing issues. Birthing issues were discussed in a number of places in the Interim Report - mainly in relation to whether there should be special compensation arrangements for this group[4], but also in relation to some of the indemnity issues[5].

10.5 The Australian Perinatal Society's submission put the point strongly that it is not generally appreciated that cerebral palsy is rarely due to the events surrounding labour or birth, and so the birth attendants are held to blame. "The injustice in claiming professional negligence in these cases is felt acutely by the caregivers who cannot prevent the pathology, cannot easily explain it and who often work long and anti-social hours to meet the high and sometimes unrealistic expectations of the public."[6]

10.6 It was said that it can be difficult to mount a satisfactory defence if the onus is on the health care professionals to prove the neurological damage preceded labour. This latter concern arises from a misunderstanding of the law - it is the obligation of the plaintiff to prove the causal connection between the action or inaction of the doctor and the injury alleged to be suffered. The submission further argued that negligence litigation resulted in the perinatal profession being used as a defacto social welfare system for the support of children with cerebral palsy. To remedy this, and the fact that litigation is an uncertain way to obtain compensation for plaintiffs, the submission proposed "... that all cerebral palsy victims have ready access to special disability pensions and rehabilitation and that there should be some type of limited protection or indemnity from litigation for health workers working in this field."[7]

10.7 Other submissions concerning birthing services outlined the professional indemnity problems of independent nurse midwives and general practitioners (GPs)[8], direct entry midwives[9] and other birth attendants[10]. Still other submissions dealt with the issues of provision of assistance to children with cerebral palsy, as was discussed in Chapter 6, some recommending special assistance like the Australian Perinatal Society[11], and others appropriate needs based assistance for all[12].

10.8 As was the case with all the work of the PIR, there were many assertions made and concerns expressed about birthing services and the impact of professional indemnity issues upon the birthing services workforce, but publicly available data on many of the issues were scarce. This chapter draws together the available information, identifies what is not currently known and makes specific recommendations in relation to birthing services and related issues.

B. Birthing services in context

An overview of birthing services and indemnity arrangements

10.9 There are currently about 260,000 babies born each year in Australia. About 33% of babies are born to mothers who were private patients of doctors[13] - some 85% of these are specialist obstetricians, 4% are IVF specialists and 10% are general practitioners (GPs), the remaining 1% being classified as "other"[14]. While there are claimed to be a number of private medical shared care arrangements in place (that is between specialists and GPs), Medicare data shows that 95% of all private confinements were paid for under the global fee item, where one practitioner is paid for antenatal care, confinement and delivery[15]. A very small number were born to mothers under the primary care of a private practitioner midwife, either in hospital or at home - planned homebirths constituted around 0.5% of all Australian births[16].

10.10 The majority (around 67%)[17] were born to mothers who were hospital public patients. There are a broad range of models of care throughout the public sector - some of these are delivered by hospital midwives and midwifery teams; some by employed medical staff with midwives; and some by visiting medical officers (VMOs) with midwives, some of whom are specialist obstetricians and some of whom, particularly in rural areas, are general practitioners. Often public patients attend their GP for antenatal care (which is then funded under Medicare[18]), and then attend a public hospital for the birth. Data on who delivers babies in the public sector is scarce. Table 10.1 provides data for Queensland and the Northern Territory in 1992, by way of illustration only. The professional indemnity issues vary for the practitioners in each of these groups.

Table 10.1: Proportion of deliveries carried out by different birthing service providers 1992 (Queensland and Northern Territory)

Accoucheur	Queensland		Northern Territory
	% of public deliveries	% of total deliveries	% of total deliveries
obstetrician	22.7	35.2	31.6
other medical officer	20.4	16.9	35.2
medical student	2.6	2.1	n.a
midwife	24.5	21.7	29.5

student midwife	24.2	19.2	3.7
other	0.3	0.3	-
not stated	5.2	4.6	n.a

Note: n.a means data is not collected under this category in this jurisdiction and is therefore not applicable.
Sources: Queensland Perinatal Data Collection (preliminary data only), Northern Territory Perinatal Register.

10.11 Medical practitioners delivering private patients generally have their professional indemnity cover provided by an MDO - this is unlimited claims incurred cover, and the premiums for this have risen dramatically over the past 7 years. For specialist obstetricians and gynaecologists, this has gone from a single rate with all other doctors in 1988, to one of the highest rates in Australia - currently in 1995 around $20,000, though ranging from $5,500 to $29,000[19]. For GPs practising obstetrics, the differentiation between different classes of general practice first commenced only in 1991-92, with some MDOs initially differentiating by "procedural/non-procedural". More recently many have introduced a separate contribution category for GP obstetrics.

10.12 Private practitioner midwives have their professional indemnity cover provided through a private insurance contract. Currently midwife indemnity cover is provided through a Queensland broker[20] on a claims made basis. Various levels of cover are available from $1 million to $5 million, with built in legal expenses cover for matters not covered by the indemnity policy up to $30,000 in aggregate, $15,000 per occurrence. The premium ranges from around $450-$850, depending upon the level of cover required. An excess of $500 per claim is payable by a midwife for the professional indemnity component of the policy. Additional legal expenses insurance is also available - for aggregate cover up to $100,000 with no limit per occurrence, the additional premium is between $130-140.[21]

10.13 Employed birthing services professionals should normally be covered by the vicarious liability of their employers, though the same confusion and difficulties arise in this area with VMOs and with private patients of employed professionals. Sometimes employed birthing professionals also carry legal assistance insurance or limited MDO cover to meet costs associated with non-claim matters, such as health care complaints processes and disciplinary hearings.

10.14 All facilities where birthing services are provided, whether government or private, have the potential to incur liability in relation to these services, either through vicarious liability for the acts of their employees or through their own independent non-delegable duty of care. These facilities need to have adequate cover to meet these claims.

The NHMRC project on effective care in childbirth

10.15 There is also broader public debates about the future provision of birthing services in Australia and about remuneration for such services, with two main issues. The first relates to the work of the National Health and Medical Research Council (NHMRC) on Effective Care in Childbirth. The terms of reference of the Expert Panel were to:

- provide an overview of current practice issues in childbirth care in Australia, patterns of intervention in labour and the puerperium, and current knowledge about clinical and social outcomes, having reference to the cultural aspects of birthing practices for Aboriginal women and migrant women;

- describe the areas where the current practice is at variance with the aim of optimising outcomes for the mother, baby and family;

- propose a national minimal data base of perinatal outcomes; and

- identify methods of improving care.

10.16 The panel commenced work in October 1991, with its draft report being presented to the Health Care Committee of the NHMRC in September 1993[22]. This report was revised following public consultation on it, with a second draft report being released in October 1994[23]. It is expected that the final report will be considered by the NHMRC in late 1995. The panel's consideration of more flexible, safe options with better continuity of care has been accompanied by Commonwealth and State funding for alternative birthing services and the expressed desires of women for more flexible birthing service choices[24].

Remuneration for birthing services

10.17 The second issue is the level of funding for birthing services, which is being examined by other areas of the Commonwealth Government. The current Medicare scheduled fee for birthing services - commonly called the global obstetric fee[25] (that is including delivery (whether vaginal or caesarean) and pre and post-natal visits) is $629.45. Additional amounts are payable for complicated pregnancies, and certain birth complications.

10.18 Many doctors, both GPs and specialists, have argued that the fee for a normal pregnancy and delivery is inadequate for the work performed and cost involved. The NHMRC also commented on the level of funding for maternity services: "The Expert Panel is particularly concerned that women's health issues have been devalued by current funding arrangements and believes that there is an urgent need for a review of the rebates available for maternity services". (Recommendation 8.4)

10.19 Medical practitioners performing private patient birthing services have argued that inadequate levels of fees has led them to charge considerably higher than the scheduled fee[26] for obstetric services, and that the global obstetric fee should be "unbundled" to encourage shared care. The Medicare Benefits Consultative Committee has recently completed a review of the global fee, and the Minister for Human Services and Health has approved a major restructure of obstetric services in the Medicare Benefits Schedule to take effect from 1 November 1995.

10.20 The key change has been the partial unbundling of the global obstetric fee, so that pre-natal visits are paid separately from the delivery and restrictions on the number of prenatal visits for uncomplicated births have been lifted. This allows individual payment between different doctors involved in the provision of birthing services (that is for shared private care between a GP and an obstetrician), but it does not assist in shared private care between midwives and doctors in

private practice. The overall level of fees does not seem to have been increased through this process for a normal pregnancy and delivery, unless practitioners intend to increase significantly the number of prenatal visits per pregnancy. The Government has indicated that it will monitor this to ensure that this is not resulting in unnecessary over-servicing of pregnant women.

Specific indemnity concerns relating to birthing service provision

10.21 While this chapter will not canvass these broader issues, in some areas they are inescapably intertwined. For example, the NHMRC indicated in its second consultation draft report, that professional indemnity issues are currently affecting the planning and provision of future birthing services. It listed the following concerns:

- the unavailability of unlimited cover for visiting midwives, and the consequent removal of back-up services by obstetricians who are concerned they may become the "deep pocket" in any litigation;

- the rising costs of indemnity for GP obstetricians, making the provision of such assistance financially unviable for many;

- the costs of indemnity for those with salaried academic positions, who exercise limited rights of private practice;

- the increasing costs of indemnity combined with the relatively low level of Medicare rebates for obstetrics for those in private practice is encouraging them to increase the numbers of births they are managing, which may, in turn, reduce the quality of service they can provide; and

- the rate of indemnity increases has not been covered by fee increases, and this may act as a disincentive for medical practitioners to commence or continue practice.[27]

10.22 The PIR considers that some of these are valid concerns, while others are more speculative. A range of other assertions have been made in the press and other forums relating to birthing services and indemnity issues:

- specialists are leaving obstetrics because of indemnity premiums;
- specialists are changing their practices from obstetrics to gynaecology because of fear of being sued;
- specialist trainees are not intending to practice obstetrics and are moving into other fields such as gynaecological oncology and infertility;
- fewer GPs are practising obstetrics because of premium increases;
- there is a rural crisis in obstetrics;
- doctors are performing more caesareans because they are afraid of being sued;
- parents have unrealistic expectations of the outcomes of child-birth, and they always expect a perfect baby;
- many parents of children born with cerebral palsy sue the delivering practitioner; and
- there are many successful tort claims paid out in relation to so-called "brain-damaged" babies.

10.23 The PIR has examined all these issues. In most cases, close examination of the evidence reveals that while superficially there may appear to be some grounds for concern, there are a complex range of issues at play, only one of these being related to professional indemnity. Many of the trends, such as the continuing decline in GP obstetrics and high levels of caesarean section rates, preceded any changes in indemnity premiums. Others appear also to be related to broader changes, such as the decline in the number of people holding private health insurance. Perhaps most significantly, the analysis of the tort system does not support many of the conclusions and causal connections claimed.

C. Tort claims and birthing services

10.24 There are few publicly available data on tort claims in this area as in any other. However, due to the assistance of some MDOs, the PIR has been able to look at the type of claims lodged against specialist obstetricians and gynaecologists, and at those claims involving children with cerebral palsy. None of the information has been universally available from MDOs and there are significant gaps. The crucial importance of the PIR's earlier recommendation that a national health care negligence data collection be undertaken across all providers of indemnity cover is illustrated by the impact of a lack of publicly available data in this area.

10.25 There has been an assumption among doctors and others that the reason MDO subscription rates for specialist obstetrician/gynaecologists have risen so dramatically has been a rapid increase in the number of successful claims in cerebral palsy cases, against the tide of scientific knowledge about the causes of cerebral palsy. This assumption is not supported by the evidence. This section looks firstly at the issues relating to cerebral palsy, then at available claims data, and finally at why MDO contributions have risen.

Cerebral palsy: what we know

10.26 Cerebral palsy is used to describe a range of conditions diagnosed in childhood, which result in the child having abnormal control of movement and posture. Between 2 and 2.5 per 1000 children born each year (around 500-600) have some degree of cerebral palsy. It arises from interference with normal brain development or irreversible brain damage, and it is not progressive. It can be accompanied by other neurological problems, such as intellectual impairment, epilepsy, visual and hearing problems.

10.27 Knowledge about the causes of cerebral palsy is patchy. The Institute for Child Health Research in Western Australia lists some of the known antenatal causes as:

> …inherited conditions (rare); prior infertility and possibly some aspects of its treatment; infections such as Rubella, Cytomegalovirus and Toxoplasmosis; malformations of the brain, particularly abnormal migration of neurones in the second trimester of the pregnancy (at present only detectable on brain scans after birth); placental problems including infection, bleeding and insufficiency; exposure to chemicals such as methyl mercury which has a special affinity for the brain; possibly thyroid hormone treatment; iodine deficiency; antenatal death of a co-twin/co-triplet; intrauterine (fetal) stroke; and

rarely, physical abdominal trauma due to such things as car accidents or domestic violence.[28]

10.28 As discussed below, only a very small proportion of cerebral palsy cases appear to be associated with birth. Cerebral palsy can also arise after birth though this is also thought to be relatively rare. In the Australian and New Zealand Perinatal Societies consensus statement, some of the causes given for cerebral palsy after birth were: complications of prematurity, untreated rhesus disease (kernicterus), meningitis, accidents or near drowning.[29] There is also a significantly higher incidence of cerebral palsy in babies born pre-term[30], babies of low birth weight for gestational age and babies born in multiple births[31].

10.29 The current improved state of knowledge about cerebral palsy has been, in part, as a result of the long-term data collection of the Western Australian Cerebral Palsy Register, which commenced its data collection in 1956. While this data shows that cerebral palsy rates have remained steady over that period, it also shows that there have been changes in the composition of those with cerebral palsy over that period.

10.30 A recent monograph noted that, as the proportion of very low birth weight babies who survived doubled between 1971 and 1989, the rate of cerebral palsy in infants weighing less than 1500gms rose from 10 per thousand to 90 per thousand. The later survivors tended to be more severely disabled than the earlier survivors with. There has been an increase in the overall proportion of children with cerebral palsy who were born more than 7 weeks before term from 11% in 1971 to 1975 to 25% in 1985 to 1989. The study also noted the impact of infertility programs on the rate of cerebral palsy, due partly to the high frequency of multiple births in these programs. Given the relatively low incidence of both cerebral palsy and births arising from infertility programs, it is not yet known if the infertility treatments themselves influence the rate of cerebral palsy[32].

10.31 Compared to the overall rate of birth defects of around 5% of all births[33], cerebral palsy is relatively infrequent at only 0.25%. However, for those who have severe cerebral palsy - particularly affecting all limbs - the costs of lifetime care for the community is very significant. The changing patterns of cerebral palsy is giving rise to many questions, but unfortunately the size of the Western Australian data base is too small to allow valid conclusions. For example, it appears the rise in cerebral palsy cases with less than 33 weeks gestation has been "cancelled out" by a decrease in the number of cases born between 33-36 weeks gestation, thus maintaining a similar overall rate[34].

10.32 Given the responsibility for the costs associated with most cases of cerebral palsy falls to government programs of assistance (and the families of children with cerebral palsy), as do the costs associated with pre-term births[35] and infertility programs through Medicare and public hospital funding, **the PIR recommends that a National Cerebral Palsy Database and Register be developed by the Australian Institute of Health and Welfare to collect national data on the incidence and possible causes or contributing factors to cerebral palsy. (Recommendation 151)** The Commonwealth Government and State Governments have a strong financial and social interest in the prevention of cerebral palsy and in determining whether there are any ways that health care services (infertility, birthing, neonatal, early intervention programs or otherwise) can be modified to reduce the incidence of cerebral palsy and minimise its disabling

effects. For this reason, **the PIR recommends that funding for the National Cerebral Palsy Database and Register should come from both the State Governments and Commonwealth Government. (Recommendation 152)**

10.33 Given that Australian courts are moving strongly to ensure the standard of care expected of doctors and other health professionals, so far as possible, is judged on the basis of available scientific evidence, information from such a data base and the Cochrane Database discussed in Chapter 3 could provide further evidence about cerebral palsy and obstetric practice for use in court proceedings, as discussed below. MDOs and lawyers involved in such litigation need to ensure that such evidence is put before the court.

Cerebral Palsy and obstetric litigation

10.34 As was discussed in Chapter 2, it was the medical profession itself which first claimed the connection between cerebral palsy and birth asphyxia.[36] It was asserted then that cerebral palsy arose from damage to the brain from lack of oxygen in the birth process. Researchers continued over many years to assert this connection, with reputable journals continuing to publish articles based on the view that the majority of cerebral palsy cases were preventable with proper obstetric care right up to the late 1970s.[37] Doctors believed therefore that if they used new technologies to detect and prevent birth asphyxia, such as fetal monitoring and caesarean section if there were any signs of "fetal distress", then the incidence of cerebral palsy would decline significantly - possibly by 50%.[38]

10.35 Despite broad use of these technologies, significantly higher caesarean section rates and a lower perinatal death rate, the incidence of cerebral palsy appears to have remained static or even have commenced to rise in a number of countries[39].

10.36 Epidemiological and other research published in the late 1980s indicated that the great majority of cases of cerebral palsy arose in cases where there was no evidence of birth asphyxia - with only around 6%[40]- 9%[41] being associated with birth asphyxia where there were no other complications such as congenital abnormalities. The Western Australian data has indicated a similar figure of around 8%[42]. Data have also showed that birth asphyxia was much more strongly associated with death of a baby, rather than survival with cerebral palsy[43]. Data also indicates that the signs of fetal distress or asphyxia may, in some cases, merely indicate the existing presence of cerebral palsy rather than result in it.[44]

10.37 Many of the tests that expert medical practitioners have traditionally used to show a causal connection between fetal distress, birth asphyxia, medical care and cerebral palsy in litigation have little predictive value. The monograph cited earlier listed the currently accepted signs of birth asphyxia as meconium staining of the liquor, abnormal fetal heart rate on auscultation or on the electronic fetal monitoring trace, low Apgar scores (for example 0-3 at 1 or 5 minutes), signs of newborn encephalopathy (such as seizures) and low scalp or cord blood pH. It continues :

> Each of these observations can result from a variety of problems other than birth asphyxia. For example, research has shown that in babies who had low umbilical artery pH (usually considered the best indicator of oxygen deprivation), only 50% had an abnormal fetal

heart rate tracing on the electronic monitor. Of all the babies with an abnormal fetal heart rate trace, more than 50% had normal umbilical artery pH. Thus the fetal heart rate trace, used so extensively in the courts to "prove" birth asphyxia is at best a very crude marker for it.

Similarly, of those infants with low umbilical artery pH, only 32% of them had had meconium stained liquor, 46% an Agpar score at 1 minute of 0-3, only 8% an Agpar score at 5 minutes between 0-3 and only 23% had signs of newborn encephalopathy. Conversely 95% of children who had moderate/severe meconium stained liquor, 84% with low Apgar scores at 1 minute, 73% with low Apgar scores at 5 minute and 80% of those with newborn encephalopathy did **NOT** have low umbilical artery pH (that is, they were classified **falsely** as **positive** for "birth asphyxia" when this is defined as a low umbilical artery pH). This means that the vast majority of children with the traditional signs of birth asphyxia are unlikely to have had significant hypoxia but had other reasons for these observations to be abnormal.[45]

10.38 In addition to the possibility that these tests could be wrongly used to impute sub-standard obstetric care in the relatively rare cases of litigation, some are used much more frequently by doctors as the basis for interventions in labour that may themselves have risks of damage to either the mother or the baby, including forceps delivery and caesarean section[46]. In the case of fetal heart traces, there is also strong evidence of variation in interpretation between individuals and within an individual's own readings.[47]

10.39 At the same time, some doctors argue that it would be overly simplistic to condemn all of these measures and to stop attempting to identify fetal distress, because there is evidence that the early detection of birth asphyxia and consequent intervention may have reduced perinatal mortality.[48] However, there is even debate about this claim, with others claiming that the claimed causal connection between increased interventions and reduced perinatal mortality is overstated.[49] Whether low levels of perinatal mortality can be achieved through different forms of care (such as where there is greater individual attention and continuity of care[50]) and different, more accurate monitoring techniques without the "downside" of current practices (such as unnecessary intervention due to misleading monitoring results)[51] requires further scientific study.

10.40 This information - much of which is relatively recent - can be used to successfully defend court cases relating to cerebral palsy cases, where appropriate. The use of such information allowed successful defence of a negligence action brought against Dr Adey, an obstetrician in Victoria last year,[52] and the PIR's case study report referred to a similar recent unsuccessful case in NSW[53]. In all cases, the plaintiff bears the burden of proving the causal connection between the alleged action or inaction of the defendant and the injury to the plaintiff, and all this information makes discharging this burden very much more difficult in most cases.

10.41 The PIR heard frequent assertions that in medical negligence cases where there is a severely disabled child, judges and juries give the benefit of doubt to plaintiffs. While the PIR has not conducted a survey of all medical negligence cases in Australia, what is available indicates that very few cases of this kind ever go to court, and of those that do, the chances of success appear to be slim. Both of the above cases involved a judge and jury, and in both cases, the plaintiffs were unsuccessful. In the recent South Australian case involving a severely disabled

child[54], liability for the injuries was admitted by the defendant hospital, and the court was only asked to assess damages. The PIR is unaware of any recent judgments where a plaintiff was successful. This should provide some encouragement to defendants and MDOs about the utility of current evidence in the defence of such cases.

10.42 One of the difficulties with such cases, even with overwhelming evidence that most cerebral palsy arises from causes unrelated to birth, is that it also seems to be accepted that a small minority of cases of cerebral palsy may be causally related to negligent obstetric care. The estimates of the proportion of cerebral palsy cases resulting from sub-optimal care range from 1-2%[55] to just under 7%[56]. The existence of such a rare possibility may still result in some litigation, particularly where the level of disability is significant and there is some evidence of substandard care and/or poor communication. Some cases that are commenced which it will be difficult for the plaintiff to win, because the parents may consider that they are one of the very rare cases where a link between negligent care and cerebral palsy can be demonstrated.

10.43 The difficulties in these cases for the plaintiff are very significant. They include: the apparent limitations in the predictive value of the various tests for fetal distress and birth asphyxia; the difficulties of demonstrating a causal link in any single case between cerebral palsy and birth asphyxia; and the difficulty in demonstrating that any of these things were causally connected to a breach in the standard of care of a particular care provider or providers. The chance of getting legal aid in these cases is likely to be low because of the small chance of success, and this same concern affects the likelihood of a lawyer agreeing to pursue such a case on any contingency basis.

10.44 The slim likelihood of success is reflected in both the average levels of payments in these cases when they are settled and the small numbers of cases where payments are made by MDOs each year. The PIR wrote to all MDOs in Australia in 1993, seeking advice on the numbers of claims paid out for cerebral palsy cases and their payment levels. Overall, the figures from 1988-1993 showed that MDOs across all States only paid out damages (either through settlements or judgments) on average in 5 cases per year, with the average payment being only $750,000 - though they ranged up to over $2M. There was at least one state where there were no such claims thus far incurred or paid over that whole period.

10.45 This level of payment is approximately consistent with the lowest end of estimates about likely frequency of cerebral palsy where health care negligence is a causal factor. What cannot be known is whether the right cases have been getting the compensation. The PIR has been unable to find satisfactory information on definitive case characteristics, that could identify these cases from other cases of cerebral palsy. **The PIR recommends that the proposed National Cerebral Palsy Database and Register seek to determine whether there are any distinguishing characteristics of cases of cerebral palsy which may have been associated with birth asphyxia, and whether or not the intervention of birthing service providers could have prevented the cerebral palsy occurring in any of these cases. (Recommendation 153) The PIR further recommends that the National Cerebral Palsy Database and Register seek to determine, as a priority, whether there are any other preventable causes of cerebral palsy, whether associated with health care or not. (Recommendation 154)**

10.46 **Given the widespread concern among birthing service providers, which has arisen from the unfounded rumours of a rapidly rising number of successful cerebral palsy claims, the PIR emphasises the need for sufficiently detailed national data on all health care negligence claims to ensure any similar concerns can be tested. The minimum data set must include the category of practitioner involved, a broad indicator of the nature of the claim and the outcome of a claim. The inclusion of whether its resolution involved settlement, a judge or a judge and jury may also be useful to monitor what effect, if any, these mechanisms have on which party is successful. (Recommendation 155)**

10.47 The public availability of this data on an on going basis is crucial also, if the effect of new scientific evidence on the outcome of cases is to be determined. There are growing calls for courts to use proper scientific data in making their decisions[57]. The PIR considers that it is important that doctors, health professionals, policy makers and the public are better informed about the operation of the tort system to avoid some of the mistaken views that have been widely held in the area of litigation about birthing services.

10.48 The PIR has been surprised that MDOs have not promoted the apparent success of their defences in this area. In one sense, their silence has allowed an illusion to develop that the reason for premium increases is in the main external to MDOs. This has served to direct any resultant anger relating to contribution increases away from the MDOs towards the legal system, which in this area at least, does not seem to be doing anything inconsistent with the medical profession's own evidence about cerebral palsy.

10.49 The MDOs have a significant number of cerebral palsy claims still unresolved - many from the mid-1980s when the scientific evidence of causation was much less clear, and much more favourable to potential plaintiffs[58]. Logic should indicate that the success in the Adey case last year and the increasing amount of international research data on cerebral palsy should be providing some downward pressure on case liability estimates and the number of new claims, though this factor may well be cancelled out through the upward pressure on the top end of payments (principally through rising care costs, which are discussed below)[59].

Tort claims against specialist obstetricians and gynaecologists

10.50 There is no doubt that, even though the number of successful claims (and even claims made) in relation to cerebral palsy cases is quite low in Australia, at least by international standards, the individual costs of these cases are at the highest end of all cases coming to MDOs. The highest cost cases paid by MDOs involve those with long-term care needs. The relative effect of these cases on the funding of MDOs was illustrated in a 1993 article in the *Medical Journal of Australia*. While the data analysis refers to the Medical Protection Society's international case load, similar conclusions would probably apply to Australia:

> ... in one recent review of 4,000 of the Medical Protection Society's case files, 0.25% of the surveyed claims by number contributed more than 60% of the total value of the claims in the study. About half of those very high claims arose from alleged obstetric negligence during the birth process. Thus the fraction of a per cent that represent obstetric negligence during the birth process contributed about 30% of the total value of the surveyed claims.

Obstetricians, who represent between 3-4% of the Society's membership by number, thus generate about 30% of the Society's contingent liability.[60]

10.51 There are estimates from other MDOs that indicate similar patterns - very low claims incidence for alleged obstetric negligence in the birth process, but very high costs of such claims[61]. By contrast, there has been a great deal of concern about the frequency of suit against obstetricians and gynaecologists. In the PIR's defensive medicine report,[62] the frequency of legal action and complaint was higher among obstetricians and gynaecologists than other groups. Why then is there this disparity?

10.52 Because of the high costs associated with this very small number of claims, public discussion on these issues has wrongly linked the frequency of suit to brain-damaged baby litigation. In fact, 80% of the cases numerically made against obstetricians and gynaecologists relate to their gynaecological practice[63]. Almost one quarter of these claims related to complications following hysterectomy, while the next two most frequent groups of claims relates to failed sterilisations (18%) and laparoscopic complications (15%). The next two groups - each around 10% - related to missed or delayed diagnoses and problems associated with intra-uterine contraceptive devices. The remainder consisted of complications arising from of various operative procedures, accidental sterilisations, failed terminations, burns, drug errors and retained swabs/instruments.

10.53 Of the remaining 20% of cases, relating to their obstetric practice, slightly less than half related to damage to the mother in the birthing process, and just over half related to damage to the baby. Brain-damaged baby cases made up almost 70% of the claims for damage to the baby, but these included a number of non-cerebral palsy cases where congenital abnormalities were not detected or misdiagnosis for example related to rubella, resulting in the birth of a severely disabled child. Of claims paid in relation to brain-damaged newborns 15% related to this group of cases. There were other cases in the brain-damaged baby group, which also fell outside the traditional hypoxia/cerebral palsy type of case, for example where pre-eclampsia was undiagnosed in a mother, who subsequently died and the baby was delivered with brain damage, and where very significant damage occurred in forceps deliveries. Of claims made for damage to the baby 18% related to death of the baby, while the remainder included isolated events like partial amputation of an ear and facial scarring to a baby in caesarean sections and delayed diagnosis of various kinds.

10.54 The 10% of obstetric and gynaecological claims that related to mothers giving birth included cases relating to mismanaged labours resulting in hysterectomy, retained swabs, burns, failure to give appropriate serum to an RH-negative mother, giving of wrong blood to a mother with a post partum haemorrhage, various complications of undetected retained placenta and severe tearing and other complications associated with forceps deliveries with episiotomy, and death of a mother from pulmonary embolus following a caesarean section. The relatively small number of cases overall did not reveal any strong patterns of claims in this group.

10.55 These data refer to claims made, rather than those where negligence was accepted or considered likely to be proved. It provides, however, a much fuller picture of the litigation position of the obstetrics and gynaecological specialty. It also explains the discrepancy between

the total number of claims taken against obstetricians and gynaecologists and those relating to cerebral palsy.

10.56 While the numbers of claims involving general practitioners performing obstetric and gynaecological services is very small (only around 5% of all obstetric/gynaecology claims), around 70% of these related to "brain-damaged" babies and 15% involved damage to the mother (including one death).

Reasons for rising MDO birthing services subscriptions

10.57 As noted in paragraph 10.11, MDO birthing service subscriptions rose very significantly over the period 1988-94, particularly for specialist obstetricians and gynaecologists, though in 1995, there were also some substantial decreases in some states by some MDOs[64]. The patterns of increases varied significantly between States and between different MDOs. Table 10.2 provides a summary of subscription rates of two MDOs that have operated across all States from 1988 to 1995. It gives an idea of the variation between states and between MDOs. The recent increases in one Queensland MDO arose because it had kept a single rate across all doctors until the 1994 subscription year.

Table 10.2: Specialist obstetrician/gynaecologist full rate[1] medical indemnity subscriptions
Selected MDOs: Australia 1988-1995 subscription year[2]

	1988 $	1989 $	1990 $	1991 $	1992 $	1993 $	1994 $	1995 $
NSW/ACT	2000	4996	7200	7920	15000	16500	28000	29000
	1992	4996	7500	12000	13250	19950	28200	19950
VIC	1450	1450	1500	1800	5300	8500	9900	14000
	1650	2600	4950	8000	8750	19950	28200	19950
SA	1500	1725	3695	2975	3350	6000	7200	12000
	1500	2050	4950	8000	8750	19950	28200	19950
WA	1500	3550	5000	6600	7850	18500	23750	23750
	1500	3200	5500	8000	8750	19950	28200	28200
TAS	1056	1100	1200	1250	2250	4000	4300	5500
	1056	1650	2750	4250	4600	7750	8500	9950
QLD	1056	1056	1100	1200	1350	1872	9000	10000
	1056	1650	2750	4250	4600	7750	8500	9950
NT	1056	1056	3695	2975	3350	6000	7200	12000
	1056	1650	2750	4250	4600	7750	8500	9950

1. Most MDOs offer reduced rates to doctors with low incomes and some rate premiums across incomes - these are the highest rate payable.
2. The subscription year varies between different MDOs - some are calendar, some financial year. This table covers the subscription rates for example for either calendar year 1988, or financial year 1988/89

10.58 Similar upward trends have emerged more recently in the premiums for GPs who practice obstetrics, though the levels of increases have generally been much lower. The differentiation between GPs performing different practices is of more recent origin. It was not until 1991-92 that any MDOs began to distinguish between procedural and non-procedural GPs, and it was not until 1993-94 that further differentiation by some MDOs distinguished between procedural GPs and GPs performing obstetrics. Some MDOs simply retain the procedural-non-procedural split, while others have a larger number of subdivisions. For those MDOs that provided information on GP premiums, the range for full rate, non-procedural GPs and ones who perform only office-based procedures was between $1,300 in Tasmania to $1,650 in Victoria. The range in any one state for this group can also be considerable - 3 MDOs operating in NSW had non-procedural GP subscription rates of $1,425, $1,450 and $1,600 respectively.

10.59 The variation for procedural classes are even greater. The smallest differences are in Tasmania, where a procedural GP with no obstetrics or anaesthetic practice is $2,100 and a GP doing obstetrics and anaesthetics pays $2,550. The highest rates apply to GPs doing obstetrics, cosmetic surgery or anaesthetics and these range up to $8,000. It is difficult also to make comparisons between States and MDOs, because of their different inclusions, and the different relevant risk ratings attributed between the different "high-risk" end of general practice. Table 10.3 gives some idea of the range for the three NSW MDOs.

Table 10.3: NSW MDO GP subscriptions - full rates[1]
1995 subscription year[2]

MDO and subscription categories	$
Medical Defence Union	
Standard GP	1,425
GP with anaesthetics	5,000
GP with obstetrics (not shared care)	5,000
GP with operative orthopaedics	5,000
GP with general surgery	5,000
GP with cosmetic surgery	7,500
United Medical Defence	
Standard GP	1,450
Procedural GP	4,650
Medical Protection Society of NSW	
Non-procedural GP	1,600
Procedural GP with no obstetrics or cosmetic surgery	4,200
GP with cosmetic surgery	8,000
GP with obstetrics	8,000

1. Most MDOs offer reduced rates to doctors with low incomes and some rate premiums across incomes - these are the highest rate payable.
2. The subscription year varies between different MDOs - some are calendar, some financial year. This table covers the subscription rates for either calendar year 1995, or financial year 1995/96.

10.60 Over the period 1988-94, there does not appear to have been a dramatic change in the incidence of claims against doctors in general. There is universal evidence that the incidence of claims rose dramatically in the 1970s-80s, from an extremely low base. For example, there were only around 140 claims recorded for the period before 1975, while claims numbers rose to around 1,000 per year in the early 1980s to between 1,500 by the late 1980s-early 1990s.[65] The number of cases where payments are actually made is substantially lower than this again, with the ABS

survey data showing only around 640 cases being paid from the 1970s to 1991, 95% for under $100,000 and three cases for over $1million[66].

10.61 Recently, there has been a significant increase in the reporting of incidents, no doubt partly arising from the efforts of MDOs to get their members to report claims earlier, and the greater awareness in the profession of medical litigation through press reports. How much of this will be translated into increased claims is far from clear, with some organisations claiming an increase in claims, and others claiming a maintenance of levels from the recent past. Establishing a national tort claims data base for health professional negligence, as discussed above and in Chapter 2, is particularly important here to ensure that any government policy decisions or actions by health professionals are made with an understanding of the real incidence of claims, where they are arising and how much they are costing, rather than on fear and misinformation[67].

10.62 The data in relation to birthing service provider actions in the 1990s indicates a steady, very low level of claims. One MDO publicly confirmed this in 1993: "the number of actions in which it is asserted that severe neurological handicap has arisen from an obstetrician's negligence appears to be both low and rising only slowly".[68]

10.63 Rather than increased claims, the three main reasons for contribution increases have been:

- the move away from a single flat rate contribution payable by all doctor members, whatever they practised and wherever they practised, which had applied to MDO business over the first 80 odd years of this century;

- the need to address long-term underfunding of liabilities, which was caused by indemnity subscriptions being held at an artificially low level for many years, particularly in the 1970s and 1980s, when the frequency of claims increased dramatically from a very low level; and

- larger awards for future care costs for severely disabled people and the need to adequately reserve for these costs in future cases.

10.64 The reasons for the disproportionate affect of subscription rises on birthing service providers are described above: obstetrics generates a very small number of very expensive claims, and gynaecology generates a significant number of generally low value claims. Obstetricians, gynaecologists and GPs practising obstetrics are being asked to bear a greater financial responsibility for the component of MDO liabilities which arises from their work - estimated above to make up 30% of their liabilities. The removal of earlier cross-subsidisation is also very significant for these groups because of their relatively small numbers compared to all doctors. Only around 7% of all GPs are involved in private sector deliveries[69]. Specialist obstetricians and gynaecologists who deliver 1 or more babies per year to a private patient constitute only 5% of all kinds of specialists[70].

10.65 Some birthing service providers have seen rising premiums as a sign of poor quality of care. They have argued against this view, stating that their college has been one of the most active in relation to quality of care initiatives and that Australian maternal and perinatal mortality statistics are among the best in the world. This reasoning arises from a misunderstanding of the

concept of risk for premium purposes. As was discussed in Chapter 9, the concept of risk relevant to MDO subscriptions is a financial, rather than a quality of care one:

> The total cost to the protection organisations of any one group is not an index of the quality of care provided by the group. The incidence of obstetric claims is low, but the average cost is very high. Other procedural specialties have a much higher incidence of much lower cost claims, and the net effect may well be a lower subscription than that set for obstetricians. [71]

10.66 Before seeking to address the question of whether MDO premiums for birthing services are too high, and what options may be appropriate if there is a problem, this chapter will consider the workforce issues for birthing service providers, which have been alleged to arise from litigation and professional indemnity contributions.

D. Private patient deliveries by doctors

10.67 Early in the PIR's work, consultations with doctors indicated that the level of indemnity premiums was forcing medical birthing service providers to stop delivering babies, and that young doctors were being dissuaded from entering obstetrics because of "fear of litigation". These concerns were reflected in the third element of the Birthing Issues Subcommittee's terms of reference set out in paragraph 10.2.

10.68 One of the first questions the subcommittee therefore sought to address was whether there had been a decline in the number of practitioners delivering babies and whether this was caused by premium rises. The second question was whether fear of litigation was causing young doctors to avoid obstetrics and, in the case of specialists, causing them to prefer a focus on gynaecological practice.

10.69 Analysis of data in this area is complex and it is difficult to determine conclusively why certain changes have occurred. At the same time as premiums have been increasing, for example, there has been a significant decline in the number of women choosing to give birth as private patients. There are also significant information gaps. For example, it is not possible to determine how many babies in the public sector are delivered by the various birthing service providers. The conclusions which can be reached from the information available on these issues is therefore indicative, rather than conclusive.

10.70 So far as overall numbers of specialist obstetrician and gynaecologists are concerned, there have been increased numbers of such specialists billing Medicare for at least one service over the period 1988-89 and 1993-94. Numbers have risen by 6% from 883 to 935 over that period.[72]

10.71 Table 10.4 summarises Medicare data on the number of doctors who have provided one or more confinement per year over the past 6 years.

Table 10.4: Number of doctors paid by Medicare for 1 or more private patient confinements 1989-95

Provider	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	% decline 1989-95
Specialist O&G	795	789	782	769	763	754	5
GP	2 343	2 189	2 000	1 804	1 660	1 705	27
Other	140	161	125	100	110	141	0
Total Private confinements	120 527	117 515	106 623	98 354	90 925	85 632	29

Source: Medicare data base

10.72 The table shows a decline across both GP and specialist medical birthing service providers providing birthing services for private patients over the last 6 years. However, this needs to be examined in an environment where there has been a significant shift away from private patient to public patient births. As can be seen, private patient deliveries declined by 29% over that same period - essentially reflecting a similar decline in private insurance. In only around one-third of all births is the mother a private patient. So far as the two-thirds of births involving public deliveries, the relative roles of both GPs and specialists in the public hospital system is another unknown.

E. Specialist obstetricians doing private deliveries

10.73 Given the overall down-sizing in their potential patient pool through the choice of mothers to be treated as public patients for their deliveries, the decline in numbers of specialist obstetricians thus far has been very modest.

10.74 Table 10.5 shows the pattern across States for those specialists who deliver more than 5 private confinements per year. If the cost of MDO premiums are a major influence on practice change, the decline in providers should be greatest in those who provide the fewest deliveries. This is because the fewer babies are delivered, the fees from deliveries will be less adequate to meet the costs of MDO premiums. The decline in the number of specialist practitioners seems to move contrary manner, with the rate of decrease greater in the group delivering more than 5 private deliveries per year at 8.3%, and the decline in those delivering one or more being only 5%.

10.75 In further trying to determine whether there is any direct causal link between significant subscription rises, as detailed in Table 10.2 above, and the small decline in specialist obstetrician numbers, variability of indemnity premiums between States may be a useful indicator. While there has been variability on the number of specialist obstetricians performing more than 5 deliveries between States, there does not seem to be any strong relationship between declining

numbers of practitioners and increasing medical defence contributions, with some states experiencing increases in numbers at the same time as premiums were increasing.

Table 10.5: Numbers of specialist obstetrician/gynaecologists performing more than five private confinements per annum 1988-1994

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
1988	270	207	103	70	55	23	5	16	749
1989	270	212	104	66	54	21	6	16	749
1990	264	212	101	66	56	20	7	16	742
1991	256	208	101	68	59	20	7	15	734
1992	255	202	100	66	59	20	5	14	721
1993	244	199	99	66	55	18	7	14	702
1994	234	195	101	65	56	17	5	14	687
% decline	13.3	5.8	1.9	7.1	-1.8	26.1	0	12.5	8.3

10.76 Proportionate declines do not appear to be directly related to rises in premiums. For example, one of the largest declines in numbers of specialists delivering more than 5 private confinements per year occurred in Tasmania (26.1%), where the premiums are the lowest in Australia at (only $5,500 in 1995). Western Australia, by contrast, which has had one of the highest increases in premiums, has had a marginal increase in the number of such specialists. In Queensland, where premiums were very low until 1994 (only $1,872 in 1993), the number of practitioners still declined marginally over that same period. From this information, there does not appear to be a causal link between MDO contribution rises and a decline in obstetricians providing private confinement services. There is considerable variability between States, not linked to State MDO premium variability, which requires further examination.

Moving from obstetrics to gynaecology?

10.77 There were also assertions that specialists were moving out of obstetrics into gynaecology to avoid medico-legal issues and to minimise their indemnity costs. There may be some such trend- the proportion of all specialist obstetrician and gynaecologists who are performing one or more private confinement per year has declined over the 5 years between 1989/90 and 1993/94 from 87% to 81%.[73]

10.78 There would seem to be practical difficulties for many specialist obstetrician and gynaecologists, in achieving a rapid change in practice mix, without a significant drop in income in the short term. For example, patients seeking obstetric services are not automatically substitutable for those seeking gynaecological services. It is also assumed that the community's overall need for gynaecological services cannot be unilaterally increased by specialists, given that there appears to be little current evidence of unmet need for their services. There is a need to

monitor whether the level of servicing of gynaecological clients is increasing, as that could be one way of otherwise minimising an income shortfall, if a practice change occurred. But practice patterns of this kind have tended to occur gradually, and are traditionally associated with both doctors and their patients getting older.

10.79 So far as obstetrics and fear of litigation is concerned, there was some evidence from the PIR's defensive medicine study that specialist obstetrician behaviour is being influenced by fear of litigation[74]. Details of these effects are discussed below. However, cessation of obstetrics to avoid medico-legal matters is not a course of action supported by claims data. As outlined in paragraph 10.52, analysis of the claims of MDOs in the obstetric and gynaecology area indicate that around 80% of the cases relate to gynaecology.

10.80 The statement that an obstetrician might cease delivering babies because of fear of being sued for a damaged baby, shows a degree of fear out of all proportion to the real risk of such legal action occurring. While there is not comprehensive data available for the public and private sectors, it seems unlikely that the total number of claims made of this kind each year is more than 20, and the total number of claims paid out between five and ten. This gives a rate of "brain-damaged" baby claim of between 1 in 13,000 to 1 in 18,000 births, and a successful claims rate of between 1 in 26,000 and 1 in 52,000.[75] If fear of being caught up in litigation were the motivating factor for practice change, then claims data would support a move out of gynaecological practice, rather than obstetrics.

10.81 So far as the claim that specialists are moving to straight gynaecology to reduce their MDO contributions is concerned, until 1992-93, there was no subscription benefit from moving out of obstetrics, because a single premium applied across the specialty. Some organisations still have no differential. The differential, where it now exists, is around $5,000 per year. This differential equates to 8 private deliveries paid at the Medicare Benefits global obstetric fee rate.

10.82 Where a specialist belongs to an MDO with a differential, and she or he cannot change MDOs to one without such a differential, and she or he only does a very small number of deliveries, it would make financial sense on the basis of a premium-income disparity, to cease the obstetric component of their practice. However, data from Medicare and the Royal Australian College of Obstetricians and Gynaecologists (RACOG) shows that most specialist obstetricians undertake much larger numbers of private deliveries than would be affected by this. Medicare data shows an average of 101 private confinements per specialist obstetrician-gynaecologist in 1994-95. Table 10.6 below gives the average number of deliveries over the various different age groups of obstetricians.

Table 10.6: Average number of private patient deliveries by doctor age group 1993

Age Band	**<41**	**41-45**	**46-49**	**50-54**	**55-61**	**>61**
No. of doctors	110	125	105	128	118	57
Average annual						

deliveries per doctor	141	164	162	120	99	60

Source: 1993 RACOG survey of members - preliminary report

10.83 The gradual decline in the average numbers of private deliveries by obstetricians as they age is consistent with general information about practice patterns in obstetrics. This indicates that as practitioners get older, the mix of their practice tends to shift away from obstetrics towards gynaecology, both because of lifestyle decisions by the doctors concerned, and because of the life cycle demands of their patients. High premium differentials may speed up this process of shifting their practice mix, though there is not strong evidence of this, and average deliveries of 60 per year in the upper age group are well beyond the area where direct financial disincentives are clear. Medicare data indicates that only 23 full-time specialist obstetricians and gynaecologists[76] deliver less than 8 private deliveries per year. This is only 3% of those who deliver at least one baby per year.

Salaried academic specialists with limited rights of private practice

10.84 As note above in paragraph 10.21, the NHMRC expressed concerns about those specialist academics who are salaried but who have limited rights of private practice. The concern is that as premiums rise, they become less affordable for this group, who in fact only do small numbers of private deliveries, often in an expert consultative capacity.

10.85 Where a medical practitioner is full-time employed, but retains a limited right of private practice, subscription rates very different to those described above for full-time self-employed obstetricians apply. While the amount varies between organisations and States, the following provides some comparative examples. Compared to a full rate, self-employed obstetrician and gynaecologist's subscription of $29,000 in one New South Wales MDO, the subscription for a specialist who is hospital or employer indemnified and retains no private practice pays $475, while one with gross fees less than $20,000 is $2,600 and with gross fees up to $60,000 is $5,700.

10.86 In one of the MDOs in Victoria with a relatively low obstetrics premium, full rate self-employed specialist obstetricians subscriptions are $11,000 per year, and hospital employed practitioners with no private practice income pay $650. Where their gross income from private practice is less than $15,000, their MDO subscription is $1,200, if less than $30,000 is $1,500 and less than $50,000 is $2,000. In the case of those with no private practice income, the amount covers the costs of administration and legal costs associated with complaints body actions, disciplinary proceedings and any other non-tort legal assistance provided by the MDO.

10.87 While these figures indicate a much lower level of likely impact than might have been imagined, this level of premium could arguably act as a disincentive to private practice. A hospital may want to encourage specialists to retain their private practice for a number of reasons. If the hospital receives a benefit from the employee's exercise of private practice rights, for example either through private patient accommodation costs at their hospital, or through various contractual contribution arrangements, then the employing hospital could be asked to pay for these additional costs as part of their employment contract.

10.88 Alternatively, the hospital or employer may decide to cover these activities, by using the model of enterprise liability in relation to any activities carried out within the hospital by their full-time employees. This model would, in turn, encourage doctors to exercise their private practice rights only at that institution.

Recruiting new specialist obstetricians

10.89 The final question that needs to be addressed is the issue of the effect of contributions on new recruits to the specialty. There does not seem to be a problem with obtaining new recruits, as there are no vacant trainee positions in the specialty. So far as the effect of fear of litigation on people taking up obstetric specialties is concerned, in the RACOG survey of members, 88% of the 134 trainees who responded (53% response rate) intended to practice obstetrics. The remainder gave medico-legal concerns, followed by lifestyle decisions as their reasons for not wanting to practise obstetrics.

10.90 In 1993, the National Association of Specialist Obstetricians and Gynaecologists (NASOG) conducted a survey in Victoria among second-year hospital medical officers on the basis that this group would have had enough training and experience to be clear about their career choices. Of the 92 respondents, only one indicated an interest in specialist obstetrics and a further 13 expressed interest in general practice obstetrics. While a number indicated an enjoyment of obstetrics, the survey results show a perception that there are lifestyle factors and medico-legal concerns associated with its practice. Of the 92 respondents, 45 rated unsuitable lifestyle as very relevant in deciding not to practise obstetrics, and 52 cited medico-legal concerns.[77]

10.91 These studies and available data on trainees would indicate that there are few problems at the moment, but that there is also a need for them to be better educated about the real risks of being sued in relation to obstetric practice. The same mythology of fear has clearly influenced trainees' perceptions about the specialty, though as yet, it seems not to have affected the take-up rate of college traineeships.

Subscription affordability

10.92 It is difficult to ascertain the total income of specialist obstetricians and gynaecologists, as some of them also carry out paid sessional work as VMOs. This work is separately remunerated from the fee income generated from private patients. Medicare has records of billed income, which is recorded on the receipts lodged for reimbursement of the Medicare rebate. There is considerable income variability within this group. Individual's income is likely to vary with their practice size, subspecialty interests (for example IVF, obstetric and gynaecological ultrasound), geographical location and how much competition there is from other specialists or GPs. For example, full-time specialist obstetricians and gynaecologists[78], who concentrate on IVF technologies have average fees charged of $785,123, with the top quartile average of $1,414,678.[79] This compares to full-time non-IVF obstetricians and gynaecologist average fees charged of $307,333, with a top quartile average of $506,048[80].

10.93 There are no separate data on their practice costs, which are also likely to vary on their geographical location and many other variables. Therefore the following Table 10.7 only provides a very broad guide to questions of affordability. It compares gross Medicare data on

fees charged across all four income quartiles for full-time obstetricians and gynaecologists and the overall average of full-time obstetricians and gynaecologists who deliver one or more private deliveries a year with the high, medium and low ends of MDO subscriptions for full-rate obstetricians, set out in paragraph 10.11. As is the case with all MDO premiums, the full cost is tax deductable. The data are presented separately for IVF and non-IVF specialists, given the large disparities in income - otherwise fees charged by the relatively small number of very high income earning IVF specialists distorts the average for the lower earning obstetricians, who deliver the majority of private confinements. This group delivered 85% of private confinements in 1994-95, compared to 4% by the IVF group.

10.94 The data in Table 10.7 shows that the IVF group generally only pays a modest proportion of its fees-charged income in subscriptions, the impact of which is considerably heavier on the lower earning non-IVF specialists. The Table shows the great variability in relative financial impact, depending upon the level of contribution required by the MDO, as well as significant earning variability across and between these two groups. It could be argued that some of these practitioners are paying a prohibitive level of contribution compared to their income, but the variability between providers and MDOs make it difficult to determine a universally appropriate response to this concern.

Table 10.7: Medicare gross fees charged for full-time specialist obstetricians compared to MDO subscription rates 1994-1995

Gross fee charged category	MDO Subscription as % of gross fee charged income		
	High ($29 000)	**Medium ($20 000)**	**Low ($5 500)**
Top-quartile average			
- IVF $1 414 678	2.0%	1.4%	0.4%
- non-IVF $506 048	5.7%	4.0%	1.1%
2nd quartile average			
- IVF $911 630	3.2%	2.2%	0.6%
- non-IVF $340 319	8.5%	5.9%	1.6%
3rd quartile average			
- IVF $555 333	5.2%	3.6%	1.0%
- non-IVF $242 958	11.9%	8.2%	2.3%
4th quartile average			
- IVF $258 852	11.2%	7.7%	2.1%
- non-IVF $140 990	20.6%	14.2%	3.9%
Average fees charged			
- IVF $785 123	**3.7%**	**2.5%**	**0.7%**
- non-IVF $307 333	**9.4%**	**6.5%**	**1.8%**

10.95 The variability of contributions between States and between MDOs within States is a strong arguments against direct government subsidisation of subscription costs, or the linking of such costs to increases in the Medicare Benefits Schedule, as was discussed in Chapter 9. The key question is how to set a level of assistance that does not overcompensate some and undercompensate others.

10.96 It is also important in such adjustment mechanisms to look at the full range of practice costs. Between 1989-90 and 1993-94, the value of Medicare benefits grew in real terms by 6.8 per cent annually - around half of this was from volume increases and half was from real price increases. The real price increases were considerably above the rate of CPI increase. While obstetrics was on the low end of the overall increases at 3.3 per cent annually, this was still a rate of increase over CPI.[81]

10.97 Rather than attempting to include any separate fee index factor for MDO subscriptions, there is an argument that the issue of professional indemnity costs should be a factor in the reconsideration of fee relativities, which is occurring as part of the Relative Value Study. The original Medicare fee scale was set at a time when MDO subscription rates were constant across all doctors - the only variability being between some States. MDO costs are now said to be set reflecting the costs associated with compensating negligence in these areas.

10.98 These are system costs, which are only one factor in considering the relative costs of different services costs arising from negligent care. As such it is arguable they need to be reflected in the Medicare Benefits Schedule fee structure itself, rather than in any adjustment mechanism. This is true for all areas of medicine, not just birthing services, as they are a "cost of production" which should be reflected in the cost of the service. This provides direct incentives to governments and taxpayers to ensure the incidence of negligent acts, unduly risky procedures and subsequent tort claims is minimised.

10.99 **The PIR recommends that the Relative Value Study consider the existing MDO subscription fee differentials in determining whether Medicare Benefit Schedule fees are appropriate for different medical treatments for different specialties. (Recommendation 156)**

10.100 Another factor of importance to the broader community is the costs arising from adverse events in various procedures and treatments, very few of which are reflected in the tort costs. However, these costs are not borne by doctors, but by the community as a whole. They need to be considered in any cost-benefit analysis of different treatments, but they are not relevant in setting the Medicare fee.

Medico-legal concerns and the number of specialist obstetricians

10.101 There is little evidence supporting assertions about a causal connection between medico-legal concerns about being sued and the work force effects on specialist obstetricians of high indemnity premiums. While obstetricians delivering private confinements have decreased by a small percentage over the past 5 years, this may be linked more directly to other changes, such as the significant decline in private patient birthing women, and women's choices to use other birthing services. Evidence of a causal connection between rising premiums and reduced numbers of specialists is slight. The low incidence of litigation involving so-called "brain-damaged babies" in Australia indicates that if such choices are being based on this concern, then they are not based on evidence.

10.102 Just as doctors are calling on courts to take note of scientific evidence about the causes of cerebral palsy, they must impose this same discipline on themselves in relation to litigation. The criticisms of early cerebral palsy research was that it was anecdotal and lacked scientific rigour. Many of these same problems seem to have been repeated in doctors' understanding of the incidence and outcomes of litigation in relation to cerebral palsy. The PIR does not blame doctors for this - little publicly available Australian data has existed to provide the answers. The widespread premium increases have provided a concrete basis for their concerns.

10.103 Persistent discussion of and referral to United States problems[82], which would appear from the PIR's research to be very different in both scale and nature from the problems that do exist in Australia, have probably also increased the level of fear and concern, which seems to exist without adding anything to the understanding of doctors the problems which do exist and require action. A small number of MDOs has encouraged such fears and concerns to distract attention from the main reason for subscription increases which relates to funding shortfalls over an extended period. Other MDOs who have been as open as they felt was possible in the highly

competitive environment that surrounds their business in Australia[83], and their efforts should be applauded. However, their voices have sometimes been ignored.

10.104 Just as information on risks, benefits and treatment options has often not been available to help doctors and patients make truly informed treatment choices, as was discussed in Chapter 3, so too the absence of data on tort claims has fostered the creation of myths whose proliferation has been encouraged by self-interested bodies, to the detriment of the search for real explanations. Further, this has unnecessarily harmed the peace of mind of many good doctors. The establishment of a National Health Care Negligence Claim Database is the only way to ensure inform discussion, which can then lead to sensible policy conclusions and practice choices.

10.105 There is much concern over the impact of subscription increases and medico-legal issues on the medical work force, with specialist doctor members of the Birthing Issues Subcommittee claiming the impact to be an important future issue in influencing career and practice choices of medical practitioners. From its research, the PIR considers that the long-term impact of these issues on workforce arrangements, for example on obstetricians ceasing or reducing their practice (except those performing very few deliveries), cannot be considered in isolation from other issues that influence practice choice, for example issues of life style and remuneration.

10.106 A 1993 survey of its members by RACOG to explore various medico-legal issues supports this conclusion. While the full report was not available to the sub-committee, a preliminary report was provided. Questions were asked about the reasons for decline in the number of private deliveries compared to 5 years ago. Medico-legal concerns rated 4th on their list of reasons (41%), behind a conscious decision to alter lifestyle (60%), insufficient remuneration for time involved (50%) and increased interest in other areas of practice. In response to the opportunity to specify "other reasons" the majority of respondents also cited the decrease in the number of insured patients as an important factor. Questions were also asked of those who had raised "medico-legal concerns". Only 12% of respondents answered this question, unfortunately, but the second most frequent concern in this group was the size of current subscription rates.

Conclusions

10.107 So far as specialist obstetricians are concerned, conclusions from the available data are that:

- as yet, MDO subscription rises have not led to a significant decline in the specialist obstetric workforce, nor to vacancies in trainee positions in the college;

- there can be direct incentives for specialist obstetricians doing very small numbers of deliveries to cease performing these, where they can substitute gynaecological practice to maintain their income, or where they were intending to retire anyway;

- there are other pressing concerns for specialist obstetricians, relating to lifestyle and remuneration, which need to be addressed if there are concerns about any future reduction in numbers;

- Medicare Benefit Sechedule fee relativities were originally struck when all doctors paid the same MDO contributions, regardless of their practice. Any new fee relativities struck need to take account of the differential costs now in place;

- specialist obstetricians claim that there are concerns for the future effect of contribution levels on the number of specialists, and that MDO contribution levels and other medico-legal concerns can combine with this factor to influence a specialist to cease practising obstetrics, but there is little evidence of this occurring;

- there has not been any readily accessible source of data on tort claims to adequately inform birthing service practitioners about the real patterns of claims, and this has led to a proliferation of inaccurate presumptions and the perpetuation of myths about these claims amongst the medical profession and the broader community;

- for some MDOs, the tacit perpetuation of these myths, usually by silence but in some cases by active promotion of the existence of a "tort crisis", has been a convenient way of diverting members attention from the main reasons for increases in subscription rates, which have to do with the financial management of MDOs;

- MDOs that have sought to fully inform members and the broader community have been constrained to some extent by the extremely competitive and secretive nature of the industry;

- specialist obstetricians' and trainees' fears about obstetric litigation reflect this lack of publicly available information about the number and types of actions taken against a specialist obstetrician/gynaecologist; and

- just as has occurred in relation to knowledge about the causes of cerebral palsy discussed above, there are various myths about litigation that need to be dispelled by greater public availability of information on the nature and type of claims and a better understanding of the legal system by doctors.

10.108 This availability of this information will allow a focus on those matters of significance, ensuring the long-term financial stability and security of health care negligence funding, and improving the provision of assistance and, where appropriate, compensation for those with long-term care needs. It will also allow a focus on whether the modest decline in the number of private obstetricians is a matter for concern, and whether there are any longer term trends in relation to the birthing services workforce.

10.109 **Given the range of factors at play, the PIR recommends that the Commonwealth Department of Human Services and Health continue to monitor the numbers of specialist obstetricians and gynaecologists involved in private birthing services, and that it seek to encourage the States to collect data on the numbers of specialist visiting medical officers as well as general practitioners and midwives, involved in birthing services in the public sector, to ensure early detection of any developing problems. (Recommendation 157)**

10.110 If in the future there appears to be a problem from MDO subscriptions, or there are problems in specific groups for example those with lower levels of earnings, then options for increased cross-subsidisation could be explored. Another option would be to increase the cross-subsidisation within the risk group - that is, MDOs could structure obstetric subscriptions so that they are more significantly affected by doctor income than they currently are. One MDO provides such a subscription scale at the moment. In 1994, for example, the United Medical Defence provided the following differential subscription for specialist obstetricians/gynaecologists :

Income less than $40,000	$3,075
Income less than $60,000	$6,150
Income less than $100,000	$9,840
Income less than $150,000	$15,370
Income less than $250,000	$16,920
Income over $250,000	$17,900

10.111 With the secrecy surrounding membership numbers and other business matters, it has not been possible for the PIR to determine whether or not this differential premium within the risk category has given that MDO a competitive advantage over its competitors, but if it were introduced more widely, it could alleviate some of the cost pressures on those whose incomes are lower.

F. General practitioners performing private deliveries

10.112 Table 10.4 at paragraph 10.71 showed that the most dramatic decline in doctors performing private deliveries is in general practitioners (GPs), at 27% between 1989-90 and 1994-95. In 1993-94, obstetricians were paid for 84% of all private births, with GPs being paid for almost 15% . The proportion of private births, where a GP was paid relative to a specialist obstetrician , has dropped over that period to 10% . This means even taking account of the decline in private confinements, the rate of decline in GP provision of such services is faster than that affecting specialist obstetricians.

10.113 Table 10.8 below provides a State-by-State breakdown for GPs performing more than 5 confinements a year from 1988 to 1994, which indicates interstate variability in the declines as well. It is important to note that this trend has continued over the whole period - that is, that it commenced long before there were differences in MDO contributions for GPs who delivered babies. While procedural and non-procedural categories were introduced in the early 1990s in most MDOs, the emergence of a separate, generally higher rate group for GPs delivering babies did not occur until 1993.

Table 10.8: Numbers of GP obstetricians performing more than five confinements per annum 1988-1994

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
1988	318	399	151	135	167	9	10	4	1,193
1989	277	368	125	105	163	11	7	5	1,061

1990	257	346	125	96	138	8	7	3	980
1991	220	315	107	80	124	5	6	5	862
1992	210	267	99	59	103	4	5	5	752
1993	159	213	88	46	99	6	4	6	621
1994	130	180	79	37	70	5	3	8	512
% decline	59.1	54.9	47.7	72.6	58.1	44.4	70.0	(+200)	57.1

10.114 The numbers of GPs delivering more than 5 private patient babies per year has declined at almost twice the rate of GPs delivering 1 or more private confinements. This is contrary to what might be expected if the main factor causing the decline was MDO subscription increases. As described in relation to specialists above, theoretically at least, one would then expect the numbers of those with the smallest number of private sector deliveries, who would not be meeting their additional premium costs from their delivery income, to be the first and highest area of decline. This does not appear to be the case, possibly indicating the influence of other factors in the movement of GPs out of obstetrics.

10.115 This is not to say that MDO differential subscriptions are not likely to be an important factor in some cases in the future. The average numbers of private GP confinements is only 5 per GP, and with the premium differential in some states for GPs practising obstetrics (and other services often required of them in rural areas, such as anaesthetics) between $1,250 to $6,400, many would not be covering their additional professional indemnity premium costs from the income received from Medicare. This provides a direct financial incentives for more GPs to cease providing private obstetric services.

10.116 These consequences conflict with the desired goal of increasing GP participation in birthing services as one way of improving continuity of care for birthing women and improving the use of skills of GPs in delivering healthy women, as set out in the NHMRC's report on childbirth options.[84] It also seems to be particularly financially disadvantageous to rural GPs who have no option but to deliver a multi-skilled service.

GPs and private rural birthing services

10.117 While their overall contribution to the provision of birthing services is relatively small overall at 10%, GPs play a very important role in birthing services for rural communities as can be seen from Table 10.9 below. The table shows that the proportion of GPs who provide private confinement services compared to specialist obstetricians is considerably higher in rural Australia than in urban areas.[85] Just under half of all rural births are handled by GPs, while less than 5% of all capital city private confinements are handled by GPs and less than 10% of provincial confinements are handled by GPs.

Table 10.9: Number of providers and services and total benefits paid to birthing services providers (excluding antenatal only) by geographic location
MBS Items 16506 - 165204 claimed in 1994-95: Number of GP providers by rural

and remote classification of provider's major practice

Location		GP	Specialist O&G (including IVF)	surgeon & other	Total - all providers
Capital city	providers	609 (48%)	571 (45%)	101 (8%)	1,281 (49%)
	services	2,974 (5%)	61,791 (95%)	580 (1%)	65,345 (76%)
Provincial	providers	104 (56%)	73 (40%)	8 (4%)	185 (7%)
	services	795 (8%)	8,836 (91%)	61 (1%)	9,692 (11%)
Rest of State	providers	991 (88%)	110 (10%)	32 (3%)	1,133 (44%)
	services	4,881 (46%)	5,573 (53%)	140 (1%)	10,594 (12%)
Total all locations	providers	1,704 (66%)	754 (29%)	141 (5%)	2,599 (100%)
	services	8,650 (10%)	76,200 (89%)	781 (1%)	85,631 (100%)

10.118 A similar table for 1992-93 was included in the PIR's paper on rural birthing issues[86]. This table shows a proportional increase in the number of GPs providing private confinement services in the capital cities and even a slight proportional increase in their share of the capital city birthing services market. That is, however, within an overall market decline over these two years of over 12,000 private births. By comparison, the market share of specialist obstetricians has increased by 3.5% in relation to private patient rural births, with a corresponding decline in GP market share. So far as the medical birthing services workforce is concerned, the composition seems to be moving to a greater proportion of GPs, oversighting a smaller proportion of births (that is, they are overseeing on average fewer births), and vice-versa with obstetricians (that is, they are overseeing a larger number of births on average).

10.119 This information seems to further complicate the evidence about the effect of MDO premiums on GP participation in obstetric service provision. If the rises in premiums were the main influence on the provision of birthing services, it might be expected that those who had the choice not to provide these services (that is, capital city-based GPs) may have chosen to cease practising, while rural GPs would be obliged to maintain their market share, because there were no other choices for the women concerned. While the numbers are relatively small, and any patterns must be looked at in the context of declining numbers of private confinements, the data seems to indicate that factors other than MDO contribution rises may be at work.

10.120 The continuing decline in numbers of GP birthing practitioners and in the availability of local birthing services has the potential to have an adverse effect upon patient safety. For example, the PIR has recived anecdotal evidence that the preference for women in rural areas to give birth close to home leads them to choose to stay at home until it becomes "too late" to go

anywhere except the local hospital. This can be because of personal preference, but more often, it can be because of financial necessity or the need for close family support. This is said to be a particular issue for Aboriginal and Torres Strait Islander women. Alternatively, where a woman has a short labour, the same result can occur as an automatic consequence of labour. The delay in attending hospital, the possible lack of facilities and expert back-up close at hand, and the consequent "emergency" nature of the birth can compromise the safety of the birthing process.

10.121 There are a significant number of government initiatives to encourage and support medical practitioners to move to country areas where there are shortages of services and to encourage those who are already there to stay. These were outlined in detail in the Birthing Issues Subcommittee rural issues paper.[87] Some elements of these, dealing with additional practice costs and training needs of rural practitioners should be of direct assistance to GPs performing birthing services. However, current MDO subscription practices would seem to act against some of them. While there appear to be other factors at work as well, the fact that for many, the premium differential appears to exceed the total private patient income earned from deliveries indicates that the decline will accelerate.

10.122 So far as rural birthing services are concerned, it also appears that, in rural areas, general practitioners have a strong continuing presence as birthing service providers for public patients in country hospitals. However, given the small number of deliveries averaged by general practitioners and the significant professional indemnity subscription rate differential between those general practitioners who practise obstetrics and those who do not, it would seem likely that the number of general practitioners involved with private obstetrics will continue to decline if no action is taken.

Some options to address the decline in GP private birthing services

10.123 The data indicate that other factors have contributed very significantly to this decline overall, which the PIR has been unable to examine in detail. These include: the closure of small local hospitals, leading to greater use of provincial centres for birthing, where specialist services are more likely to be available; a degree of difficulty for GPs in obtaining visiting rights, particularly where there is an obstetrician available; difficulties associated with running a busy rural practice and delivering babies; and the overall decline in numbers in rural practice. There is a need for further work to address these issues.

10.124 Similar issues arise in relation to other procedural aspects of rural practice, such as surgery or anaesthetics. The PIR's study on defensive medicine looked at practice changes amongst GPs, finding there has been a marked decline in both obstetrics and anaesthetics (around 45%), family planning procedures (28%) and a lesser decline in orthopaedics and surgery (around 10%)[88]. This survey was undertaken in February 1992, and related to practice changes over the previous 5 years. This was before there were any direct financial effects from undertaking any of these practices in MDO subscriptions in most States, so it seems highly likely that there were other key factors in these changes, such as organisational or structural changes within medicine. Simply addressing the additional, more recent element of increased MDO subscriptions would, on its own, seem to be unlikely to stem these long-term changes.

10.125 **The PIR recommends that the Australian Health Minister's Advisory Council (AHMAC) establish a Working Group to determine what can be done to encourage the retention of skills and practices, such as obstetrics, anaesthetics and surgery in rural general practice, in addition to addressing any direct financial disincentives arising from MDO subscription concerns as discussed below. (Recommendation 158)**

10.126 Some decline in GP private birthing service provision in the country may simply be a result of the transfer of patients into the public sector. In small country hospitals, where the number of doctors providing birthing services is likely to be very small, a woman may well take that chance that the GP who has provided her antenatal care will be available for her public sector birth as a VMO. Without data on the frequency of use of GPs in public sector births, it is not possible to be certain, but this view was put in consultations with birthing women from rural areas. This still allows continuity of care, but it shifts the costs from Medicare and private insurance onto public hospital funding.

10.127 Options which could increase premium stability were discussed generally in Chapter 9. Three of these which could reduce the cost of premiums to general practitioners are:

- Subscriptions could be based on income rather than specialty or risk. This would benefit birthing service providers with lower incomes, such as general practitioners, whose average earnings were only around half of those of specialist obstetricians/gynaecologists[89]. Cross-subsidies would arise between high income earners with low risk and low income earners with high risks.

- Legislation could require that there is no differentiation between different classes of general practitioners. This would address the disincentives associated with general practitioners providing birthing services and allow them a full range of practice options without affecting their indemnity subscriptions. It will particularly benefit rural general practitioners, whose practices require them to provide a range of services. This would make the cross-subsidisation within the group of all GPs.

- Hospitals could accept the concept of enterprise liability and take over the liability for any birthing services (and possibly other high-risk services which they wanted GPs to remain involved in, such as anaesthetics) provided through their hospital by a doctor, who has visiting rights there. This transfers the costs onto the hospital, and so should reduce the MDO subscription to the same level as a non-procedural GP. The hospital would then have maximum incentives to ensure that those who had visiting rights were properly trained and practising in a safe manner.

10.128 A modified version of the latter option was recently offered by the Victorian Government, for rural fee for service VMOs so far as their treatment of public patients were concerned in certain rural hospitals. The PIR understands the offer was rejected because the nature of the cover offered was not satisfactory to many of the doctors concerned and the Australian Medical Association (AMA). The Victorian public hospital system's indemnity arrangements are based around a capped, claims made policy of insurance. The PIR understands that the concerns of the AMA related to the nature of the cover, and the likelihood that their MDO cover would need to be drawn on to meet shortfalls in the Government's policy. These

shortfalls were considered likely to arise because of the level of the cap (currently $5.75 million; damages awards in severe disability cases can exceed that level even now); the fact that the cap at the time of notification of the incident applies to the cover (that is if an incident was notified today, but not settled for 8 -10 years as regularly occurs in these cases, the potential inadequacy of the cap would be further magnified); and concerns about the continuity of the run-off cover if were there a change of insurer or change of government policy.

10.129 These are clearly legitimate concerns arising from the nature of the Victorian government's primary cover. The criticisms of claims made policies were discussed in detail in Chapter 9, and the concerns of doctors epitomise the shortcomings of this type of policy in providing doctors and patients with proper security in relation to health care professional indemnity risks. Any option developed needs to ensure that the cover offered, whether for public patients or all patients treated in the facility, does not have such "holes" in it.

10.130 **The PIR considers that the determination of the most appropriate means of addressing subscription disincentives for GPs from the three options of income-related subscriptions, a single GP subscription rate and enterprise liability should be a top priority for the proposed AHMAC rural general practice working group, to avoid further reduction in the numbers of GPs providing obstetric and other services in rural areas. (Recommendation 159)**

G. Availability of cover for midwives

10.131 In Chapter 9, the PIR recommended that professional indemnity cover be compulsory for all health professionals, either through vicarious liability for employed health professionals or through the holding of separate cover by self-employed people. Similar recommendations were made in relation to health care institutions. The PIR also suggested a product, claims incurred unlimited cover, as the most desirable from the perspective of both consumers and health professionals. It outlined the pitfalls with claims made cover.

10.132 For self-employed midwives, the only product currently available is a limited claims-made policy as discussed above in paragraph 10.12. There are still very few self-employed midwives operating in Australia, and the very small pool of practitioners adds further complications for this group compared to specialist obstetricians, and even general practitioners in obtaining insurance cover. One option that exists in the United Kingdom is that MDOs provide cover for these health professionals. Whatever the source of the product, **the PIR considers that it is important that the premium for midwives be determined on the claims risks associated with midwife birthing services, rather than the claims experience of either GPs or specialist obstetrician/gynaecologists. (Recommendation 160)** Midwives have only one line of business (compared to a GP) and they cannot perform the same range of interventions as either GPs or specialist obstetricians, which themselves can add to the risks of claims.

10.133 The availability of similar cover for midwives should address the problems some faced in obtaining back-up support, because of MDO fears of having the whole liability thrust back onto them. The obligation for self-employed people to hold cover and the recommendations about clarification of vicarious liability set out in Chapter 9 disposes of the need to consider any

changes to the laws about joint and several liability, by ensuring that all potential defendants have cover.

10.134 **As part of its implementation strategy for the PIR's recommendations on professional indemnity cover, the PIR recommends that the Department of Human Services and Health ensure that products are available at a reasonable cost to the full range of self-employed health professionals, including midwives, to minimise any unintended workforce effects of professional indemnity arrangements. (Recommendation 161)**

10.135 Another option, given the developments in alternative birthing services and the options discussed above in relation to GP birthing service providers, would be the broader use of enterprise liability, including its applicability to midwives who have visiting rights.

10.136 Yet another option is the funding of midwifery services through the public sector on an employment basis, including homebirths through home nursing extension services attached to hospitals. In these cases, the use of vicarious liability would avoid any problems related to product availability. The provision of back-up services would also become simply one of hospital organisation. Such a model fits in well with the continuum of services now being provided in many hospitals from antenatal care through birthing centres, through hospitals and home again.

H. Public sector birthing services

10.137 There is also growing evidence that more women are having their babies as public patients, rather than through private obstetric care, or through a mix of prenatal care from a general practitioner and hospital delivery as a public patient. The above model relating to alternative birthing services is also based on the public sector.

10.138 The effect of this shift, theoretically, should be to move potential liability into the public sector, and away from the medical defence organisation (MDO) sector and private birthing practitioners. However, such a shift depends upon the arrangements under which such practitioners work in hospitals.

10.139 As was discussed in Chapter 9 doctors working in public hospitals delivering public patients in some States have argued that they are not part-time employees, but rather contractors for services. They have argued for different and preferential income and benefit arrangements as part of this strategy. They are often paid at a significantly higher hourly rate than would be a part-time employee doing similar work. In these circumstances hospitals have often required them to carry their own indemnity cover, and in some States, doctors may be called on to reimburse a proportion of any liability paid out by the hospital, where they are considered to have been negligent.

10.140 In Victoria and South Australian metropolitan hospitals, the whole of the liability for public patients is accepted by the public sector, and no reimbursement is sought against doctors. This appears to have kept premiums for some groups considerably lower in these states in some MDOs. For specialist obstetricians in Victoria, premiums in two of the MDOs are $14,000 and $11,000 respectively, with one in South Australia being $12,000[90]. In South Australia, rural practitioners providing services in public hospitals have opted for different arrangements, and the

premiums for GPs in South Australia who deliver babies are some of the highest in Australia. While it is difficult to determine the basis for MDO subscription calculations with any certainty, the issue of who pays for cases involving public sector patients must have a bearing on premiums.

10.141 **The PIR recommends that all State Governments adopt a policy that the costs associated with negligence in public patient birthing services will be borne by the public sector, with no recovery from either employed health professionals or VMOs providing these services. (Recommendation 162)** This fits in with the greater responsibility hospitals are taking in relation to quality of care.

I. Quality of care and birthing services

Numbers of births: does this affect quality of care and frequency of litigation?

10.142 There are many anecdotes and a lack of data about the effects on both the quality of care and incidence of litigation associated with both high and low numbers of births. For example, the PIR was told that doctors were being forced to increase their number of obstetric patients to cover the costs of indemnity, and this was giving them less time to talk to their patients, which in turn could put them at higher risk of being sued. There were also arguments put that a high case load itself may lead to higher intervention rates, as the doctor tried to fit more deliveries into a busy schedule. There are some data to support this concern. In a 1992-93 study of caesarean section rates in the ACT, those doctors delivering over 300 babies per year had a significantly higher intervention rate than those with lower numbers[91].

10.143 Another view was that if practitioners were only doing a very small number of births each year, there skills would be insufficient to provide quality services. There are a large number of GPs who deliver small numbers of private sector deliveries. Only 512 of 1705 practitioners in 1994 delivered more than 5 babies per year - that is almost 70% deliver 5 or less private deliveries per year. This clearly is not a question solely related to private sector births. It may be that some doctors with very small numbers of private sector births are also providing significant public sector birthing services, and so maintaining adequate levels of proficiency and skill.

10.144 The issue of skill maintenance is perhaps even more important in rural areas, where GPs may be obliged to deal with emergency situations, which in larger centres, may be transferred to specialist care. The need for more advanced skills is recognised in the Rural Training Program, through its three different skill levels, which are seen as supplements to the Diploma in Obstetrics.[92]

10.145 So far as the PIR could ascertain, there were no data upon which to base either of these two views. However, they are clearly significant issues for hospitals granting visiting rights, for individual practitioners planning work loads and for MDOs and insurers in setting appropriate subscriptions. Further study is needed on the quality of services provided by GPs and other birthing service providers, who are involved in very low numbers of births per year.

10.146 **The PIR recommends that the NHMRC determine whether there are any significant outcome differences for birthing women and babies with practitioners who**

undertake different numbers of deliveries each year, and whether there are any differences in relation to the incidence of claims of negligence. (Recommendation 163)

Practice patterns, workforce retention and quality issues

10.147 Other disadvantages of models need to be addressed. Most private obstetricians work on a one-to-one basis with women in their care. Because of the unpredictable arrival time of babies, self-employed doctors and midwives tend to have very unpredictable lives. A group practice model in which a small number of potential carers becomes known to the woman during pregnancy may allow doctors and midwives to arrange times for other aspects of their lives, while still ensuring continuity of care for mothers and babies.

10.148 Such models could also help address intervention rates, if it is true that some interventions occur because of rushed schedules and the need to attend several women in a short period of time, and communication problems. They could also address the issue of fatigue, which was discussed in Chapter 5.

10.149 **Given the apparent concerns among specialist obstetricians about lifestyle factors described in the RACOG survey of members in 1993, and the possible impact fatigue or haste can have on quality of care, the PIR recommends that RACOG look towards encouraging different models of care, which can recognise the validity of lifestyle issues, as well as the need to ensure high quality care and minimum intervention rates. (Recommendation 164)**

Defensive medicine

10.150 Recent World Health Organisation studies show that Australia's rate of medical intervention in all aspects of the birthing process is very high by world standards, and often significantly exceeds the World Health Organisation's recommended levels.[93] While some specialists argued that the intervention rate resulted in one of the lowest perinatal morbidity rates in the world, the contribution of these intervention rates to improved outcomes has long been the subject of debate[94]. Many also claim that similar outcomes can be obtained with lower intervention rates, through better targeting of interventions. The view was put to the PIR that the main reason for the higher intervention rates is the increasing fear of litigation among doctors.

10.151 Once again, when the data are examined, the picture seems more complicated. Caesarean section rates, for example, in Western Australia, as measured from 1975 to 1990 had increased almost fourfold.[95] The NHMRC birthing options report shows long-term high-level patterns of other interventions, such as induction (20-22% since 1981) and forceps deliveries (which declined from around 15.2% in 1981 to 12.7% in 1990). It also shows considerable variability between states - ranging from 13.8% in Tasmania to 21.4% in South Australia.[96]

10.152 Intervention rates in Australia have been increasing for much longer than the more recent development of concerns about litigation. However, a research project funded by the PIR supports the conclusion that, at least in some areas, fear of litigation is leading specialist obstetricians to adopt certain practices.[97] For example, 76% of obstetricians stated that they often or occasionally opted to intervene rather than manage a patient expectantly (with

performance of a caesarean being given as an example). This is a very different pattern from all other types of doctors surveyed - only 32 per cent of these provided a positive answer to this question. In other areas of possible practice change, which may be expected to be useful in avoidance of litigation, such as monitoring patient progress more closely and improved record keeping, specialist obstetricians have had no different behavioural change rate than other parts of the profession.

10.153 Some practitioners argued that caesarean sections were being performed to prevent the risk of litigation in the event that the baby has cerebral palsy. While this may have been an issue before the late 1980s, the data on this shows that the vast majority of cerebral palsy cases arise antenatally. As discussed earlier there is little evidence that birthing interventions have any positive effect on cerebral palsy. If this is the reason, then doctors are themselves continuing to support a false scientific theory, by using procedures that can carry risk of harm. This in turn may result in a breach of duty of care by the practitioner, particularly if there are few clinical indications for such interventions.

10.154 Other studies show that caesarean sections are being done more often on women who have private insurance[98], and that non-clinical factors are very significant determinants of the decision to intervene in childbirth. For example, a prospective study of first time mothers in Victoria showed that those most likely to be at risk of having a caesarean and to a lesser extent instrumental delivery were "privately insured, well-educated, assured married women with mature personalities"[99]. This study suggested that "obstetrician anxiety, convenience factors and the response of the medical profession to confident, informed consumers may be factor which are contributing to the marked differences observed in obstetric intervention rates in the Western world."[100]

10.155 Given the apparent lack of improved birthing outcome from current intervention levels, the higher costs for institutions of such interventions, and the additional discomfort, temporary disability and risks of complications for mothers of many of these interventions, there is a need to question the frequency of these practices, particularly where they are being undertaken principally for defensive reasons. Where decisions are not made in the best interests of the mother or child but with a view to protection of the doctor against litigation, this is itself a failure of duty of care. In such circumstances, a mother could take a legal action for breach of duty of care for the carrying out of such interventions.

10.156 "Fear of litigation" by a birthing service provider is not a legally sufficient reason for undertaking a procedure which itself has risks for the mother and baby, particularly if there is a adverse outcome. Where such interventions are undertaken, they need to be accompanied by proper disclosure of the risks of the intervention, as well as information about alternatives and their risks.

10.157 **The PIR recommends that professional bodies of birthing service providers and institutions where births occur be required to develop intervention guidelines and procedure audits to ensure that such procedures are only being undertaken when clinically appropriate and not because of fear of litigation. Appropriate monitoring mechanisms to look at the practices of individual birthing service providers and of institutions need to be put in place as well. (Recommendation 165)**

10.158 To ensure that mothers have adequate information upon which to base their choice of birthing service provider and institution, and to ensure they have a more realistic perception of the risks and complications inherent in the birthing process, **the PIR recommends that both the intervention guidelines and the performance monitoring information be publicly available. (Recommendation 166)**

10.159 There are examples in Australia and overseas where appropriate guidelines and reviews of all caesareans have reduced the intervention rate considerably with no compromise to the safety of mothers or babies.[101]

J. Information Needs

10.160 Birthing services providers and users lack of readily accessible information upon which to base their decisions, so all the recommendations in Chapters 2-4 relate equally to this group. However, more information is available here than in other areas, particularly about evidence-based practice, as pregnancy and childbirth was one of the first areas of attention under the Cochrane Collaboration[102]. The widespread promulgation of the results of this work amongst all birthing service providers and consumers is an important task.

10.161 Doctors claim that prospective parents have unrealistic expectations about the outcome of pregnancy, and that they know little about the incidence of cerebral palsy and other conditions which can affect babies. Similarly, they may not be aware of the different procedures and risks associated with various interventions.

10.162 Some overseas jurisdictions have opted to legally require that all pregnant women are provided with basic information. For example, the State of New York produces a booklet "Your Guide to a Healthy Baby", which all mothers are required to be given by their birthing service provider, and which provides detailed background information on many aspects of birth and talks about the establishment of a birth plan with the provider. It contains caesarean rates of all hospitals in the State of New York, sets out a summary of patient rights and responsibilities, and indicates where more information on specific issues can be obtained.

10.163 **The PIR recommends the development through the NHMRC of an information booklet for parents in Australia, which details the outcomes associated with pregnancy, the various interventions and their risks, and the normal process of pregnancy and childbirth as well as the risks associated with childbirth, based on the best scientific information currently available through the Cochrane Collaboration and other sources. It should also set out birthing service options (that is different providers, public versus private, different locations), as well as the costs associated with these. (Recommendation 167)**

10.164 **The PIR recommends that groups with special information needs, because of cultural or language differences, have adequate information freely provided to them (Recommendation 168).** The development of such information may also serve to inform birthing service providers about the special needs of these health care consumers.

10.165 **The PIR also recommends the development of a set of agreed minimum data that all hospitals and birthing service professionals will collect and monitor, including number of births and outcomes, practice patterns, intervention rates of various kinds and patient satisfaction. Such data should be available free of charge to patients and health care consumers in the proposed information booklet (Recommendation 169).**

K. Other reform measures

10.166 Many of the other PIR recommendations - particularly those to do with better ways of dealing with care costs, as set out in Chapters 6 and 7, and those to do with the health care partnership set out in Chapter 8 - also have particular relevance to birthing service providers. Perhaps more than any other area, the importance of good relations and communication, and sensitive awareness of a woman's needs for information and care, are crucial to avoiding complaints in this area.

10.167 The availability of structured settlements will reduce the overall cost of the very small number of cases involving a severely disabled neonate, where negligence can be shown. The needs for all the children with cerebral palsy who cannot show any such connection will be better served by reforms to community-based assistance. It may be that the better availability of such assistance will itself act to reduce the numbers of claims made, particularly if these reforms are accompanied by better-informed consumers, better-informed and communicative health professionals and ongoing monitoring of standards of care and practice by all health professionals.

Appendix A : Terms of reference of the PIR

1. To examine and report to the Minister for Health, Housing and Community Services on:

   (a) current arrangements relating to professional indemnity insurance for health professionals;

   (b) current experience with compensation for medical misadventure;

   (c) the effect of (a) and (b) on the performance of services by health professionals, including their effect on service quality and type of service provided; and

   (d) any difficulties with these current arrangements including problems with coverage, benefits, quality or any other matters.

2. To develop a range of options to address any difficulties identified under 1(d), in consultation with an Advisory Committee, which includes representatives from:

   (a) the ACTU and health unions;

   (b) the Australian Health Ministers Advisory Council;

   (c) relevant consumer organisations;

   (d) the Australian Medical Association; and

   (e) the Commonwealth Government.

   Consultation will be undertaken with relevant organisations, agencies, individuals and State governments as necessary.

3. To make recommendations to the Minister for Health, Housing and Community Services on the feasibility, appropriateness and estimated costs and benefits of the options identified in 2.

Appendix B : Submissions on the Interim Report

In addition to the formal submissions listed here, the PIR received other correspondence which has assisted in its work. The PIR would like to thank all correspondents, including those not listed below. The sign * denotes that more than one submission was received.

Alcohol & Other Drugs Council of Australia
Anti-Cancer Council, Victoria
Anyinginyi Congress Aboriginal Corporation
Arnold, P (Dr)
Association for Australian Rural Nurses Inc
Association for Improvements in the Maternity Services (AIMS)
Atkinson, K (Dr)
Attorney-General, Perth
Attorney-General's Department , Central Office, Civil Law Division
Australian Institute of Health & Welfare
Australian Council of Deans of Nursing
Australian Council of Professions Ltd
Australian Physiotherapy Association
Australian Perinatal Society
Australian Psychological Society Ltd
Australian Dental Association, Victorian Branch Inc
Australian Plaintiff Lawyers' Association Inc (APLA)
Australian Association of Pathology Practices (via Southern Pathology)
Australian Plaintiff Lawyers' Association Inc
Australian Association of Social Workers Ltd
Australian Association of Occupational Therapists Inc
Australian Nursing Council Inc
Australian Chemical Trauma Alliance, Queensland Branch

Barrett, J (Mrs)
Beavis, E.L.G
Boughton, C.R. (Professor)

Chelmsford Victims Action Group
Citizens' Commission on Human Rights (Psychiatric Violations) Inc
Committee of Presidents of Medical Colleges*
Community & Health Services, Northern Region Tasmania*
Consumer Help Against Malpractice (C.H.A.M.P.)
Consumers' Health Forum of Australia Inc
Council of Retired Union Members Associations of New South Wales

Darwin Homebirth Group Inc
Department of Health & Community Services Victoria
Dietitians Association of Australia
Disabled Peoples' International, Australia

Faulkner Street Medical Practice
Friends of Susanna

Health Care Complaints Commission Victoria
Heidelberg Repatriation Hospital
Higgins, M (Mr)
Hunt and Hunt, Lawyers

Ian Hislop Pty Ltd
Institute of Hospital Engineering, Australia
Institute of Ambulance Officers, Australia
Insurance Council of Australia Limited

King, M.E (Mrs)

Law Council of Australia
Leithhead B.S (Mr) & Associates Pty Ltd
Levy, L.A (Mr)

Maher, P (Dr)
Maisey, K (Ms)
MaLAM (Medical Lobby for Appropriate Marketing Inc)
Maternity Alliance Inc
McCarthy, P (Mr)
Medical Defence Union Ltd
Medical Indemnity Company of WA Pty Ltd
Medical Scientists Association and the Victorian Psychologists Association
Medical Protection Association of Australia
Medical Consumers Association of New South Wales
Mills Oakley McKay, Solicitors
Myrtleford District War Memorial Hospital

National Council of Health Complaints Commissioners
National Rural Health Alliance
National Centre for Epidemiology and Population Health (NCEPH)

New South Wales Medical Board*
New South Wales Nurses' Association
Nurses in Independent Practice
Nursing Board of Tasmania

O'Connor, D (Mr)

Pharmacy Guild of Australia, National Secretariat
Private Hospital's Association of Queensland
Public Interest Advocacy Centre

Quadrio, C (Dr)
Queensland Health, Peninsula & Torres Strait Region

Richards, FO & AC
Royal Melbourne Hospital, Department of Gastroenterology
Royal Australian & New Zealand College of Psychiatrists
Royal Australasian College of Surgeons
Royal Australian College of Obstetricians & Gynaecologists

Sibbald, M (Ms)
Slater & Gordon, Barristers & Solicitors
Southern Pathology
St John Ambulance Australia*
Swan Hills Division of General Practitioners Ltd

Traill, M.A (Dr)

University of Newcastle, Department of Sociology and Anthropology
University of Melbourne, Department of Surgery
University of Sydney, Western Clinical School of Medicine

Victorian Cytology Service
Vietnam Veterans Association of Australia, New South Wales Branch Inc

Welfare Rights Centre
Westmead Hospital Staff Specialists' Association, Department of Surgery

Appendix C : PIR publications summary

Copies of published reports were distributed widely and deposited in libraries throughout Australia. Reports marked with an (*) were also included as part of the Department of Human Services and Health government information on the Internet. The patient and provider information guidelines are presented in full in Appendix D.

Compensation and Professional Indemnity in Health Care: a discussion paper

This discussion paper was the first publication of the Review of Professional Indemnity Arrangements for Health Care Professionals (PIR). It was released in February 1992 to promote public discussion on compensation for medical negligence and professional indemnity insurance for health care professionals. The views expressed in the discussion paper represented the body of knowledge and opinion considered early in the review process.

Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: a discussion paper*. HHCS February 1992 Canberra.

Report on Consultations on First Discussion Paper

This report is a description of the consultations which were undertaken in connection with the release of the PIR's first discussion paper. As part of the consultation process, the PIR funded four full-day symposiums in Melbourne, Sydney, Adelaide, and Perth. The symposiums were held during the first two weeks of May 1992. Invitations were sent to a wide range of interested parties, including health care professionals, professional organisations, relevant legal officers/firms, health unions, and health consumer groups. A number of guest speakers addressed each symposium.

The symposiums presented the opportunity for interested members of the public, health care professionals, and other interested groups to exchange information and opinion. Strong emphasis was placed on debate and open discussion.

HHCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on consultations on first discussion paper*: prepared by Purdon Associates. HHCS November 1992 Canberra.

The Health/Medical Care Injury Case Study Project*

The PIR undertook a research project to assess the adequacy and effectiveness of compensation arrangements for health care injuries. This report is a case study analysis of 24 people who had an adverse outcome resulting from the provision of health care. Another 15 people provided information to the study in a supplementary manner, given their concerns about non-disclosure clauses in their settlements. The study is not statistically representative.

The study describes the type of injury experienced by participants and their experiences with health and medical care providers and lawyers. It also examines the attitudes of the participants to the current system of compensation. All of the participants experienced problems with access to information and finance and neither the medical nor the legal system adequately provided participants with the support they and their families desired.

The majority of participants considered they were financially disadvantaged as a result of the injury, even after an award of compensation, and that the sums awarded were too small compared to the obvious and less evident personal and family costs of care. Many participants felt that the health/medical care provider responsible for the injury was not sufficiently brought to account. A complicating factor in cases of severe injury and dependency was the difficulty in assessing the costs of full-time care over a projected lifetime.

HHCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical care injury case study project*: prepared by the National Centre for Socio-Legal Studies, La Trobe University: authors Garry Coventry, Jeanne Daly, Merilyn Evans, Cathy Lowy, Marilyn McMahon, Gail Roberts. Australian Government Publishing Service (AGPS) February 1993 Canberra.

Defensive Medicine and Informed Consent*

This research paper describes the results of a study undertaken to assess whether doctors reported adopting practices identified with defensive medicine to reduce the possibility of malpractice litigation.

A mail questionnaire was sent to a national stratified random sample of Australian doctors, chosen proportionately to State/Territory and medical specialty by the Medical Statistics and Analysis Section of the Commonwealth Department of Health. A representative sample size of 1,158 doctors was obtained.

The objectives of the questionnaire were to identify doctors' perceptions of the relationship between medical litigation and clinical practice and their views and practices with regard to issues of informed consent. The major finding of this study is that Australian doctors are very aware of the threat of litigation. This fear appears to have led a significant proportion of doctors to adopt defensive medical practices.

Most doctors thought that the risk of being sued for malpractice had increased in the last five years, with obstetricians and gynaecologists being influenced to change their clinical practices most frequently. The study concludes that doctors' fear of litigation is generally far greater than the actual likelihood of being sued or having a complaint made against them.

Commonwealth Department of Health, Housing, Local Government and Community Services (HHLGCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra.

Report on the Feasibility Study of an Australian Hospitals' Adverse Health Care Incidents Study

Central to its work, the PIR had significant interest in determining the incidence of adverse patient outcomes and the human and financial costs of their occurrence. The PIR maintained that this information was vital to understanding the causes of adverse outcomes and the development of prevention strategies to improve the quality of health care.

After reviewing the Harvard Medical Practice Study (HMPS), the PIR commissioned the Australian Institute of Health and Welfare to determine the feasibility of replicating the HMPS in Australia. A central component of the work was to determine whether information collected in Australian hospitals was adequate to support such a study.

The Feasibility Study determined that with some modifications, the methodology and screening forms of the HMPS were useful in the development of an Australian adverse events study. The review of medical records by registered nurses, medical record administrators and clinicians proved to reliable and valid. With its focus on prevention, the PIR determined not to include an assessment of whether negligence was involved in the occurrence of the adverse event. This prompted the need for additional alteration of the HMPS screening forms.

HHCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on the feasibility study of an Australian hospitals' adverse health care incidents study*: prepared by Roy Harvey and John Goss, Australian Institute of Health and Welfare. HHCS December 1992 Canberra.

Survey of Medical Defence Organisations

During 1992–93, the PIR funded a detailed confidential survey of the financial claims experience of medical defence organisations (MDOs) operating in Australia. This survey was designed to provide an estimate of the cost of current arrangements for health care professionals in order to determine the appropriateness of this cost and compare the cost to options for reform. This survey was undertaken by the Australian Bureau of Statistics (ABS).

The PIR had intended to publish the results of the survey. However, the ABS survey revealed significant differences in definitions and actuarial calculations. Given the information from the MDO industry was commercially sensitive and confidential in nature, it was decided not to release the survey results. The concerns identified by the ABS survey prompted the need for a further consultancy, described below.

HHCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *Survey of medical defence organisations*: prepared by Statistical Consultancy, Australian Bureau of Statistics. Unpublished material April 1993.

Report on Medical Professional Indemnity Arrangements

This report details a review of the prudential requirements of the medical defence industry undertaken by consultants commissioned by the PIR. The ABS survey revealed that the dramatic increase in subscriptions rates since 1988 did not appear to relate to any new acceleration in claims frequency nor in dramatic increase in total amounts paid in respect of successful claims for damages. Rather it appeared to relate to industry moves away from a single common contribution rate towards specialty-based risk-rating and efforts to improve the level of funding of past liabilities.

In addition to these issues, the report explored arrangements for the *proper* funding of the Australian medical defence industry, the workplace implications of current indemnity arrangements, and the administrative, legal and compensation costs of current arrangements.

The report highlights the need to remedy the under-funding of liabilities as a matter of priority. Most MDOs claim their *known* liabilities are fully funded but that their *incurred but not reported* liabilities are not. The estimated range of unfunded liabilities is between $100–250 million Australia wide.

The report supports the development of industry *best practice* in claim definition and case estimation procedures as part of the audit assignment. It supports the development of a data set which would facilitate the publication of industry claim and financial experience.

Commonwealth Department of Human Services and Health (HSH). Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on medical professional indemnity arrangements*: prepared by John Walsh and Jann Skinner, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd. HSH March 1994 Canberra.

Compensation and Commonwealth Health and Community Services Programs*

This report is a detailed discussion of the often complex interactions between the wide variety of Australian compensation arrangements, including common law damages and the programs of the Commonwealth Department of Health, Housing, Local Government and Community Services. The report was commissioned to clarify the variety of both statutory schemes and statutory modifications to common law in the various jurisdictions, and the many different funding, eligibility and administrative arrangements covering the Commonwealth programs.

HHLGCS. Review of the Relationship between Compensation and Health and Community Services Programs. *Compensation and Commonwealth health and community services programs: a discussion paper*: prepared by Tom Brennan and John Deeble. AGPS June 1993 Canberra.

So You Want to Know More About the Commonwealth Quality Assurance Legislation

This booklet provides background information on the Commonwealth quality assurance legislation. The booklet provides a brief overview of the role of quality assurance in improving health outcomes and the establishment of quality assurance activities throughout Australia. The booklet then describes the *Health Insurance (Quality Assurance Confidentiality) Amendment Act 1992*, and its application.

The booklet provides information on a number of issues included in the application form including eligibility criteria, the type of activity performed, and the requirements of the authorising body. Discussion of the role of the legislation with regard to disclosure of information, activities of national significance, credentialling and procedural fairness, and evaluation is also included.

HHLGCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *So you want to know more about the Commonwealth Quality Assurance Legislation*: booklet, July 1993.

Birthing Issues: Background Paper

In response to a number of publicly made statements about the effects of professional indemnity arrangements on birthing services in Australia, the PIR established the Birthing Issues Sub-Committee. Membership of the Sub-Committee was diverse, and was listed in the endnotes to Chapter 10.

To promote informed discussion, the PIR released this paper which explores the impact of indemnity issues on birthing services. The issues discussed include whether practising specialists and general practitioners are ceasing to provide obstetrics services because of increasing indemnity premium levels, and that wider use of midwives is being discouraged because of the difficulty in obtaining adequate professional indemnity cover. The paper also explores medical indemnity contributions, contingent liabilities of MDOs, Statutes of Limitations, and the issue of causation.

The paper concludes that there are a range of factors which influence obstetric practice in rural and remote areas, including the irregularity of work hours. While the paper acknowledges that indemnity premiums had increased, analysis of Medicare data undertaken by the PIR did not indicate that practitioners were shifting from obstetrics to gynaecology or other sub-specialties. The paper notes that although medical indemnity costs had risen, overall practice costs had not increased for the same period.

HHLGCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: background paper*. HHLGCS August 1993 Canberra.

Birthing Issues: A Rural Perspective

This paper further explores the issues impacting on the delivery of birthing services in rural areas. The paper reviews data on the number of confinements performed in obstetric practice by both specialists and general practitioners, by geographic location. Discussion is then provided on the range of issues which have in both the Australian and overseas context been said to influence obstetric practice. The paper concludes that the shortage of rural obstetric services is not solved simply by improving economic incentives to practitioners.

The paper presents a range of options proposed from a wide body of participating service and provider groups. Options include providing general practitioners with adequate training to perform procedural medicine, support for post-graduate training in obstetrics and family planning, removing access barriers to midwives providing hospital birthing services, and strengthening the development of clinical support networks.

HHLGCS. Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: a rural perspective*: prepared by Madonna McGahan, PIR. HHLGCS December 1993 Canberra.

Compensation and Professional Indemnity in Health Care: an interim report*

The Interim Report presented an overview of the work of the PIR, including material provided through consultations, submissions, and commissioned research. The report provided the opportunity for the PIR to review its research and inquiries in the broader context of other reforms occurring in the health/medical care system. The report encouraged interested individuals and organisations to comment on the policy direction outlined in the report. The report offered 47 specific recommendations and requested views on 22 related topics.

The report outlined a number of major issues facing the Australian health system. These included discussion of strategies to prevent the occurrence of adverse patient outcomes; implementation of integrated risk management and quality assurance programs; equitable provision of support for people with disabilities, regardless of compensation status; the adequacy of professional indemnity for health care professionals; and improving the responsiveness of the legal system to situations alleging medical negligence.

HSH Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* AGPS February 1994 Canberra.

Conference Proceedings: Incident Monitoring & Risk Management in the Health Care Sector

The PIR hosted a national conference on incident monitoring and risk management during November 1994 at which consultants reported on the outcomes of each incident monitoring pilot, including an analysis of findings.

The conference consisted mainly of presentations from the speciality-based incident monitoring pilots, as well as presentations on issues of patient safety, risk management and communication skills as components of undergraduate education. The conference was opened by Dr Andrew Theophanous MP, on behalf of the Hon Dr Carmen Lawrence MP, Commonwealth Minister for Human Services and Health. Professor James Reason from Manchester University who is a world expert on human error psychology, was the keynote speaker.

Detailed findings of these pilots are to be published as a supplement of the Medical Journal of Australia in late 1995.

HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *Incident monitoring and risk management in the health care sector: conference proceedings.* Radisson President Hotel, Melbourne 29–30 November 1994. HSH 1994 Canberra.

Final reports of the incident monitoring pilots

As part of its research into adverse patient outcomes, the PIR sought practical strategies for finding out what goes wrong in the health care system and how such events can be prevented. Pilot studies were funded in intensive care, general practice, gastroenterology, obstetrics and gynaecology, emergency medicine, and psychiatry as well as continued funding of anaesthesia. The pilots commenced in mid 1993.

In the final report of the pilot studies, consultants reported on:

- the methodology used;
- evidence of rigorous data analysis;
- any problems encountered in the running of the pilot;
- estimation of costs in maintaining and extending the pilot;
- preventive and educative strategies developed from the pilot; and
- ways that the pilot can be applied or modified to identify and prevent incidents which reduce the patient safety margin.

Related pilots also occurred in institution-wide incident monitoring - the Australian Health Care Incident Monitoring Study, and in institution based risk management - the South Australian Risk Management Pilot. Separate reports are available for each of these pilots.

Patient Guidelines: Consultancy for the Development of Information Guidelines for Patients in the Event of an Adverse Patient Outcome*

In its Interim Report, the PIR recommended the development of information guidelines which would ensure that patients know how to find out information if an adverse patient outcome occurs. The patient guidelines are designed to assist consumers to understand their rights in health care and access further information and the assistance of various bodies responsible for health care complaints and disciplinary processes. The patient guidelines have been presented in the style of a booklet. The booklet is intended to be adapted and amended to suit the requirements of specific consumer groups. The booklet does not address all the needs of special needs groups, such as Aboriginal and Torres Strait Islander peoples or people with disabilities.

HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *Consultancy for the development of information guidelines for patients in the event of an adverse patient outcome*: prepared by the Victorian Health Services Commissioner and the Health Issues Centre, Victoria. HSH March 1995 Canberra.

Provider Guidelines: Consultancy for the Development of Information Guidelines for Health Care Professionals in the Event of an Adverse Patient Outcome*

In its Interim Report, the PIR recommended the development of information guidelines which would provide consistent and clear advice for health care professionals in the event of an adverse patient outcome. The provider guidelines are designed to help providers provide relevant information to consumers and to respond positively to comments or complaints. The provider guidelines have been presented in the style of a booklet. The booklet is intended to be adapted and amended to suit the needs of particular groups of health care professionals. The booklet does not at present address all the needs of particular health care professionals.

HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *Consultancy for the development of information guidelines for health care professionals in the Event of an Adverse Patient Outcome*: prepared by the Victorian Health Services Commissioner and the Health Issues Centre, Victoria. HSH March 1995 Canberra.

Structured Settlements as Payment of Compensation for Personal Injury

This discussion paper explores the use of structured settlements as payment of compensation, both in Australia and overseas. The report addresses several issues including whether compensation recipients would benefit from the periodic payment of compensation monies to fund their future care and income requirements. The report notes the effect of tax and social security arrangements on current compensation arrangements and identifies impediments and incentives to greater use of structured settlements in Australia.

HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *Structured settlements as payment of compensation for personal injury: a discussion paper*. HSH June 1995 Canberra.

Report on Taxation Treatment of Compensation Payments

This report contributes to the work of the PIR on the adequacy and appropriateness of current arrangements for compensation. As discussed in the above report, structured compensation settlements can address some of the problems associated with the provision of compensation in a lump sum.

This report was commissioned in response to concerns that the current taxation treatment of compensation payments for personal injury is an impediment to the wider use of structured settlements. That is, the current taxation regime is a disincentive for claimants accepting structured settlements, or converting a lump sum payment to a structured settlement. Australia makes no special provisions for structured settlements. This report documents the current taxation regime applying to payments made as compensation for personal injury, examines reform options, and estimates the cost to the Commonwealth of those reforms.

HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on taxation treatment of compensation payments*: prepared by prepared by John Walsh, Neil Wilson and Ian Farmer, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd. HSH June 1995 Canberra.

Compensable and Non-compensable People with Disabilities: equal needs – unequal assistance*

This discussion details the work of the PIR on the systems of support available in the community for people with disabilities and the responsiveness of the compensation and community support systems to patients who have long-term, often life-long, support and care needs. Research by the PIR has demonstrated the significant overlap between the arrangements for compensation and the health and community assistance programs. The interaction of Commonwealth service programs and State compensation schemes is complex and often leads to opportunities for gaps and/or overlaps in services, and cost-shifting or double-dipping. The PIR has argued that it is inequitable that access to needed services is largely determined on the basis of compensation status.

HSH. Review of the Professional Indemnity Arrangements for Health Care Professionals. *Compensable and non-compensable people with disabilities: equal needs – unequal assistance: a discussion paper*. HSH August 1995 Canberra.

Appendix D : Patient and provider information guidelines in the event of an adverse patient outcome

Purpose of the Guidelines:

These two sets of information guidelines were prepared as part of the work of the Commonwealth Government's Review of Professional Indemnity Arrangements for Health Care Professionals (the PIR) by the Victorian Health Services Commissioner and the Health Issues Centre Victoria to address recommendations made in the Interim Report of the PIR.

Recommendation 35 of the Interim Report of the PIR recommended:

> "... that information guidelines be prepared for patients to ensure that they know how to find out information if an adverse patient outcome occurs; are aware of their various rights, for example, to complain to a complaints or disciplinary body and to seek damages in some circumstances; and are aware of any requirements to seek damages within a set period of time".

Recommendation 20 of the Interim Report of the PIR recommended:

> "... that consistent and clear advice for health care professionals on disclosure of information should be developed as a matter of urgency by lawyers and medical defence organisations involved in medical litigation. This will be important for both consumers and health care professionals in the event of an adverse patient outcome".

Please note:

The following information guidelines are intended to begin to address these recommendations. Due to time constraints as the PIR drew to a close, the information guidelines were developed with limited consultation with interested parties. They do not address all the issues of special needs groups, such as Aboriginal and Torres Strait Islander peoples, or people with disabilities. The PIR notes that adaptation of the information guidelines will be necessary to ensure they meet the requirements of specific consumer/provider groups.

The guidelines have also been prepared with reference to Victorian contact points, and with de-identified examples from the Victorian Health Services Commission. Different States and Territories, and different professional or consumer groups may wish to put in different contacts and examples to make them appropriate for each location and different consumer or professional groups.

Patient Information Guidelines

Table of contents

A patient's guide: what to do when you are not happy with your health care

Section 1: A good partnership promotes good health care

As a patient you receive health care from many people. Your doctor, dentist, pharmacist, chiropractor and optometrist are all **health care providers**.

In a hospital you will receive health care from a variety of health care providers, including nurses and physiotherapists. You may also attend natural or complementary health practitioners such as naturopaths or acupuncturists.

All the health practitioners who treat you – whether in or out of hospital – are health care providers.

This information guideline is about the relationship you have with health care providers and your rights in relation to the treatment they give you.

You – together with your doctor, hospital team, or other health care provider – are partners in making sure you receive good health care.

The partnership works best when you respect each other and communicate openly and honestly.

When you give your health care provider a full description of your symptoms and your medical history, when you agree on a diagnosis and you carry out a treatment plan such as taking medication, you are doing your part to make sure your health care works for you.

Your health care provider should also do his or her part by making sure you feel comfortable talking about your illness or condition and by explaining the treatment options and making sure you understand all the risks and benefits of different treatments.

You are entitled to expect quality health care provided by competent health care professionals who respect you, listen to you, and pay attention to your wishes and choices about your health care.

But sometimes things go wrong.

Sometimes you may not be satisfied with your health care. Perhaps you have not had enough information to understand the diagnosis or treatment. Perhaps you feel injured or damaged by your treatment.

Section 2: If you are not happy with your health care you can take action

This information guideline tells you what your rights are and what you can do if you are dissatisfied with your health care.

What action you take will depend on what you want to achieve. This could include:

- an explanation of what happened and why;
- an apology for an unsatisfactory outcome;
- financial compensation for an injury;
- action to ensure that other people do not have to put-up with poor treatment from that particular health care provider or hospital.

Sometimes things go wrong in health care and it is nobody's fault. At other times, you might feel dissatisfied and not know whether someone is responsible.

Most people can sort out their concerns about their health care very quickly by telling the practitioner or hospital that they are concerned about their health care. But sometimes talking it over won't be enough. You will want to take your concerns/ complaint further.

The information in later sections of this information guideline will tell you what you can do and where you can go for help.

Section 3: Your rights in a good health care partnership

As a patient you are a consumer of health services. As such you have many rights and entitlements. A **Public Hospital Patients Charter** will set out what you can expect in a public hospital.

Many hospitals will have a printed statement of **Patients Rights** which sets out what you can expect while you are receiving health care in that hospital. It should include information about where and how to lodge a complaint and how complaints are heard by an independent organisation. If you are going to be admitted to a public hospital, you can ask to see the hospital charter.

Regardless of whether you are a public or private patient you have:

- a right to be treated competently and with care and courtesy;
- a right to the most appropriate treatment regardless of gender, race, disabilities, or other characteristics;

- a right to get a second opinion or to complain, or to take legal action if you are not satisfied with your health treatment. If you do, you have a right not to be penalised or deprived of the appropriate health care you need.

If you live in a rural or remote area you may find it more difficult to complain as there may be few alternatives to your usual local hospital or health care provider. In this situation the Health Complaints Authority in your State/Territory can advise you.

You also have rights about *your* TREATMENT, *your* PRIVACY and *your* MEDICAL RECORDS.

Section 4: Do I have to accept the treatment my health care provider recommends?

Nobody can give you any medical/health treatment or procedure unless you give *informed consent*, that is, you agree to it after your health care provider has explained the benefits and risks, answered your questions or responded to your concerns, and told you what alternatives there are to that particular treatment.

To have any treatment you must give *informed consent* to it except in circumstances such as where there is an emergency and you are unconscious or you are an involuntary mental care patient.

Your health care provider has a responsibility to help you decide by setting out all the options and the risks and benefits, and giving advice about what he or she considers is best for you.

But only you have the right to choose what sort of treatment you are willing to accept. You may have personal reasons for preferring one form of treatment over another. Or you might choose to refuse treatment, despite the advice of your health care provider, that it is necessary for your well being. Only you can decide on your treatment after considering all the information given to you.

If any health care provider treats you without your permission you have a right to complain as this is an assault on you. If the assault causes you *damage* you might want an apology or financial compensation. Damage can be physical or psychological. In the following case the patient suffered psychological damage:

> A consultant in a teaching hospital was doing his rounds with a group of medical students. He approached a patient whom he had never previously met and without any discussion proceeded to perform a rectal examination on him. The man who knew nothing about the consultant was outraged and felt publicly humiliated. He suffered psychological symptoms and lodged a complaint against the consultant.

Section 5: What if I do not understand what the health care provider is saying?

When you see your health care provider or go into hospital, the diagnosis and types of treatment available for your illness or condition should be explained to you in a way you can understand.

If you don't understand English very well you can ask for a **Professional Interpreter** to interpret the information given to you.

You are not required to get a member of your family or a friend to interpret for you and a professional interpreter should *not* be present when you are being examined or are talking to hospital staff or other health care providers unless you want them to be with you.

Also, you may not want your family to know the details of your health care. You may be embarrassed about discussing your illness in front of the family or you may be worried about the way your illness may affect them. If you feel your illness is a private matter and you don't want to involve your family, you should ask for a **Professional Interpreter** who will not reveal any information about you to anyone else.

But if you would rather have your family or some other helpful person like a friend involved in the discussion you have a right to ask them to be present.

If you come from a country with a different approach to health care, health care providers should be sensitive to your beliefs and wishes.

Section 6: Is the information I give my doctor or health care provider confidential?

Confidentiality of any information passing between you and your health care providers is essential if you are to have a partnership based on trust.

It is important that you be able to tell your health care provider private and sensitive things which affect your care. They have a responsibility as far as possible to keep confidential anything you say about your health. But there are some situations where health care providers may have to reveal some of your private health care matters to other people.

In a hospital there may be many people caring for you who need information about you. But they should not pass this information on to anyone who does not have a clear role to play in your care, or dealing with the administration of your care (like sending accounts).

Sometimes the law requires a doctor to report certain diseases to a central registry to assist in government health planning, or it obliges a doctor to report such things as child abuse. In these cases the doctor has to pass on information about you, even if you don't agree. However you should be told if he or she has to do this.

Medical research

Sometimes researchers will want to study a particular illness or type of treatment that you may have/have had. They may want access to information about your illness or treatment as part of a research study involving people with the same illness or treatment. In Australia, medical research can only be carried out after it has been approved by a hospital or institutional **Ethics Committee**. No researcher can have access to information about you unless his or her research has been *approved* by an Ethics Committee which imposes strict conditions to protect your privacy.

In most cases the researcher should *request your permission* before obtaining information from the hospital about your illness or treatment. But in some cases this will not be possible particularly if the information the researcher wants relates to an illness or treatment that took place some time ago.

Whether or not the researcher asks for your permission, the hospital will usually only give information about you in a way that does not identify you and the researcher has a duty not to identify you in any way in any report that is written as part of the research.

The researcher must not disclose anything about you or your health care to any other person and must make sure that all the information obtained about everyone in the research study is kept *secure and confidential*.

Section 7: Can I see the health care records kept about me?

To participate fully in your treatment or the progress you are making under treatment, you may want to know what is in the records kept by your doctor or hospital or other health care provider.

Most health care providers know that making records available when requested by a patient promotes an open relationship. It encourages trust and helps avoid misunderstandings about a diagnosis or the outcome which can reasonably be expected from a particular treatment.

Although health care records remain the property of the health care provider, the Commonwealth Government and the State/Territory Governments have agreed that in public hospitals and community health centres, patients will be able to have access to their records in most situations.

Depending on whether you are in a public hospital or community health centre you may have a legal right to have access to your patient records. Even where you do not have a legal right to see your records, health care providers may allow you to see the records and to correct any errors in them.

Access to records for a public hospital patient

In most States/Territories, if you are a patient in a public hospital or community health centre you are entitled to have access to the records of your treatment.

To obtain your health care records you may need to make an application under the **Freedom of Information (FOI) legislation**. Your hospital or community health centre should give you information on how to go about making an **FOI application** or you can contact one of the organisations listed in the back of this guideline.

If you make such an application you may not get access to all your records if they contain information which is subject to certain exemption provisions in the FOI legislation.

Access to health care records for a private patient

The FOI laws do not give you a right of access to health care records held in a private hospital or held by a private doctor, unless these documents are in the possession of a State/Territory Government or the Commonwealth Government and so come under the State/Territory or Commonwealth FOI laws.

If your doctor or private hospital does not allow you to see and make copies of your records, the health care provider might make a summary available or allow a doctor of your choice to see the records, even though there is no legal obligation to do so.

If there is a **Health Complaints Authority** in your State/Territory, the staff may also be able to help you get access to your health care records or a summary of them. Sometimes the **Medical Board** for doctors in your State/Territory may help as well.

Health care records are often confusing as they contain abbreviations, or unfamiliar medical or technical terms. They will usually include facts about your care, as well as opinion or medical speculation. For example, your practitioner might have made notes about possible diagnoses he or she wanted to investigate. For these reasons it is often helpful to have the person who wrote the record or another health care provider explain the information to you. You might wish to arrange this when requesting access to these records.

Section 8: If I am dissatisfied with my health care – what are my options?

Most patients are happy with the care they receive most of the time. Their health care providers communicate well and offer competent and courteous treatment.

But sometimes things go wrong. A medical procedure or an operation may not have turned out as expected. It may not be anyone's fault. It may be an unfortunate accident. But you may not know that. All you know is that things haven't turned out as you had hoped.

You may be confused, disappointed or angry about your treatment. You may not know what you want to do but feel you want to know more or that something should be done.

This section tells you what you can do if your health care has not lived up to your expectations. If you are dissatisfied with your health care you have a number of options. Which option you choose will depend upon why you are dissatisfied and what you think should be done.

Section 9: What can I do if I want more information?

You may not know whether a disappointing outcome from your treatment was completely unavoidable, whether it was an accident or whether someone was responsible for it. Your concerns about your treatment might be resolved by having a complete picture of what the treatment was intended to do and how it was carried out.

Alternatively you may want more information to decide whether you should make a formal complaint about the treatment or whether you should take legal action. How you get the information you want can depend on whether you are a private patient or a hospital patient.

If you are thinking about legal action, you might want to consult a solicitor before taking any of the action suggested below.

Private Patient

If you are unhappy with health care from a *private practitioner* you should make an appointment to see him or her at the surgery or clinic to discuss your fears, suspicions or concerns/complaint.

You might like to take a friend or member of the family with you as it is sometimes difficult to take-in or remember everything that is said, particularly if you are feeling confused or upset. It might also be useful to ask for a written explanation or to ask for diagrams describing the procedure to make the explanation clear.

You may also wish to see the health care records kept about you. While private practitioners are not legally required to show you these records, many will do so to help you understand what happened. If you are refused access to these records you might wish to request your records by making an application under FOI legislation if the records are kept by the Commonwealth or a State/Territory Government (see Section 7 above).

Hospital Patient

As a public hospital patient you have a right to see the health care records kept about you. See Section 7 above for information on how to do this.

If you are a patient in a health care facility like a hospital, you could ask to speak to the person responsible for receiving complaints. You could also ask about the hospital's *complaints procedures*. You might be referred back to the person who treated you to discuss the matter further, or the hospital complaints officer might investigate your complaint.

Regardless of who you speak to, you should be treated courteously and your concerns should be dealt with promptly.

Section 10: Am I entitled to an apology when things go wrong?

When you are disappointed with a treatment outcome you are entitled to a factual explanation of what happened and why. It is also common courtesy for a health practitioner to acknowledge your disappointment.

If your health care provider apologises for a less than expected treatment outcome, this is not an admission of liability.

They are not admitting that they have done anything wrong, unprofessional or negligent. They are simply showing you that they care about the effect the problem is having on you.

In some cases a health care provider will give you a written apology or offer to take steps to minimise the damage. This could be by further treatment or referral to another practitioner. This may resolve the problem for you. But if you decide to take the matter further your health care provider's apology or offer to try and minimise the damage does not constitute an admission of legal liability.

Section 11: What can I do if I want to take further action over the way I was treated?

If you are not satisfied after talking with your health care provider and you want to take the issue further, you have a number of options. Which you take depends on the nature of your complaint and what you hope to achieve. Whatever action you take will require time and effort and it may not achieve your goal. However it is your right to take any of the following actions:

- lodge a complaint with the **Health Complaints Authority** in your State/Territory. New South Wales, the Australian Capital Territory, Queensland and Victoria have established complaints authorities;

- report the matter to the **Registration Board** which registers the health care provider to practice;

- take **Legal Action**.

These options and how to approach them are described in Section 12.

Section 12: Health Complaints Authorities

Most States/Territories now have a **Health Complaints Authority** set up by an Act of Parliament to investigate complaints from consumers of health services. These are **independent bodies** which can investigate all types of complaints, including how the health care provider dealt with you and the quality of the health care you received.

If your complaint is against an individual practitioner the **Health Complaints Authority** will discuss the matter with the **Registration Board**, which registers the health care provider to practice, to determine whether the Complaints Authority or the Registration Board should **investigate** the complaint.

The Complaints Authority will usually **refer your complaint** to the Registration Board if it involves possible **disciplinary action** against the practitioner. However in New South Wales, the Health Care Complaints Commission investigates all complaints about health care practitioners.

In investigating a complaint, the Health Complaints Authority might contact your health care provider to get a clear picture of what happened. The practitioner is not obliged to co-operate with the Authority but where the complaint is *serious,* they have the power to investigate without the agreement of the person about whom you have complained.

The Health Complaints Authority can also **conciliate** between you and the practitioner if you both agree to conciliation as a way of resolving the problem. Conciliation is a statutory process involving **private discussions** between the patient and the provider, **mediated by the Complaints Authority**. Everything said in conciliation is **confidential** and cannot be used in legal proceedings.

If you complain about the care you were given in a health care facility like a hospital or nursing home and you do not want anyone else to experience the problems you have had, the Health Complaints Authority can **recommend changes** to the practices in the hospital or nursing home to avoid the problem occurring again. Where you want a change in the way health care is delivered either in a particular facility or in the wider health care system, the Health Complaints Authority is best placed to deal with the issue.

Health Complaints Authorities have **different powers** in different States/Territories. However, generally they can help resolve your complaint by helping negotiate an agreement between you and the health practitioner which provides an **apology**, **financial compensation**, or some **other outcome** such as a change in practice standards.

Apology

An apology or acknowledgment that the health care was not satisfactory or the outcome of a procedure not ideal, is sometimes all you want from your health care provider.

A concern that the problem should not recur and a belief that they were entitled to an apology motivated the family to complain in the following case:

A surgery patient (male) who was on very high doses of morphine for pain relief was re-admitted to hospital at the weekend. The specialist who was treating the patient was not on duty and the patient was put under the care of a junior doctor. The patient's family asked that he be given his usual high dose of morphine but the junior doctor considered this to be excessive or even dangerous and refused. The patient was in great pain and the family requested the staff to contact the specialist to get approval for the higher dose but this was also refused as the staff did not want to disturb the specialist at home. On the following Monday the specialist returned and was very concerned at the patient's treatment and immediately increased the morphine.

The family complained to the Health Complaints Authority who took the matter up with the specialist and the hospital. The hospital apologised to the patient and the family for the distress they had suffered and introduced new procedures to ensure that the problem did not recur.

Financial compensation

Financial Compensation is sometimes negotiated where there has been legal negligence by the health care provider. In the following case the family felt that financial compensation was the only fair way of redressing the problems they had suffered:

A child with a hearing defect was admitted for minor corrective surgery at the same time as a child with a different ear problem requiring different surgery. Although both children were provided with identifying arm and leg tags no-one checked the name of the child with the hearing defect and she was treated with the procedure intended for the second child. When the mistake was discovered she had to undergo a second operation in 24 hours to overcome the effects of the wrong surgery.

Her parents complained to the Health Complaints Authority. A financial settlement was negotiated covering all the family's immediate medical expenses, future medical expenses and general pain and suffering for both parents and child. This was based on the acknowledgment that the hospital had been negligent in that it did not follow proper procedures in identifying patients for surgery.

Other compensation

Occasionally, where it is not clear whether anyone is at fault but there is good will all round, the Health Complaints Authority may be able to negotiate an agreement to provide services where a patient has special needs, or an agreement about paying for extra services. In the following case there was no proof that the doctors or hospital staff had been negligent. The outcome, although very serious for the patient, was not caused by anyone's negligence or incompetence or failure to follow proper procedures:

> A woman went into the operating theatre for a straightforward back procedure. After the operation she was paralysed but there was no proof that the operation was connected to or caused the paralysis. The hospital while not acknowledging that it was in any way responsible, arranged for her to have personal services and modifications to her house to make her as comfortable and independent as possible.

This is a very unusual case as the patient was compensated even though there was no proof of negligence.

To obtain any kind of compensation, you usually have to prove that the practitioner or hospital was *negligent* in that proper procedures were not followed and that this caused the harm you have suffered. It is not enough to show you have been damaged. *You must prove that the damage was caused by negligence and is not simply an unfortunate accident.*

If the Health Complaints Authority is able to negotiate an agreement involving a financial offer of settlement, you may want to get legal advice as to whether it is a fair offer and whether you should accept it.

If you accept the offer you may be prevented from going to court for further compensation. As well, you may have to keep all details of the case confidential and not disclose the agreement to anyone. You may want to talk to a lawyer before accepting an offer with these conditions.

Section 13: What can I do if there is no Health Complaints Authority in my State/Territory?

Under an agreement between the Commonwealth and State/Territory Governments all States/Territories should soon have a **Health Complaints Authority**. They may have different names like the Health Care Complaints Commissioner in New South Wales, the Health Rights Commissioner in Queensland, the Health Complaints Commissioner in the Australian Capital Territory, and the Health Services Commissioner in Victoria. But they all have essentially similar roles.

If there is no Health Complaints Authority in your State/Territory there are other options for dealing with your complaints about health care. You can:

- contact you **Local Member of Parliament**;

- approach your **Ombudsman** if the complaint is about a State/Territory run health service;
- contact the **Health Department** and speak to the Complaints Unit.

Information about these agencies is included in Section 18 of this guideline.

Section 14: Registration Boards

All doctors and many other health professionals, such as nurses, must have professional qualifications and they must also be registered to practice in Australia.

If you are concerned about the poor quality of the care you received and/or you do not want anyone else to be treated in the same way, you may want to complain to the **Registration Board** which controls the practitioner's right to practice.

A Registration Board is set up under an **Act of Parliament** and is made up of members of the same profession and sometimes a lawyer and a non-professional representative.

In those disciplines where registration is required, health professionals are subject to the rules laid down by the professional board. Under the Commonwealth and State/Territory mutual recognition legislation, once a health care provider is registered in one State/Territory he or she can practice anywhere else in Australia, providing they notify the local registration board and pay the fee for local registration. The arrangements for mutual recognition applies to a number of health professions including:

- doctors
- nurses
- dentists.

If you feel that a health care provider has acted in an unprofessional manner or has very poor standards of practice you can complain to the State/Territory Registration Board for his or her profession.

The role of the **Registration Board** is to protect the public from incompetent or immoral practitioners. It can investigate complaints from the public to determine if a person is fit to practice. What it considers to be poor clinical practice may be different from what you consider could put patients at risk.

If you **lodge a complaint** with the Registration Board it will investigate the complaint and it may hold a hearing, like a court hearing, to determine if the actions you are complaining about are below **acceptable professional standards**. The exception is in New South Wales, where all complaints are investigated by the Health Care Complaints Commission and heard before the **Medical Tribunal**. The Medical Tribunal is an independent Tribunal consisting of a judge, two medical practitioners, and a non-professional representative.

You may need to be present at the hearing to give evidence but you will *not* be able to have a lawyer represent you. The Registration Board may have a lawyer assisting and the practitioner against whom you have brought the complaint may be represented by a lawyer. As a result of the investigation the Registration Board can:

- discipline the health care provider and impose conditions on his or her right to practice;
- order him or her not to practice in a particular field;
- suspend him or her from practice;
- deregister the practitioner so that he or she cannot practice in the State/Territory.

A Registration Board cannot pay you compensation if you have been badly treated. You will have to take other action if you want financial compensation for any injury or damage you have suffered at the hands of a health care practitioner.

Information on Registration Boards is included in Section 18 of this guideline.

Section 15: What should I do if I want financial compensation for any injury or damage I suffered?

If you want financial compensation you have 3 options. You can:

- make a request direct to the provider;
- complain to a Health Complaints Authority;
- take legal action.

Approaching your health care provider

If only a small sum of money is involved you may want to approach the health care provider directly. This could occur when you need further surgery or treatment to correct an unsatisfactory result and you do not think you should have to pay for it. You could ask the practitioner to pay for the extra care made necessary because of the treatment you received.

Complaining to a Health Complaints Authority

The role of the Health Complaints Authority is set out in Section 12 above. If you complain to a Health Complaints Authority, it can conciliate a settlement of your complaint and part of this could involve financial compensation. But the Authority can only conciliate a matter if both parties agree. If the practitioner refuses to co-operate you will not be able to obtain financial compensation through the Health Complaints Authority.

Taking Legal Action

Taking legal action involves suing the health care provider for financial compensation where you have suffered damage from the treatment he or she gave you.

Section 16: When should I take legal action?

You should only take legal action after you have had **expert legal advice**. It is for your lawyer to advise whether you should sue in the courts or whether some other option such as conciliation through the Health Complaints Authority is preferable.

Generally, there are two situations in which you might want to consider taking legal action. These are:

1. where you have not given informed consent to a treatment that has been carried out;

2. where the health care provider has been negligent in his or her treatment of you.

Where there has been no informed consent

It is very unusual for a health care provider to treat you without any agreement on your part. Most arguments are around the extent of the consent you gave and whether you had enough information to make an informed consent.

However, occasionally a procedure will be carried out without any consent. This may occur where it is presumed that you would want a procedure done even though it has not been discussed. The following case illustrates this:

> A patient requested a surgeon to remove bunions from his feet. Whilst he was under the anaesthetic the surgeon discovered he had clawed toes and proceeded to straighten them, reasoning that it was in the patient's interest to

have this done as he was already under an anaesthetic and it would avoid the necessity of undergoing another operation at a later date.

Although the surgeon acted in what he believed to be the patient's best interest and carried out the operation according to established procedures, he committed an assault because the patient did not give **informed consent** to the procedure.

To show there has been an assault and successfully sue for compensation you only have to show that there was no consent, that the treatment was given and that you suffered damage. You do not have to show that the practitioner was unreasonable or that he or she breached some other duty of care. The damage could range from an extended hospital stay to nervous shock and pain and suffering.

Is very rare for a legal action to be brought against a health care provider claiming there was no informed consent. The issue of informed consent usually only arises as part of a negligence case.

Where you believe you have not given a fully informed consent to a procedure you should consult a lawyer as legal action may not be the only way of dealing with your particular case.

Where a health care provider has been negligent

To win a medical negligence case in court you must prove that you have been injured or harmed by the actions of a health care provider who exercised inadequate care or failed to meet a legally acceptable standard of competence.

It is not enough to show that you have suffered physical or psychological damage. Even if you are very seriously disabled following treatment, that does not necessarily mean that you will win compensation.

You must prove that the damage was not just an unfortunate or unavoidable result of the treatment, but that it was the *direct result* of the practitioner's failure to exercise his or her duty of care to you. It is not the extent of your injuries that determines whether you can obtain compensation but whether the doctor or other health carer provider was negligent in carrying out the treatment.

You must also show that the damage has caused you financial loss such as more medical expenses, the need for special care, pain and suffering or loss of wages or employment prospects.

It is always a **big decision** to start a legal action. It can take months or even years before the case goes to court or is settled out of court. It is **stressful and time consuming** and there is **no guarantee** that you will succeed.

Before you decide to take legal action you should get expert legal advice.

There are a number of **specialist lawyers** in most major cities who are expert in medical negligence law. They will often agree to give you preliminary advice about your chances of success before you commit a lot of money to a legal claim. Your lawyer should also explain what the **time limits** are on taking legal action in your State/Territory.

Some lawyers will take on a case on the basis that they will only charge professional fees if you win. You will still bear the costs of obtaining medical reports to prove your case, court fees and any other expenses. Before entering a **contingency fee arrangement** like this you should check what fees are payable should you wish to withdraw from the arrangement.

Legal Aid is also available for some people who have a good case and cannot afford to pay legal fees up front.

Your lawyer should explain in detail what is involved so that you can make an informed decision as to whether legal action will help solve your problem.

Legal action involves suing the health care provider. He or she will usually be insured and the medical insurance fund will mainly direct how the practitioner handles the legal action.

Section 17: What can happen if I decide to take legal action?

The result of your legal action depends on the strength of your case and how you feel about going to court.

If you have a strong case the insurer may decide not to defend it and make an offer of settlement. You will then need to decide whether to accept this offer or still proceed to court.

If you feel strongly that everybody should know what happened to you and that the health care provider was negligent, you might not accept their offer and continue with the court case. *Before making that decision you would need to consult your lawyer.*

If the medical insurance fund considers that you do not have a strong case, it may decide to defend it in court. This could take a long time and may involve a lot of expense if you do not have Legal Aid or a solicitor who works on a contingency fee arrangement. You would need expert legal advice in this situation.

Sometimes a case can be settled even after the court hearing has commenced. The chances of this happening in your case should also be discussed with your lawyer.

In general, you should only decide to go to court to seek financial compensation after carefully considering all the issues and discussing them with your family/friends and your lawyer.

Section 18: Where to go for help if you are not satisfied with your health care – a Victorian consumer's guide

If you want to complain about your general treatment:

You can lodge a complaint about your general treatment or health care with any of the following organisations:

If you are a **Patient** in any **Public Hospital** or any of the following **Teaching Public Hospitals**:

- Royal Melbourne Hospital
- Royal Women's Hospital
- Alfred Hospital
- Austin Hospital
- St. Vincent's Hospital
- Monash Medical Centre

You can **Lodge a Complaint** with:

- the **Complaints Liaison Officer** or **Patient Advocate** by ringing the general hospital telephone number or by asking hospital staff to refer you to the Officer/Advocate;

- the **Victorian Department of Health and Community Services, Complaints Section**, Telephone: **(03) 9616 7777**.

If you are a **Public** or **Private Patient** of any **Health Care Provider** you can **Lodge a Complaint** with:

- the **Health Services Commissioner,** Telephone: **(03) 9655 5200**.

If you want to complain about professional conduct:

If you want to complain about your health care provider's **Professional Conduct** you can contact the **Registration Board** for that particular provider. For doctors, dentists and nurses these are:

Doctors:
The Medical Practitioners Board of Victoria Telephone: (03) 9616 8071

Dentists:
The Dental Board of Victoria Telephone: (03) 9654 7506

Nurses:
The Victorian Nursing Council Telephone: (03) 9616 8393

If you want information about privacy and health care:

If you want information about privacy and your health care or if you want information about your right to see health care records kept about you, contact:

- the **Federal Privacy Commissioner**
  Telephone: **(02) 229 7600**;

- the **Victorian Freedom of Information Office**
  Telephone: **(03) 9603 4720**.

If after contacting these organisations you are still dissatisfied with your health care or treatment:

For complaints about **Government Health Services** you can contact:

- the **Ombudsman of Victoria**
  Telephone: **(03) 9603 8811**;

- **Your Local Member of Parliament**
  Telephone: **(03) 9651 8911**.

If you have a mental illness or an intellectual disability or are elderly and incapacitated, you can in addition contact:

- the **Office of Public Advocate**
  Telephone: **(03) 9660 1444**.

If you need an interpreter:

If you need an **Interpreter** you can ask your doctor or hospital to arrange one or you can contact the:

- **Victorian Translating and Interpreting Service**
  Telephone: **(03) 9416 9999** or **1800 112 477**;

- **Victorian Ethnic Affairs**
  Telephone: **(03) 9412 6300**.

If you need legal advice:

If you need **Legal advice** or want a **Referral** to a lawyer you can contact:

- the **Legal Aid Commission of Victoria**
  Telephone: **(03) 9607 0234**;

- the **Law Institute of Victoria**
  Telephone: **(03) 9602 5000**.

Specialist Legal Services:

In Victoria there are a number of **Specialist Legal Services** for people with special needs:

- **Intellectual Disability**
  Villamanta Legal Service
  Telephone: **008 014 111**;

- **Mental Illness**
  Mental Health Legal Service
  Telephone: **(03) 9417 4599**.

Provider Information Guidelines

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What to do if your patient is not happy with your treatment or if something has gone wrong

Section 1: Introduction

Being a patient is a difficult time for anyone. Patients may be anxious, vulnerable, and *not at their best*.

People worried about their health can have **unrealistic expectations** of their doctors or other health care providers. They may expect that you will be able to *cure* whatever is wrong with them – to make them feel *better*. When that does not happen, they can feel very confused, let-down and upset.

Even if clinically they have achieved good results from your care, if the outcome is not what they expected, they may feel aggrieved.

If your patient does not have a good relationship with you then disappointment and sense of grievance can lead to a complaint about the care provided.

Good health care involves a **partnership**. Open and honest **communication** between the patient and provider of health care is the basis of a good relationship which is vital for accurate diagnosis and the implementation of a treatment plan. When effective communication breaks down a poor relationship, unsatisfactory outcomes often result.

In a good health care partnership, you and your patient understand the diagnosis and are committed to a treatment plan.

In this partnership, your role is to provide quality health care. You are expected to provide not only high quality clinical treatment, but to treat your patients kindly and sensitively, to listen to their wishes and concerns, and to explain carefully what is happening to them.

Your patients also have a role to play in their successful treatment. They should be encouraged to offer as much information as is relevant or necessary to make a diagnosis or provide care and be as clear as possible about their expectations of the health care you provide.

Most of the time, the partnership between you and your patient works well. In some circumstances, how well it works depends on a number of things, including whether you speak the same language as the patient, understand each others' culture, and how the patient perceives his or her illness.

But sometimes, things go wrong.

When the health partnership has not worked for your patients they might complain to you. They might feel you have not given enough information about treatment. They may be dissatisfied with your care, or believe it has caused an injury.

Most complaints can be resolved informally by you on the spot, if you take the time to deal with them appropriately.

However, if the complaint is serious, your patient might want to have his or her concerns investigated by an independent agency or Health Complaints Officer, established to deal with complaints about health care. He or she might also go to your professional registration board or to a lawyer.

It is important to recognise that errors are an integral part of complex procedures. The fact that something has gone wrong, or a mistake has been made, does not mean that you are incompetent.

This information guideline has been developed to help you deal with these situations and to avoid problems in the future. Using it is part of good **risk management**.

Section 2: Preventing complaints

Good communication is an essential part of good health care and the most effective way to preclude patient complaints. Good communication involves giving patients all the information they need to be active participants in planning in their own care. It also involves helping them to understand the information you give them. Informed consent and where appropriate, cross cultural communication, are central to good communication and the avoidance of misunderstandings which generate complaints.

This section sets out the entitlements of patients in relation to their health care and makes suggestions about how to make the most of working with your patients to minimise the chance of misunderstandings and complaints.

Informed consent and disclosure of risk

Before you commence any treatment or procedure on a patient you have a legal obligation to obtain *informed consent* from the patient. The only exceptions to this are express direction by the patient, in emergencies where intervention is necessary to preserve life or avoid serious harm, or where the person is an involuntary patient with a mental health problem.

If the patient does not give *informed consent* your treatment or procedure is an assault on the patient. This can have serious consequences for your reputation and may result in financial compensation if it involves either physical or psychological damage.

As well as being a legal requirement, it is in your interests to **disclose the risks as well as the benefits** of the treatment you propose. Even when you believe that the treatment is clinically necessary and in your patient's best interest, in most cases it is up to the patient to make that choice. **You must provide the information, but the patient must choose.** The final decision and the responsibility for the consequences of that decision must lie with the patient.

Sometimes, treatment has unpredictable results, or involves known risks. The patient will generally be better able to handle any problems that emerge if you have both discussed them beforehand and clarified the patient's concerns.

It is vital, for your sake as well as your patients', to communicate effectively. You need to allow your patients plenty of time to ask questions and express their concerns. You should remember that it is not a slight on your professional judgement if they ask for a second opinion. On the contrary, patients will respect you more if you accommodate their wishes. Sometimes, even if they do not ask for one, obtaining a second opinion before proceeding with treatment increases the patient's understanding of the treatment and their confidence in your care.

It is important to recognise that many complaints emerge from the different expectations patients and practitioners have of a particular treatment. As such, it is worthwhile spending time clarifying the patient's expectations and making sure the patient understands the possible consequences of the treatment and that he or she understands what is an acceptable outcome if the final result is not the expected *cure*.

The National Health and Medical Research Council (NHMRC) Guidelines for medical practitioners on providing information to patients are a useful guide to **best practice** in obtaining **informed consent**.

Where a treatment is very minor or the effects are self-evident it may not be necessary to provide all the details in the NHMRC Guidelines. But you should ensure that the patient has a clear picture of what you propose to do, why you propose the procedure, and the consequences of doing or not doing it. If you follow the NHMRC Guidelines you can be confident that you have provided the necessary information for your patient to give **informed consent**.

The NHMRC Guidelines recommend that you discuss the following with your patient before commencing treatment:

- the possible or likely nature of the illness or disease;

- the proposed approach to investigation, diagnosis and treatment:

  - what the proposed approach entails,
  - the expected benefits,
  - common side-effects and material risks of any interventions,
  - whether the intervention is experimental,
  - who will undertake the intervention;

- other options for investigation, diagnosis and treatment;

- the degree of uncertainty about the therapeutic outcome;

- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;

- any significant long term physical, emotional, mental, social, sexual or other outcome which may be associated with a proposed intervention;

- the time involved;

- the costs involved, including out of pocket costs.

Many practitioners are uncertain how much they should tell patients about the risks of treatment and fear that knowing all the very remote risks may deter patients from having necessary treatment. Since the High Court case of **Rogers v. Whitaker 1992**, you are required to disclose the risks of treatment that a patient in the circumstances would want to know. If the patient appears very anxious or has particular questions you must address his or her concerns no matter how remote the risk may be.

You cannot withhold information from a patient for fear that the patient would refuse treatment.

If you are uncertain about disclosure of risks you should follow the NHMRC Guidelines. These note that:

Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare.

A doctor's judgement about how to convey risks will be influenced by:

- the seriousness of the patient's condition, for example, the manner of giving information might need to be modified if the patient is too ill or badly injured to digest a detailed explanation;

- the nature of the intervention, for example, whether it is complex or straightforward, or whether it is necessary or purely discretionary. Complex interventions require more information, as do interventions where the patient has no illness;

- the likelihood of harm and the degree of possible harm. More information is required the greater the risk of harm and the more serious it is likely to be;

- the questions the patient asks. When giving information, doctors should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the doctor to find out what is important to the patient;

- the patient's temperament, attitude and level of understanding. Every patient is entitled to information, but these characteristics may provide guidance to the form it takes;

- current accepted medical practice.

Cross cultural communication

Patients cannot give informed consent unless they understand the information you give to them. Many **non-English speaking background (NESB) patients** will have difficulty understanding your medical explanations even if they cope reasonably well with English for everyday matters. Where you have any doubts about the capacity of a patient to follow your explanation of the diagnosis, treatment and risks and benefits of a procedure, you should arrange for an interpreter to be present at the consultation.

Many patients will come to the surgery with a family member who may speak better English than they do. **While it may be convenient to rely on the family member to interpret for you this is not good practice and should be avoided.**

Your patient has a right to privacy. Some patients will be embarrassed discussing sensitive medical matters with a family member particularly of the opposite sex. Others will want to protect their family from the seriousness of the condition. Others may be fearful of the family's reaction to a particular condition.

You need to be sensitive to these matters and unless the patient can assure you that he or she is happy for the family member to interpret, you should postpone any discussion about highly personal or complex matters until you can arrange for a qualified interpreter to assist.

Some NESB patients will have a history of personal dislocation and trauma. They may be refugees or survivors of torture. These experiences may affect their expression of symptoms and their acceptance of particular treatments. If you are likely to be treating a number of people with these characteristics you might find it helpful to talk to specialist services such as the **Centre for Ethnic Health** about their special needs.

Details about these services are included in Section 10 of this guideline.

Patient access to records about their health care

Good professional practice requires that you keep clear and factual patient notes.

Patient records should contain only relevant information and be *free of unnecessary comments* which might be offensive to the patient. Not only is this part of providing good quality care, it will also be very important if the patient makes a complaint or legal action is involved. Good records can protect you, as they can provide evidence of the quality of your care and be the key to a strong legal defence.

A patient may want to know what is recorded about his or her medical treatment. Although medical records remain the doctor's property, greater emphasis on patient autonomy has led to review of laws dealing with patient access to health care records.

Public hospitals and community health centres are subject to **Freedom of Information** (FOI) laws, which gives all members of the community the right to access files and records containing personal information about them. There are some exceptions, such as where you think that disclosure would be harmful to the patient's health, or dangerous to someone else.

The FOI laws also give private patients a right to access their medical records where these are held by the Commonwealth Government or a State/Territory Government.

Also, when the records of a private health practitioner or private hospital are the subject of a subpoena from a Court, you must make them available to the patient or the Court.

It can be in your interest to give patients access to records about their health care, even when you are not obliged to do this – unless, of course, you believe that to do so would damage their physical or mental health.

Making health care records available to a disgruntled patient seeking information, can reduce the patient's anxiety and diffuse a potentially difficult situation. People who are denied access to their records can become suspicious and think you have something to hide. They could take legal action, simply to get access to their records.

The international evidence on the factors which contribute to medical negligence claims suggests that **releasing patient records can decrease the likelihood of a patient taking legal action**. If you are open with patients and share the information in files with them you are more likely to sustain a good relationship with them and reduce the likelihood of their confusion generating a complaint and a complaint escalating into legal action.

Even if you consider that giving the record itself to the patient is not appropriate, you should always be prepared to provide a summary of the record, in language which the patient can understand, or make the record available to another doctor of his or her choosing who can make a summary report for them.

If you are uncertain about releasing a medical record, you should check with your indemnity organisation or professional association. It will have policies and advice on releasing medical records to patients.

Confidentiality

Confidentiality between you and your patient is essential if you are to develop a partnership based on trust. It is important for good health care that your patient feels able to tell you the most private and sensitive things relevant to treatment in complete confidence.

Whilst you must respect this confidence, there are some situations in which you will have to make information about the patient available to other people.

You are obliged to report certain conditions such as sexually transmitted diseases to a central register even without your patient's consent.

In a hospital there may be many people caring for a patient who need information about them. But they have no authority to pass this information on to anyone who does not have a clear role to play in providing patient care.

Other people such as police, lawyers, social workers, or government officials like the Public Advocate may request information as part of an investigation they are carrying out or a case they are preparing. In some circumstances you have a legal obligation to provide information even though your patient has not consented to its release.

If you are uncertain about your duty to provide or withhold patient information where the patient has not consented to its release, you should contact your indemnity organisation or professional association and seek advice.

Sometimes medical scientists will want to study a particular illness or type of treatment affecting your patient. They may want access to information about the patient's condition or treatment as part of a research study.

In Australia no medical research can be carried out unless it has been approved by the **Ethics Committee** of a hospital or some other health facility. The Ethics Committee applying the NHMRC's guidelines on privacy in medical research will impose strict conditions on what information can be obtained and how it is to be managed to ensure that your patient is not identified and that information about him or her is kept secure and only accessed by approved researchers. *These conditions protect your patient's confidentiality but in most cases you should not release information to a researcher unless your patient has given consent.*

If you work for the Commonwealth Government or an Australian Capital Territory department or agency, you should become familiar with your responsibility to protect patient's personal information. The **Federal Privacy Act 1988** safeguards personal health information collected by Commonwealth and Australian Capital Territory agencies, and sets out principles of privacy which cover access to records, their accuracy, and use and disclosure by others. Patients may complain to the **Privacy Commissioner** if these are breached.

Section 3: Situations where a complaint may be made

There are lots of reasons why patients might complain about their health care. The most common situations in which patients complain include:

- they are not satisfied with the results of their treatment;
- they feel they have been treated badly;
- they have been injured or suffered harm from their health care.

A patient unhappy with the outcome of his or her health care may experience a mixture of emotions. He or she may feel confused, disappointed, vulnerable or angry. He or she may not be clear about the most appropriate way of dealing with an adverse outcome and may be uncertain about what it is he or she wants to achieve.

How you deal with the early stages of the process of working through the patient's response to an adverse outcome can influence him or her in formulating goals. If you are rude or off-hand or perceived to be unsympathetic when a patient is feeling let-down or devastated, your attitude can convert distress into litigation.

The action the patient takes will depend on the result he or she ultimately wants to achieve.

A dissatisfied patient may have one or a number of the following goals:

- to find out what happened;
- to get some acknowledgment or apology from you for the difficulties;
- to be compensated for the financial burdens caused by the injury or slower than expected recovery;
- to ensure that what happened does not happen to anyone else.

A patient dissatisfied about a health care outcome can:

- complain directly to you;
- lodge a complaint with a complaints authority such as the Health Care Complaints Commission in New South Wales, the Health Complaints Commission in the Australian Capital Territory, the Health Rights Commission in Queensland, or the Health Services Commission in Victoria;
- lodge a complaint with a professional registration board;

- seek legal advice on possible court action.

The following information is designed to help you deal with different cases and to suggest what you can do to help resolve an issue to everyone's satisfaction.

Notifying your indemnity organisation/insurer

You should always advise your defence organisation or insurer (or your employer if you are employed) where a patient is unhappy about a treatment outcome. On other occasions whilst you know that an outcome may not be ideal, the patient may not be immediately aware of this. Where a complaint could possibly be made you should notify your indemnity organisation/employer.

There are three key situations in which you should notify your indemnity organisation or employer about a case. These are where:

- a patient complains about your treatment or management of his or her health care and this may have legal implications;

- a *significant* incident has occurred even though the patient has not complained;

- you are uncertain about your obligations such as whether to release information to third parties.

It is important to alert your indemnity organisation/insurer or your employer as soon you are aware that an incident or outcome could lead to a complaint.

If a formal complaint against you has been lodged, you should notify your indemnity organisation immediately. It will have suggestions and procedures for dealing with patient complaints and can give you confidential advice on whether your actions are defensible and how you should respond.

If you are employed, you are probably indemnified as an employee through your employer's insurance policy. This is an alternative to drawing on your personal insurance policy, or your membership of an indemnity organisation where you are employed by another organisation but have both personal and employer provided insurance.

If you are indemnified by your employer, you should find out what the insurance policy allows you to say to the patient about the issue. Saying sorry or giving a factual account of what happened is not an admission of liability. It may help in dealing with an upset patient.

Section 4: Managing complaints

A complaint may be made about the treatment or care provided in a health care facility, like a hospital, or by a private practitioner. Some complaints can be handled informally. Others

require more formal processes, in particular complaints involving a Health Complaints Authority, or a Registration Board, or the legal system.

Complaints to a health care facility

In a hospital, day procedure centre or other health care facility, clear procedures should be established to handle complaints. These procedures should focus on addressing patients' concerns promptly, sympathetically, and in a way which respects their rights.

If you receive a complaint and you work in a facility like a hospital, you should be supported by proper procedures, and advice and training on responding to it.

Complaints systems should be **accessible** to patients and staffed by skilled people who understand their role. If possible, complaints should first be referred to the treating staff, who in turn should be trained to deal with complaints. **Health complaints officers** can also help staff resolve complaints.

Hospital management should demonstrate their commitment to these processes and ensure that information gained from complaints is used in quality assurance and risk management programs. *The information can prove extremely useful in improving the design and delivery of services.*

Complaints to an individual practitioner

When a patient's complaint is directed to you as an **individual practitioner**, it is in your interest to handle the matter from the beginning, in a way that will increase the chance of resolving the issue on the spot. This means being open, sensitive to the patient's concerns, and courteous, particularly when the patient is likely to be distressed.

Dealing with stressed patients

In dealing with patients who are dissatisfied with the results of their treatment, you should remember that they may believe that you, as their practitioner, could have prevented the problem. They may be angry, crying, in shock, frightened, or nervous. Different cultural backgrounds and beliefs are also likely to influence the way people react.

You may feel their complaints are unfair or their expectations about a better outcome unreasonable. You too may be disappointed about the outcome and feel anxious about the patient's reaction.

However, you are trained to deal with **difficult situations** and, even though you might feel uncomfortable or angry, you need to stay in control of your own feelings and allow the patient to express his or her feelings and to complain to you. The more a person is able to express frustration or dissatisfaction initially, the easier it will be to deal with later.

You should remain calm and sympathetic and listen to the patient, even if you think he or she is being difficult or unreasonable.

You should assure the patient that you are listening attentively and reflect back what has been said. It may help to acknowledge, in a sympathetic manner, that you understand that he or she is going through a difficult experience.

If you can encourage the patient to explain his or her understanding of the situation you might create an opportunity to clarify a misapprehension. It is likely to help if you do not interrupt while they talk.

A patient's body language can offer clues to his or her thinking and yours can indicate sympathy, genuine concern, disinterest or defensiveness. Maintaining eye contact and using effective listening skills can reassure a patient that you are taking their concerns seriously and that you understand the problem from their point of view. This approach can promote an attitude of *working together* to resolve the problem.

A hurried discussion, evasive answers to questions or an off-hand attitude can prompt an already dissatisfied patient to take his or her problem to someone who will listen. This could be a Health Complaints Authority or a lawyer.

People can only take in a limited amount of information when they are upset. In some cases you could draw a diagram explaining the situation for the patient to take home, or you can encourage him or her to write things down.

It is also wise to make another appointment to see the person the next day or soon afterwards to explore any further issues. The more you can do at the beginning, the less will need to be done later on.

It is also important to use interpreters if patients are not comfortable expressing themselves in English. You need to be sensitive to the patient's family situation and involve them in the discussion if this is appropriate.

Responding to the patient's questions

Most, if not all of the indemnity organisations/insurers in Australia, now encourage their members or clients to provide a full explanation to a patient who complains and where appropriate, an apology in the event that something has gone wrong. Such an explanation should *not* include an admission of liability.

There is a difference between **apologising**, and admitting **legal liability** in the event of an adverse outcome. Explaining how an unwanted outcome occurred, acknowledging that a patient is unhappy with an outcome and expressing concern about the difficulties experienced by the patient as a result of the outcome, is not an admission of liability in the sense of accepting blame. For example, "I did it – it is all my fault", may be admitting liability. "I am really sorry that this happened to you. It happened because ....", is not.

The patient should be given a **factual account** of what happened in a way which respects their culture and in a language they understand. You may need to involve a qualified interpreter in your discussions. If there are mitigating factors, it will do no harm to mention them.

Your attitude should show that you regret that a problem has been caused. Your patient will appreciate a genuine apology. Saying you are sorry that this has happened, without implying that you are responsible for it, is common courtesy and *does not* constitute an admission of liability.

It might help to offer a written apology, including brief details of what steps will be taken to help minimise the damage and limit the chance that it will happen again.

You may also wish to refer your patient to other sources of advice or information, or suggest a second expert opinion which could reinforce your explanation. However, you need to be cautious about nominating specific practitioners, as such referrals can be misconstrued as collusion. It would be better to nominate an independent eminent specialist rather than your partner in the practice. Alternatively, you could offer to refer them to a doctor of their choice.

If you show your regret that they should have experienced such a bad result, empathise with their pain and anxiety, and give them a factual explanation of what happened, you will not be exposing yourself to any particular increased legal risk, and will be doing a lot to reduce it.

International research suggests that patients whose concerns are taken seriously at the beginning are less likely to take legal action later on. If they are listened to, given the information that they are looking for without delay, and receive an acknowledgment that the outcome is less than expected, they are less likely to sue.

Action where a patient refuses to talk to the practitioner

In some situations, relations between you and your patient could deteriorate to the point where he or she is no longer willing to talk to you. In these circumstances, you may wish to involve an independent third party. In this way, lines of communication might be re-established, which can help resolve the situation.

In States/Territories with a **Health Complaints Authority**, you could suggest that the patient contact the Authority and consider conciliation. In a hospital, the **Patient Advocate** or **Complaints Officer** may assist as a mediator. *Details about these organisations are included in Section 10 of this guideline.*

Section 5: Formal mechanisms for dealing with complaints

A patient who is still dissatisfied after discussing the complaint with you has a number of options. He or she can go to one of several formal bodies responsible for dealing with complaints about health care. The dissatisfied patient can:

- complain to a Hospital Complaints Officer;
- complain to the independent statutory Health Complaints Authority in some States/Territories;
- lodge a complaint with a Registration Board;
- take legal action.

The result for the patient and the likely outcome for you, as the provider, will depend to some extent on which avenue the patient chooses to pursue his or her complaint.

Section 6: Hospital Complaints Officer

Under the Medicare Agreement, the States/Territories have made an agreement with the Commonwealth Government to develop **Public Patients' Hospital Charters**. The charters must include information explaining how people can lodge complaints and how complaints will be dealt with independently. This is usually done by a **Hospital Complaints Officer**.

Patients dissatisfied with their hospital treatment can complain to the **Hospital Complaints Officer** or seek help from a **Patient Advocate**. The patient may be referred back to you for information to explain why the result occurred. The Complaints Officer may also investigate the complaint in accordance with established hospital procedures.

Section 7: Independent Health Complaints Authorities

A patient who does not want anyone else to put up with the kind of treatment he or she has had or who is still dissatisfied after talking to you may complain to a **Health Complaints Authority**.

Under the Medicare Agreement the Commonwealth Government requires all States/Territories to establish independent Health Complaints Authorities which have powers to resolve complaints by consumers about public hospital services.

The Health Complaints Authorities also have a role in systemic change and in improving health care systems by recommending improvements in health services based on information from patient complaints. So far, New South Wales, the Australian Capital Territory, Queensland, and Victoria and have established complaints authorities which deal with complaints about public and private health care. *A list of these services is included in Section 10 of this guideline.*

Health Complaints Authorities are independent, and usually report to Parliament. They generally have quite extensive legal powers to investigate, or inquire into a complaint, but these powers are not used in every case. They are only used where the complaint is serious, and the Authority cannot get the required information in any other way. They do not themselves have powers to make a legally enforceable decision about who is right or wrong but they may take the complaint or refer it to a Board or tribunal which can.

If your patient complains to a Health Complaints Authority, the Authority will probably contact you to obtain your side of the story. You are not obliged to co-operate with the Authority at this stage. However, it will be in your best interests to do so, as this is often the most successful and least stressful method of clarifying the situation. If the complaint is not resolved at that point, you might become involved in an investigation to find out what happened, and if you agree, in conciliation.

The purpose of conciliation is to try and resolve the complaint between you and the patient. It is voluntary and informal. *Discussions occurring in conciliation are confidential and cannot be used in legal proceedings.*

In most States/Territories when a complaint is lodged, the Health Complaints Authority will refer it to your **Registration Board** if it involves possible disciplinary action against you. However in New South Wales, the Health Care Complaints Commissioner will investigate and prosecute breaches of professional standards.

Powers of a Health Complaints Authority

The Health Complaints Authorities have different powers in different States/Territories but generally they can resolve a complaint by obtaining an apology from you or assisting in the formulation of an agreement for financial or other compensation. If they hold a formal

investigation they can also reach conclusions about the care you provided and make recommendations.

Apology

An apology or acknowledgment that the care was not satisfactory or the outcome of a procedure not ideal, is sometimes all a dissatisfied patient will seek from you or your hospital.

A concern that the problem be acknowledged and that it should not recur motivated the family to complain in the following case:

> A surgery patient (male) who was on very high doses of morphine for pain relief was re-admitted to hospital at the weekend. The specialist who was treating the patient was not on duty and the patient was put under the care of a junior doctor. The patient's family asked that he be given his usual high dose of morphine but the attending doctor considered that this was excessive or even dangerous and refused. The patient was in great pain and the family requested the staff to contact the specialist to get approval for the higher dose but this was also refused as the staff did not want to disturb him at home. On the following Monday the specialist returned and was very concerned at the patient's treatment and immediately increased the morphine.
>
> The family complained to the Health Complaints Authority which took the matter up with the specialist and the hospital. The hospital apologised to the patient and the family for the distress they had suffered and introduced new procedures to ensure that the problem did not recur.

Financial compensation

The Health Complaints Authority can also negotiate financial compensation where you and your indemnity organisation agree to the complaint being resolved by the Authority as an alternative to going to court.

In the following case financial compensation negotiated by the Health Complaints Authority satisfied the patient's family without recourse to court:

> A child with a hearing defect was admitted for minor corrective surgery at the same time as a child with a different ear problem requiring different surgery. Although both children were provided with identifying arm and leg tags no one checked the name of the child with the hearing defect and she was treated with the procedure intended for the second child. When the mistake was discovered she had to undergo a second operation in twenty four hours to overcome the effects of the wrong surgery.
>
> Her parents complained to the Health Complaints Authority which negotiated a financial settlement covering all their immediate medical

expenses, future medical expenses and general pain and suffering for both the parents and the child. The settlement was based on the acknowledgment that the hospital staff had been negligent in not following proper procedures to identify patients for surgery.

Other compensation

Where it is not clear that you or anybody is responsible but an adverse outcome has followed treatment, the Health Complaints Authority can sometimes negotiate an agreement to provide needed services to the patient if there is good will all-round.

In the following case there was no proof that the doctors or hospital had been negligent. The outcome, although very serious for the patient, was not clearly the result of anyone's incompetence or failure to follow proper procedures:

> A woman went into the operating theatre for a straightforward back procedure. She came out paralysed but there was no proof that the operation was connected to or caused the paralysis. The hospital while not acknowledging that it was in any way responsible, arranged for her to have personal services and modifications to her house to make her as comfortable and independent as possible.

This is an unusual case as the investigations usually have to show that you or your colleagues were responsible before compensation can be negotiated.

Section 8: Registration Boards

If you are a registered health professional, patients may lodge a complaint concerning your professional conduct directly with your professional Registration Board. In some States/Territories your complaint may be referred to the Registration Board by the Health Complaints Authority. For doctors this will be the Medical Board.

The primary role of registration boards and tribunals is to **protect the public**. They are made up of members of the profession and sometimes a lawyer or non-professional representative.

When a complaint is received, the Registration Board can deal with it in a number of ways either by investigating it or referring it to another suitable body. An example of how a Registration Board functions is that of the Medical Board in Victoria. In dealing with complaints the Medical Board can:

- forward it to the doctor for comment where there is no *prima facie* case of serious professional misconduct;
- refer it to the Health Services Commissioner if it appears appropriate for conciliation;

- refer it to the Registration Board's Investigating Officer (a doctor) for investigation;
- refer it directly to the Registration Board for consideration or an inquiry;
- refer it to the Government Solicitor in preparation for a formal disciplinary inquiry.

In investigating a complaint or conducting a hearing to determine whether you have maintained proper professional standards of practice the Registration Board does not assess whether you have been **negligent** in a legal sense, and the hearing does not result in compensation for patients.

All complaints are considered at a meeting of the Registration Board. Some of these will be resolved between doctor and patient or by the Health Complaints Authority. Other serious complaints may be the subject of an inquiry by the Registration Board.

At an inquiry hearing you are entitled to be legally represented. The patient may be called to give evidence but will not be represented. The Registration Board itself may be assisted by a lawyer.

Unlike other States/Territories, in New South Wales the Health Care Complaints Commission investigates every health complaint and prosecutes medical practitioners before the Medical Tribunal.

Powers of Registration Boards

Registration Boards have a range of powers from reprimand to deregistration. For example, in Victoria if a complaint is upheld the Medical Board can take one or more of the following actions:

- reprimand
- fine
- impose conditions on a practising certificate
- suspend from practice
- remove from the register, that is, deregister the practitioner.

The powers of a Registration Board are significant. However the Registration Board cannot order the payment of financial compensation to a patient who complains. Compensation can only be ordered by a court or negotiated by a Health Complaints Authority or by a lawyer who settles a legal case against you.

Section 9: Legal action

If your patient wants to be compensated for the harm he or she has suffered, he or she may decide to take legal action against you.

This can be very stressful and difficult for you. Cases may take years to finalise and can cost a lot of your time and money. The process is likely to be distressing and you might feel that your professional reputation is damaged. You may also find that things affect you very personally. If you find yourself in this situation, try to remain objective and understand that the patient is not necessarily out to get you. Instead, he or she is using the legal system to get compensation for the damage caused.

Patients may take legal action to obtain financial compensation in two situations:

- where they believe they have been damaged by your negligence;
- where they believe there was no informed consent for a procedure.

Negligence

In the legal system, the word **negligence** does not have the same meaning as it does in ordinary every day speech. To succeed in a case of medical negligence, a patient must show that you as a health care provider had a duty of care to him or her and that you breached that duty. A *slip or error* is enough in some cases to constitute such a breach.

The patient must also show that he or she has **suffered damage** which is quantifiable in financial terms.

Finally, the patient must establish that there was negligence as defined by the law, that is, that the practitioner has exercised **inadequate care**, or has fallen below the required standard of competence on that occasion and that the negligent act was the cause of the harm experienced by the patient.

Negligence can arise from your failure to act as well as from your active treatment. A doctor could be negligent in any aspect of medical practice such as:

- failing to diagnose when tests have been carried out, that is, misunderstanding a CT scan or nerve conduction tests or an ultrasound;
- failure to refer for specialist advice;
- failure to screen for reversible conditions such as not recommending a Pap smear where a delay in diagnosing cervical cancer may result;
- failure to treat competently such as not prescribing a necessary drug;
- failure to warn of the dangers of a drug especially in pregnancy or of the risks of a procedure.

Research indicates that it is actually quite difficult for a patient to establish a legal entitlement to compensation for negligence. Less than half of all medical negligence claims result in payment of compensation to the patient.

An action for negligence is a *civil* action. It has nothing to do with proof of criminal guilt.

Even if the court finds that legally you are negligent in a specific case and awards financial compensation to your patient, you are not guilty in a *criminal* sense. Nor have you been found guilty of professional misconduct.

Although you may be the subject of legal action, it does not necessarily follow that you are an inadequate practitioner. The incident, although classed as legally negligent may be the result of understandable human error, rather than an act which clearly demonstrates a pattern of incompetence. Very few cases actually reach court. Either the patient decides not to proceed, or your lawyer (or your insurers' lawyer) advises that the patient does have a strong case and suggests settling out of court to save time, stress, and money.

Settling a case out of court does not mean that you have been found, or have admitted to, negligence or incompetence. If a case is settled out of court, it will nearly always involve a **confidentiality clause**, preventing the release of any details of the case, the names of the parties, the amount involved, or even that settlement was reached. In contrast, a trial in a court is always public. You should bear this in mind when discussing with your indemnity organisation/insurer or legal adviser whether to settle the case or go to trial.

Even if the patient is successful, it is important to remember that the size of an award does not reflect the extent of the practitioner's legal negligence. The size of the award is determined by the degree of damage the plaintiff has suffered and the financial cost of making amends. A very small mistake may still result in your insurer making a large payout if the patient's injury has been severe or had lasting results. The amount of money awarded reflects the needs of the patient not your moral culpability.

Absence of informed consent

In certain circumstances your patient can also take legal action for medical trespass or assault where he or she claims that no informed consent or insufficient consent was given for the procedure.

A patient could successfully argue that he or she did not give informed consent where the surgeon amputated the wrong leg. This may seem an extreme case but the example above of the child undergoing the wrong ear surgery is a similar case. Another example of how a procedure can take place without the patient's consent is the following:

> A consultant was doing his ward rounds accompanied by a group of students. He approached a patient who was unknown to him and without any discussion proceeded to perform a rectal examination for the observation of the students. The patient was outraged and felt his privacy had been invaded. He suffered psychological effects and lodged a complaint about the assault.

Whilst this is a case in which the patient could never be expected to gain any benefit from the unwanted procedure, in other cases even if you believe that it is in the patient's interest to have the procedure, if you act without informed consent you can be sued as the following case demonstrates:

> A patient was undergoing surgery for the removal of bunions from his feet when the surgeon observed that he had *clawed* toes. He proceeded to straighten the toes reasoning that it was in the patient's interest to have this procedure done when he was already under an anaesthetic and so avoid the necessity of having another anaesthetic at a later date. The patient had consented to the bunion removal but as there had been no discussion of the state of his toes he had not consented to that procedure. He suffered extra pain and suffering from the procedure and claimed damages for assault.

These cases where there was no informed consent at all are very unusual and rarely go to court. Most of the cases involve a dispute about the extent of the consent.

The issue of inadequate informed consent usually only arises as part of a negligence case.

It can be a factor in a medical negligence claim such as where a patient agrees to cosmetic surgery or breast reduction surgery but has not been told the full risks of scarring which may result and later sues for disfigurement caused by the scars arguing that if the full risks were known she would not have undergone the surgery.

Unlike a negligence action, to succeed in a medical assault case the patient only has to show that the procedure took place and that there was inadequate consent and that damage has resulted. This can be hospital expenses, loss of wages or pain and suffering.

The patient does not have to show that you acted unreasonably or that in carrying out the procedure or treatment you failed to follow established procedures or that you fell below acceptable professional standards. *However informed consent is usually only one of a number of issues considered by a court in deciding negligence claims. It is rarely the main issue in contention.*

The field of medical law is complex and you should always receive expert legal advice about any legal action brought by a patient. In addition, you should consult your indemnity organisation/insurer on any medico-legal action in which you may become involved.

Section 10: Medical practitioner's information guide to dealing with an adverse treatment outcome – A Victorian practitioner's guide

Contacting your medical indemnity fund or insurer:

You should know the telephone **"Hot Line"** number to your indemnity organisation/insurer and use it even after hours to obtain advice where:

- a treatment **Could lead to a complaint**;
- a **Patient has Complained** about your care or treatment;
- **Legal Action is commenced** against you;
- you are uncertain about **Releasing Patient Information** to the patient or anyone else.

The Hot Line for my Medical Indemnity Fund is: .....

Obtaining advice from professional organisations:

You can obtain advice on your professional rights and responsibilities:

- from your **Professional Association**. Doctors in Victoria you can ring the **"Hot Line"** of the Victorian Branch, **Australian Medial Association** on **(03) 280 8722**.

Complaints bodies which assist dissatisfied patients:

A dissatisfied patient can complain to the:

- public hospital **Complaints Officer** or a **Patient Advocate**;

  The telephone number for the Complaints Officer or Patient Advocate in my hospital is: .....

- **Health Services Commissioner**
  Telephone: **(03) 9655 5200**;

- **Medical Board of Victoria**
  Telephone: **(03) 9616 8071**;

- **Federal Privacy Commissioner**
  Telephone: **(02) 229 7600**;

- **Victorian Freedom of Information Office**
  Telephone: **(03) 9603 4720**;

- **Office of Public Advocate**
  Telephone: **(03) 9660 1444**.

  This agency will specifically assist people with an intellectual disability, a mental illness, brain damage or dementia.

Interpreter Services:

You should try to use **Professional Interpreters** when your patient has difficulty communicating in English. There should be professional interpreters in your hospital. If not, use the following services which should also be used by all private practitioners:

- the **Victorian Translation and Interpreting Service**
  Telephone: **(03) 9416 9999** or **1800 112 477**;

- the **Victorian Ethnic Affairs Commission**
  Telephone: **(03) 9412 6300**.

Cross cultural information and training groups:

Contact your professional association or Division of General Practice for information on organisations which can assist you in dealing with patients from a different culture.

The following may also assist:

- the **Centre for Ethnic Health**
  Telephone: **(03) 9427 8766**;

- the **Transcultural Psychiatry Unit**
  Telephone: **(03) 9417 4300**.

  This agency will specifically assist NESB patients with a suspected mental illness.

If you have patients with an intellectual disability, mental illness, brain damage or dementia, you can obtain advice on your responsibilities from:

- the **Office of Public Advocate**
  Telephone: **(03) 9616 1444**.

Appendix E : Information privacy principles under the Commonwealth *Privacy Act 1988*

Principle 1: Manner and purpose of collection of personal information

1. Personal information shall not be collected by a collector for inclusion in a record or in a generally available publication unless:

(a) the information is collected for a purpose that is a lawful purpose directly related to a function or activity of the collector; and

(b) the collection of the information is necessary for or directly related to that purpose.

2. Personal information shall not be collected by a collector by unlawful or unfair means.

Principle 2: Solicitation of personal information from individual concerned

Where:

(a) a collector collects personal information for inclusion in a record or in a generally available publication; and

(b) the information is solicited by the collector from the individual concerned;

the collector shall take such steps (if any) as are, in the circumstances, reasonable to ensure that, before the information is collected or, if that is not practicable, as soon as practicable after the information is collected, the individual concerned is generally aware of:

(c) the purpose for which the information is being collected;

(d) if the collection of the information is authorised or required by or under law – the fact that the collection of the information is so authorised or required; and

(e) any person to whom, or any body or agency to which, it is the collector's usual practice to disclose personal information of the kind so collected, and (if known by the collector) any person to whom, or any body or agency to which, it is the usual practice of that first-mentioned person, body or agency to pass on that information.

Principle 3: Solicitation of personal information generally

Where:

(a) a collector collects personal information for inclusion in a record or in a generally available publication; and

(b) the information is solicited by the collector;

the collector shall take such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is collected:

(c) the information collected is relevant to that purpose and is up to date and complete; and

(d) the collection of the information does not intrude to an unreasonable extent upon the personal affairs of the individual concerned.

Principle 4: Storage and security of personal information

A record-keeper who has possession or control of a record that contains personal information shall ensure:

(a) that the record is protected, by such security safeguards as it is reasonable in the circumstances to take, against loss, against unauthorised access, use, modification or disclosure, and against other misuse; and

(b) that if it is necessary for the record to be given to a person in connection with the provision of a service to the record-keeper, everything reasonably within the power of the record-keeper is done to prevent unauthorised use or disclosure of information contained in the record.

Principle 5: Information relating to records kept by record-keeper

1. A record-keeper who has possession or control of records that contain personal information shall, subject to clause 2 of this Principle, take such steps as are, in the circumstances, reasonable to enable any person to ascertain:

(a) whether the record-keeper has possession or control of any records that contain personal information; and

(b) if the record-keeper has possession or control of a record that contains such information:

(i) the nature of that information;

(ii) the main purposes for which that information is used; and

(iii) the steps that the person should take if the person wishes to obtain access to the record.

2. A record-keeper is not required under clause 1 of this Principle to give a person information if the record-keeper is required or authorised to refuse to give that information to the person under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.

3. A record-keeper shall maintain a record setting out:

(a) the nature of the records of personal information kept by or on behalf of the record-keeper;

(b) the purpose for which each type of record is kept;

(c) the classes of individuals about whom records are kept;

(d) the period for which each type of record is kept;

(e) the persons who are entitled to have access to personal information contained in the records and the conditions under which they are entitled to have that access; and

(f) the steps that should be taken by persons wishing to obtain access to that information.

4. A record-keeper shall:

(a) make the record maintained under clause 3 of this Principle available for inspection by members of the public; and

(b) give the Commissioner, in the month of June in each year, a copy of the record so maintained.

Principle 6: Access to records containing personal information

Where a record-keeper has possession or control of a record that contains personal information, the individual concerned shall be entitled to have access to that record, except to the extent that the record-keeper is required or authorised to refuse to provide the individual with access to that record under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.

Principle 7: Alteration of records containing personal information

1. A record-keeper who has possession or control of a record that contains personal information shall take such steps (if any), by way of making appropriate corrections, deletions and additions as are, in the circumstances, reasonable to ensure that the record:

(a) is accurate; and

(b) is, having regard to the purpose for which the information was collected or is to be used and to any purpose that is directly related to that purpose, relevant, up to date, complete and not misleading.

2. The obligation imposed on a record-keeper by clause 1 is subject to any applicable limitation in a law of the Commonwealth that provides a right to require the correction or amendment of documents.

3. Where:

(a) the record-keeper of a record containing personal information is not willing to amend that record, by making a correction, deletion or addition, in accordance with a request by the individual concerned; and

(b) no decision or recommendation to the effect that the record should be amended wholly or partly in accordance with that request has been made under the applicable provisions of a law of the Commonwealth;

the record-keeper shall, if so requested by the individual concerned, take such steps (if any) as are reasonable in the circumstances to attach to the record any statement provided by that individual of the correction, deletion or addition sought.

Principle 8: Record-keeper to check accuracy etc. of personal information before use

A record-keeper who has possession or control of a record that contains personal information shall not use that information without taking such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is proposed to be used, the information is accurate, up to date and complete.

Principle 9: Personal information to be used only for relevant purposes

A record-keeper who has possession or control of a record that contains personal information shall not use the information except for a purpose to which the information is relevant.

Principle 10: Limits on use of personal information

1. A record-keeper who has possession or control of a record that contains personal information that was obtained for a particular purpose shall not use the information for any other purpose unless:

(a) the individual concerned has consented to use of the information for that other purpose;

(b) the record-keeper believes on reasonable grounds that use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person;

(c) use of the information for that other purpose is required or authorised by or under law;

(d) use of the information for that other purpose is reasonably necessary for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue; or

(e) the purpose for which the information is used is directly related to the purpose for which the information was obtained.

2. Where personal information is used for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue, the record-keeper shall include in the record containing that information a note of that use.

Principle 11: Limits on disclosure of personal information

1. A record-keeper who has possession or control of a record that contains personal information shall not disclose the information to a person, body or agency (other than the individual concerned) unless:

(a) the individual concerned is reasonably likely to have been aware, or made aware under Principle 2, that information of that kind is usually passed to that person, body or agency;

(b) the individual concerned has consented to the disclosure;

(c) the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or of another person;

(d) the disclosure is required or authorised by or under law; or

(e) the disclosure is reasonably necessary for the enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue.

2. Where personal information is disclosed for the purposes of enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the purpose of the protection of the public revenue, the record-keeper shall include in the record containing that information a note of the disclosure.

3. A person, body or agency to whom personal information is disclosed under clause 1 of this Principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.

Appendix F : Terms of reference of the Compensation Review

1. To examine and report to the Minister for Health, Housing and Community Services on the relationship between current compensation and common law arrangements, and the general health care system.

2. To examine and report to the Minister for Health, Housing and Community Services on the relationship between current compensation and common law arrangements, and other areas of portfolio responsibility.

3. To develop a range of options to address any difficulties identified under terms of reference 1 and 2. Consultation will be undertaken with State and Territory Governments, as well as other relevant organisations, agencies and individuals as necessary.

4. To make recommendations to the Minister for Health, Housing and Community Services on the feasibility, appropriateness, and estimated costs and benefits of the options identified in term of reference 3.

Appendix G : Court management reform initiatives in Australian States

A. Case flow management in New South Wales

History

In late 1988, the New South Wales (NSW) Supreme Court established a Delay Reduction Committee to examine the question of case management and delay reduction. A number of strategies and procedures have since been used to improve case disposition and management:

- the appointment of a single list judge to monitor every aspect of the Common Law Division;
- the establishment of monthly statistics;
- the adoption of firm adjournment policies;
- the adoption of arbitration as a supplementary means of resolving matters; and
- the introduction of case flow management.

Differential Case Management

All proceedings commenced after 1 January 1994 in the Common Law Division of the Supreme Court of NSW are managed under a system of Differential Case Management (DCM).[1] DCM is designed to achieve the settlement of proceedings as soon as possible and before hearing dates are given, by ensuring that both parties are in possession of the information necessary for that purpose.

In addition to filing pleadings, both parties are required to file a set of DCM documents. These provide both parties with information vital to the successful undertaking of early settlement negotiations. The plaintiff's (and defendant's where indicated) DCM documents are to include:

- a concise statement of the facts which the plaintiff (defendant) intends to prove on the issue of liability;
- a statement as to the identity of any person that the defendant may be entitled to seek a contribution or indemnity from if the case is decided in favour of the plaintiff (defendant is also to provide);
- in personal injury cases, a copy of any police accident report or any report prepared by the Work Cover Authority of NSW, the Department of Industrial Relations,

Employment, Training and Further Education, or the Department of Mineral Resources;

- a statement as to whether the plaintiff has brought any other proceedings for damages for personal injuries, whether or not related to the event out of which the current proceedings arise, which may be significant in the assessment of damages;

- a statement as to whether the plaintiff has suffered any other accident or injury which is not the subject of the claim in the current proceedings and which may be significant in the assessment of damages in the proceedings;

- where the plaintiff (defendant) is represented by a solicitor, a statement setting out the opinion of that solicitor on the need for discovery or interrogatories;

- where the plaintiff (defendant) is represented by a solicitor, details of any special feature relating to the plaintiff's (defendant's) claim which may affect the complexity or length of the trial;

- where the defendant (or their insurer) has interviewed the plaintiff in order to prepare for litigation, a copy of any interview transcript; and

- any claim form or written report received by the defendant or its insurer from the plaintiff for the purposes of litigation.

However, exchange of any medical reports in their possession is not required as part of the DCM document process.

If a plaintiff commences an action by filing a statement of claim but does not file the DCM documents, the proceedings will be placed on the *Not Ready List* until one party files their DCM documents. Matters will also be placed on the Not Ready List where no application for a status conference has been filed (see below). Where proceedings have remained on the Not Ready List for six months, a notice is sent to the plaintiff's solicitor, to be forwarded to the plaintiff, informing the plaintiff that the case remains on the Not Ready List and of the possible consequences. If a matter remains on the Not Ready List for 12 months, a *callover* will take place. The callover will be conducted before the List Judge, who can make orders to achieve the "just, efficient and cheap disposal of the proceedings including, where necessary, an order dismissing them."

Under DCM, matters will only be set down for trial once they have undergone case management and:

- the parties have turned their minds to what the case is really about and what their chances of success are, so that settlement is attempted earlier rather than later;

- the issues in dispute have been narrowed and refined; and

- it has been determined that the case is ready for trial.

In most cases (and in all personal injury/professional negligence cases), the matter will proceed towards trial in accordance with one of three court determined timetables. The plaintiff may elect the *Standard Case Management Track* which sets down a timetable for the completion of all interlocutory processes. The plaintiff must file and serve a Certificate of Compliance (with the steps listed in the timetable) before day 276. The final conference (discussed below) is to take place on or before day 291.

If the plaintiff does not opt for the Standard Track, or decides within 135 days of electing the Standard Track that he or she does not wish to continue to proceed under it, or if the defendant does not wish to proceed along the Standard Track, a Status Conference will take place. The conference will be before a Judge or Registrar and its purposes include:

- to examine the DCM documents in order to define at the earliest possible date the real issues, and to inquire whether liability is genuinely in issue and, if not, to secure an early admission of liability;

- to direct the parties attention to the possibility of settlement and, if appropriate, to give directions which will promote settlement;

- to determine whether the proceedings are suitable for alternative dispute resolution (ADR) and to give directions for ADR;

- to inquire whether any party requires a jury and, if so, to examine the need and reason;

- to allocate proceedings to the appropriate case management track; and

- to give directions which ensure that all necessary interlocutory steps are completed so that a Final Conference can take place within 210 sitting days, or in the Special Case Management Track, such time as is fixed by the court.

At the Status Conference the matter will be allocated to either the Special or Individual Case Management track. Proceedings will normally only be allocated to the Special Case Management track if they are particularly complex or of unusual urgency. For example, the Special Track might be chosen where the plaintiff has only a short time left to live, the matter is particularly complex and will require the frequent intervention/exercise of supervision of the court, or the proceeding is a class action.

Directions will also be given and a timetable for undertaking interlocutory steps, for example, discovery, service of medical reports, and exchange of expert reports. The plaintiff is required to file a *Certificate of Compliance* covering the steps set in the timetable by the date stipulated in the timetable. Where a Certificate is not filed by the date stipulated, the proceedings will be listed for a Default Conference within 10 days. At a Default Conference, the Judge can issue new directions aimed at progressing the proceedings, and he/she can award costs against the party responsible for the delay, dismiss the proceedings, or lower the priority of the matter.

If the Certificate of Compliance is filed as directed, the Final Conference will be held. The court will again explore the prospect of settlement or the use of ADR. The parties will also be required to seek agreement on economic loss components and, in the absence of agreement, to identify the unresolved issues. If settlement negotiations at the Final Conference are unsuccessful the parties must jointly sign a "comprehensive, detailed and precise statement of the real matters in dispute." A hearing date will also be set for the proceedings.

Court based arbitration

Since 1990, the Supreme Court has offered a form of arbitration, where matters are referred to a named day, in court accommodation, to one of a panel of arbitrators sitting at the same time, where the time for the hearing is estimated to be less than 3 hours and if the matter is regarding a sum over $3,000. In practice cases often go beyond the three hour limit

The award of the arbitrator becomes the judgement of the court if neither party applies for a re-hearing (before a judge) within 28 days after the sending out of the award by mail.

Of the 1,309 cases referred to arbitration in the Supreme Court Common Law Division during 1993–94, 991 were disposed of either by award or settlement, without litigation.[2]

The District Court's pre-trial conference program introduced in 1990 achieved a settlement rate of 29% State-wide during 1993–94.[3] The District Court also uses general arbitration, where the matter is referred to an arbitrator and the parties and the arbitrator determine a date and place, and Philadelphia style arbitration. As with the Supreme Court, all arbitrators are contractors. The main advantages of this latter style of arbitration for the court are that the court maintains control over the timing of the arbitration and a panel of 5 arbitrators is able to hear 25 cases per day.

Early Neutral Evaluation

A pilot of early neutral evaluation is currently being conducted by the National Dispute Centre in Sydney in conjunction with the Supreme Court. The first evaluations took place in early September 1994 and the pilot was scheduled to run for six months.

Under the pilot, experienced practitioners give an early neutral evaluation of cases to assist the parties to negotiate an informed resolution of their case. The adversarial nature of proceedings often denies the parties a realistic perspective of the case as a whole early in the litigation process. Evaluations in the pilot:

- are provided without cost to the parties;
- do not affect the progress of the case towards a hearing;
- are on a confidential basis so that the result of the evaluation is not communicated to the court; and

- are usually conducted outside court hours.

Evaluations are conducted at the National Dispute Centre (Sydney) by an evaluator selected from a panel approved by the court. For personal injuries matters, evaluators are *respected* practitioners (barristers) in the personal injuries field.

For personal injuries matters, at the Status Conference (see discussion on Differential Case Management above) the court will ask the parties whether they wish to participate in neutral evaluation. Where the parties agree to participate the court sets a date for the evaluation.

The plaintiff is required to serve, not later than 15 days before the evaluation:

- a statement setting out the damages claimed under each head of damage;
- a concise statement of the facts giving rise to the damages claimed; and
- copies of any medical reports it wishes to rely upon in the evaluation.

The defendant must serve, not more than 10 days before the evaluation:

- a statement of any facts the defendant proposes to prove in relation to damages; and
- copies of any medical reports it wishes to rely upon in the evaluation.

The plaintiff is required to attend the evaluation in person and the insurer must be represented by an appropriate officer. The plaintiff's representative outlines the plaintiff's case and the evidence on liability and damage. Similarly, the defendant's solicitor outlines the defendant's case and the evidence relied on.

The evaluator listens to both parties arguments and then gives an opinion on:

- the degree of probability of the plaintiff succeeding in the action.
- any reduction in damages on the basis of any contributory negligence by the plaintiff; and
- the range of damages which the plaintiff would be likely to recover if successful in the action.

The fact that the evaluation has occurred, but not the details of the evaluation, are communicated to the court within seven days.

The District Court also currently offers free neutral evaluation to parties in old cases on the motor accident list (cases from the period when the GIO was the sole CTP personal injury insurer in NSW). Early neutral evaluation is an available option for parties on other lists

($750 per party). However, parties can have the matter arbitrated for free within a similar time frame.

Mediation and neutral evaluation legislation

The NSW Parliament has passed the *Courts Legislation (Mediation and Evaluation) Amendment Act 1994* to give legislative recognition and protection to early neutral evaluation and mediation. The notes below are based on the Bill as the Act was not available at the time of writing. Amendments to the Bill may have been made prior to it passing into legislation.

The Bill applies to the Supreme, District, Land and Environment, Industrial, Compensation and Local Courts, and it establishes a legal framework for neutral evaluation and mediation. The Bill defines mediation as "a structured negotiation process in which the mediator, as a neutral and independent party, assists the parties to a dispute to achieve their own resolution of the dispute."

Neutral evaluation "means a process of evaluation of a dispute in which the evaluator seeks to identify and reduce the issues of fact and law that are in dispute. The evaluator's role includes assessing the relative strengths and weaknesses of each party's case and offering an opinion as to the likely outcome of the proceedings, including any likely findings of liability or the award of compensation.

The Bill provides that:

- the costs of mediation or neutral evaluation are to be borne by the parties;
- a court may refer a matter to neutral evaluation or mediation with the consent of the parties. The parties must also agree on the evaluator/mediator;
- courts may make orders to give effect to any agreement arising out of a mediation session;
- the Chief Justice, the Chief Judge or the Chief Magistrate (as the case may be) of the relevant court can compile lists of persons suitable to be mediators or evaluators;
- mediation and neutral evaluation sessions, and documents and material produced for them, have the same privilege with respect to defamation proceedings that judicial proceedings have; and
- a mediator or evaluator whose name is included in the list of mediators or evaluators prepared under the amendments is protected from liability for things done in good faith for the purposes of a session under the new provisions.

Expert Reports

Since 1986 the Commercial Division of the NSW Supreme Court has required any party intending to rely upon the evidence of one or more expert witnesses to serve a copy of the report of each expert no later than 28 days before the date fixed for hearing.[4] Where a party serving the report calls the expert at the trial they may not, without the court's leave, lead evidence from that witness the substance of which is not included in the report served. This helps prevent trial by *ambush*.

To reduce the length of the proceedings, the court may also direct that the statement served (or a part of it) shall stand as the evidence-in-chief of the expert. The other party retains the right to cross-examine the expert on the statement and/or any oral evidence given in chief.

To assist in narrowing/defining the issues which are in contention the court may direct that experts, whose reports have been served, consult at a without prejudice meeting, to narrow any points of difference and give reasons for those differences.

The Common Law Division of the NSW Supreme Court also requires the parties to exchange expert reports prior to trial. For example, for cases allocated to the standard track:

> "(a) the plaintiff shall serve primary reports of medical experts and available hospital reports on of before day 61 (from the date the plaintiff files an election to proceed on the standard case management track);
>
> (b) the defendant shall serve primary reports of medical experts on or before day 131;
>
> (c) all other medical experts reports and all other hospital reports shall be served on or before day 261;
>
> (d) the plaintiff shall serve all expert reports other than medical expert's reports and hospital reports on or before day 141; and
>
> (e) the defendant shall serve all expert reports other than medical expert's reports and hospital reports on or before day 161".[5]

Statements of Agreed Issues and Notices to Admit Facts

The Commercial Division of the NSW Supreme Court has the power to request, at the first directions hearing, that the parties file a statement of agreed issues. This limits the scope of the hearing to those issues truly in dispute.

In the Common Law Division, if settlement negotiations at the final conference are unsuccessful, the parties must jointly sign a "comprehensive, detailed and precise statement of the real matters in dispute."

The Commercial Division can therefore request a statement of agreed issues at an earlier stage than the Common Law Division. This would seem to be preferable as it should cheapen

and simplify the interlocutory steps, for example, parties will be able to better target their resources in discovery/interrogatories.

Reform of Discovery and Interrogatories

In the Commercial Division of the NSW Supreme Court orders will not usually be made for the service of lists of documents (discovery) or for interrogatories until the issues have been defined.[6] Even then, orders will only be made where a party can establish, by reference to the issues between the parties, the need for discovery or interrogatories.

Where there is a large number of documents, the court can order that the list describe the nature of a group of documents without describing each individual document. If interrogatories are sought the court is to ensure that orders are only made for those interrogatories which are truly necessary and, in particular cases, may limit the use of interrogatories to particular issues.

Offers of compromise

Available in the NSW Supreme Court, offers of compromise are essentially offers of settlement which may be considered by the court when determining costs. The Supreme Court Rules Provide:

- a party may make more than one offer;

- where a plaintiff does not accept a defendant's offer and ultimately obtains judgement that is no more favourable to him than such offer, then while he is entitled to costs up to the time of the offer, he will not be entitled to further costs and may be liable to pay the defendant's subsequent costs on a party-party basis; and

- where a defendant fails to accept a plaintiff's offer, then he may be liable to pay the plaintiff's costs on an indemnity (effectively solicitor-client) basis from the date of the offer if the plaintiff succeeds in obtaining a judgement that is no less favourable to him than the terms of the offer made.

The rule is designed to encourage practitioners to focus carefully on the strengths and weaknesses of their case and it requires clients to view their case realistically.

Performance Monitoring

Caseflow management and other delay reduction initiatives have significantly improved the processing time before the NSW Supreme Court. In the New South Wales Supreme Court, case management and delay reduction initiatives have helped to reduce the caseloads of the Common Law, Equity, Criminal and Commercial Divisions by 30–50%, aided by a decline in filings in both the Common Law and Commercial Divisions.[7] The number of matters on hand, and matters where a notice to set down for hearing has been filed, in the Common Law Division of the Supreme Court has dropped substantially in the period June 1990 to March

1994 from 7419 to 4329.[8] The estimated time to dispose of matters on hand fell from 3.9 years in 1989 to 1.5 years in March 1994. It should be noted that the number of notices filed to set matters down for hearing has dropped substantially over this period, from 2,174 in 1989 to 1,192 in March 1994.[9] This would have had a bearing on the improved disposition rates.

The 1992 Special Sittings resulted in the settlement of a significant number of matters. From an initial list of 1,300 cases, it was decided that 188 of these would be dealt with after the sittings; 946 of the cases were settled and 91 resulted in a verdict.[10]

The District Court Civil Division has reduced the number of matters on hand from 38,081 in June 1990 to 10,174 in March 1994. Over the period 1990 to 1994, the median time from filing a praecipe (notice of readiness to proceed to trial) to finalisation in the District Court (Sydney) fell substantially:[11]

PERIOD	Time taken for matters to be finalised (Months)		
	At Hearing	At Arbitration	By Settlement
1990	47.1	37.7	37.5
1991	50.2	47.5	45.4
1992	50.8	41.4	39.0
Jan-June 1993	46.1	28.4	25.2
July-Dec 1993	36.7	19.6	19.2
Oct-Mar 1994	39.9	17.7	17.1

Substantial decreases were recorded in all three categories. There appears to be a correlation between the median time taken to finalise matters by arbitration and by settlement. The median time to finalise matters by settlement is in all years only marginally lower than the median time to finalise matters by arbitration. This may suggest that parties delay settlement until just before a third party is scheduled to impose a solution.

B. Case flow management in South Australia

Both the Supreme and District Courts in South Australia have taken an active approach to case management. Case Flow Management was introduced into the District Court of South Australia in January 1990.

District Court

The District Court has developed a computer program which provides each party, when the appearance is filed, with a schedule of the dates by which each step in the action is to be completed (compulsory timetable).

A standard path is used primarily for personal injury matters, where the progress of the action is automatically monitored to pre-trial conference. A matter will be placed on the managed

path at the request of all parties or if the Judge/Registrar orders that it be placed on the managed path.

Where a matter is allocated to the managed path a status conference is held to:

- discuss the possibility of settlement by negotiation or some other means of dispute resolution; and,

- ensure that all pre-trial activities are given appropriate attention to ensure a timely trial.

Proceedings under both paths then progress, according to a fixed timetable set down in the rules, towards a pre-trial conference.

The aim of the pre-trial conference is to conduct a detailed review of the action with the parties with particular reference to:

- the conduct of final negotiations for settlement of the action or of issues arising from within the action;

- the final possibility of resolving all or some of the issues arising in the action by ADR;

- any difficulties that may arise with respect to the availability of witnesses for the trial; and

- whether agreement can be reached between the parties with regard to such matters as the quantum of special damages, the tendering of medical or other reports of expert witnesses and other matters that may be capable of agreement in the interests of expediting the trial.

Supreme Court

Since July 1993, the Supreme Court of South Australia has used a three track caseflow management scheme:

- the Expedited Track for matters which are summary or urgent in nature and will usually come to a conclusion quickly;

- the Normal Track; and

- the Long/Complex Track where a case is likely to last 15 or more days.

A standard timeline of 52 weeks is set for cases in the normal track (from issue of proceedings to trial date).

A limited number of Court interventions have been introduced to oversee the progress of each action towards trial : the Status Conference; the Case Evaluation Conference; and the Pre-trial Conference.

Issues to be addressed at the Status Conference include:

- whether arbitration or some form of mediation is appropriate;
- confirmation of track assignment;
- the possible use of Supreme Court Rule 50 (Expeditious Management of Commercial and Other Cases). The parties can apply (when filing the summons commencing the proceedings in the case of the plaintiff and when filing an appearance in the case of the defendant) to be dealt with under the rule. The Court will look at the likely length and complexity of the case when deciding whether it should be run under this rule. Where a case is run under Rule 50 the Court may:
  - direct that the issues be defined other than by formal pleadings;
  - dispense with or abridge the time for the taking of any interlocutory step;
  - direct that any party deliver to any other party a written statement setting out the evidence proposed to be called from all witnesses or any particular witness(es), which statement shall, subject to any further order or direction, be signed by the proposed witness and be received at the trial as the evidence-in-chief of the witness giving the statement;
- use of notices to admit;
- discovery issues, including whether automatic discovery is adequate and appropriate; and,
- discussion of expert reports.

The case evaluation conference is designed to review the progress of the parties preparations for trial:

- critical evaluation of the state of pleadings;
- check expert reports re release and exchange;
- reassess the situation relating to ADR; and
- confirm accurate trial duration, including likely witnesses to be called and witness availability and scheduling.

Tight restrictions are placed on the seeking of extensions or adjournments. At both the Status and the Case Evaluation Conference, Masters will take a hard line against adjournments except in compelling circumstances. If adjournments are granted they will be for the minimum time necessary and will be vigorously policed.

The pre-trial conference is used:

- as a final opportunity for ADR;
- to seek assurances of witness availability;
- to refer the case to a listing conference for allocation of a trial date.

A computerised system has also been introduced to assist in the operation of the caseflow managements system. The system is modelled on the District Court system but with many extensions, and includes the following features:

- generation of conference notices to all parties;
- generation of case flow warning notices when parties are in default of filing certain documents;
- control of the Inactive Actions List, for actions that will automatically be struck out if no appearance, affidavit of service or application to extend time for service is filed; and
- the provision of a comprehensive set of statistical reports required to monitor the effectiveness of the CFM initiatives.

Mediation and arbitration in South Australia

In the Supreme and District Courts of South Australia mediation[12] and arbitration[13] is available. Parties have the option of mediation by a court officer (including a Judge) or an agreed external person. Any discussions/disclosures are completely confidential and nothing said or done may be disclosed at the trial. Any agreed outcomes are to be filed with the court and they are binding.

Arbitration is available either under the terms of the Commercial Arbitration Act or in a court sponsored form. Court annexed arbitration requires the full consent of all parties. Features include:

- the arbitrator is a judge;
- it will have truncated interlocutory processes (possibly more advantageous to large well resourced defendant's such as MDOs who have the resources to cope with this);

- pleadings will be replaced by simple plain english statements of issues;
- use of written witness statements instead of in lieu of evidence-in-chief encouraged;
- discovery processes restricted to critical documents or classes of documents and then only after the exchange of notices to admit. Interrogatories are not usually permitted;
- with the consent of the parties the Court may limit the time the parties have at the arbitration to; present evidence; examine or cross-examine witnesses; or make submissions; and
- the arbitration is to be conducted, as far as possible, in accordance with the *Commercial Arbitration Act 1986*.

Expert reports

The rules of the Civil Divisions of the Supreme and District Courts of South Australia state that within 21 days of the close of pleadings each party must deliver to the other party(ies) a "full copy of every medical report in his possession or power relating to any matter in issue in the action" and "a list setting out all other expert's reports".[14] The other party may request copies of the other listed expert reports (for a fee).

The rule further requires that parties must obtain and furnish (as just described) all expert reports which they intend to rely on no later than seven days before the pre-trial conference. The rule has one exception: where a party contends that disclosure of a report would unfairly prejudice their case they can seek an order that they not be required to disclose it.

Statements of agreed issues and notices to admit facts

The South Australian Supreme and District Courts also have a mechanism whereby a party may serve a notice to admit upon another party in writing (not less than 28 days prior to the pre-trial conference):[15]

- detailing facts and/or opinions which are asserted to be formal or beyond reasonable contention (including the authenticity or admissibility of any relevant document) and signed by the person or persons who would need to be called to establish those facts and/or opinions; and
- requesting that the other party consent to the tender of the document as proof of the facts/opinions it contains without calling the witness(es) or, that they consent to the tender of the document in return for an undertaking to call the witness for cross-examination (ie. document stands as witnesses evidence-in-chief).

The truth of a fact or the authenticity/admissibility of a document specified in a notice to admit is deemed to be admitted unless the party receiving the notice files and delivers to the party giving the notice a written statement that:

- specifically denies the truth of the fact or the authenticity of the document and gives reasons;

- or states that the refusal to admit etc. is made on the grounds of privilege or irrelevancy or that the request is otherwise improper, and gives detailed reasons for the refusal.

Where a party unreasonably objects to the tendering of the document, or they unreasonably insist that the witness be called for cross-examination, the Court can order that party to pay the costs resulting from the objection. Such a rule assists in ensuring that hearing time is not wasted on "proving" facts and/or opinions which are not (and never were) in serious dispute.

Reform of Discovery and Interrogatories

Discovery is an expensive and time consuming part of the pre-trial process. The Supreme Court of South Australia's *Case Flow Management Changes to the Civil Jurisdiction: An Information Statement for the Legal Profession* notes that:

> [I]n major litigation it is almost the invariable case that the process of discovery generates considerable costs and is usually the greatest single cause of delay in preparation for trial ... it is often the case that significant costs are run up in relation to examining and copying large numbers of documents which are never resorted to at trial and, in reality, are only of relatively peripheral relevance or importance.

The rules of the South Australian Supreme Court and of the Civil Division of the District Court (Rule 58) allow the court, on its own motion or on application of the parties, to:

- direct discovery by waves or phases;

- limit initial discovery to documents which, prima facie, are likely to bear on the outcome of the proceedings, or are of a stipulated class(es);

- postpone discovery; and exempt certain documents or class(es) of documents from discovery (factors to be considered include the time, cost and inconvenience of making discovery as opposed to the amount involved in the action, the likely relevance/importance of the documents to any issue(s) in the action).

Furthermore, where there are large numbers of documents or the relationship between documents is complex, any documents ordered to be delivered or produced are to be according to topic, class etc. or according to some other sequence or system.

The South Australian Supreme Court and District Court Civil Division Rules (57) state that interrogatories may only be filed and delivered with the leave of the relevant Court. Where leave is sought the proposed interrogatories must be put before the Court for its approval.

Performance Measurement

The District Court program has been successful in eliminating the backlog of cases and hence the delays that were occurring in the civil jurisdiction. In January 1990 there were nearly 6,000 cases in the trial list. As at October 1993 there were 130 of those matters remaining. Approximately 73% of actions commenced in the civil jurisdiction are finally disposed of by judgement or settlement within nine months of the service of the summons upon the defendant or within 12 months of the commencement of the action.[16]

C. Case flow management in the Northern Territory

The Supreme Court of the Northern Territory has a case flow management system in place with provision for settlement conferences at any time. Settlement conferences may be made compulsory. The Supreme Court rules also provide for notices to admit facts, the use of written expert reports and witness statements, and conferences and the giving of evidence by video and telephone. Proceedings that are ready for trial may be heard within approximately three months.

D. Case flow management in Queensland

In Queensland, as a result of an initiative of the Court Administration Division and the Judges of the Supreme and District Court's, a committee of Judges, practitioners and staff has been developing a case flow proposal for the Supreme and District Courts Brisbane. The Queensland Government has announced but not introduced legislation to require parties to personal injury actions to make formal offers, disclose medical reports and attempt mediation before filing any originating documents. If matters still proceed there are a number of initiatives to improve the process. These are:

- introduction of case flow management in all cases in Brisbane Supreme and District Courts. Standard cases will be required to meet vastly reduced time lines and other complex, long or difficult cases may be individually assigned to Judges to manage. As in South Australia, a new computer system is being developed to support the case flow. Pre-trial conferences have not been introduced in the higher courts except in Townsville. It is argued that the benefits likely to arise do not appear to be justified by the additional resources required and the increased cost to practitioners. The proposed caseflow management scheme excludes status and pre-trial conferences for this reason.

- a new rule for disclosure of documents to replace the previous *tactical* device of discovery. This new order requires parties to automatically disclose all relevant documents and allows interrogatories and discovery only at the order of the Court. This rule is in effect.

- encouragement of evidence by telephone and video. In Queensland, because of its de-centralised nature cases outside Brisbane are often delayed or subject to increased costs by the need for medical witnesses to travel to the location. A new rule is in

draft stage to allow evidence to be taken by phone. However, on a number of occasions Courts have already started to take such evidence with the consent of the parties.

The Supreme Court has developed a detailed statistical process to monitor progress of cases after the filing of the certificate of readiness and to measure delay. The new computer system being developed will also allow close monitoring of delay in the period between commencement and certificate of readiness.

A settlement week run by the Bar Council is held annually, but it is not clear whether the number of settlements is in excess of those that would happen anyway.

E. Case flow management in Western Australia

The Western Australian Supreme Court introduced new rules embodying the principles of case flow management effective from 26 March 1993.

F. Case flow management in Victoria

Long causes list

Victoria has established a *Long Causes List*. Entry into the List is not automatic, but is by application. For cases in the List, directions will be given about future interlocutory steps and each party will be required to file and serve on other parties a statement setting out the issues of law and fact which the party filing the statement anticipates will be the principal issues in contention at the trial.

The Judge in charge of the List will allot a Master to each case. If any interlocutory disputes arise they are to be heard before that Master. At the conclusion of the interlocutory steps, the Judge in charge of the List will set a trial date and allocate the case to a Judge who will preside at the trial and who will give any further directions.

Witness Statements

The Supreme Court of Victoria's *Guide to Commercial List Practice* requires each party to file and exchange a list of the witnesses they propose to call at the trial, together with a copy of a statement of each witness.[17] The witness statement acts as the witnesses evidence-in-chief, thus removing the necessity in most cases to give evidence-in-chief orally.

Once any challenges have been made to the admissibility of any part(s) of the statement, for example on the grounds of hearsay, the witness is asked to sign the statement. Additional oral evidence-in-chief may be adduced with the court's leave, but only in limited circumstances such as answering allegations which could not reasonably have been anticipated prior to the hearing.

Where evidence as to particular events is hotly contested or allegations of impropriety are made, witnesses may be asked to give that evidence orally without reference to their statement. Cross and re-examination take the ordinary course.

Generally, if no statement of evidence of a proposed witness is filed and served, no evidence can be adduced from that witness. Exceptions to this rule exist, for example where allegations of fraud are involved a party will not have to provide a statement, as to do so might require that party to incriminate him/herself before the other party has made out a case to answer.
The Guide notes that the primary benefit of the use of witness statements is that they reduce hearing times. In terms of cost, they may not be cheaper than adducing the evidence orally in court: their preparation would involve quite extensive work by the parties legal representatives. There is also the danger that written statements allow for greater manipulation of the witnesses evidence than the giving of oral evidence.

Reform of Discovery and Interrogatories

In the Victorian Commercial List parties are *encouraged* to agree on orders for limited discovery.[18] Interrogatories will not usually be permitted (given the exchange of witness statements): a party must apply, and produce a list of the proposed interrogatories, to the court if it wishes to use interrogatories.[19]

G. National case disposition guidelines

The NSW Supreme Court (for the Standard Case Management Track) and the SA Supreme and District Courts set case disposition timelines as a part of their case management strategies. In "A Discussion Paper on the Development of National Objectives or Goals for the Disposition of Cases in the Higher Trial Courts", Chief Judge Brebner and Mr Richard Foster, Registrar, of the District Court of South Australia, investigated the possibility of developing national case disposition guidelines.

They listed the advantages of national case disposition guidelines as being:

- objectives established after appropriate consultation help to ensure that judges, administrators and legal practitioners go about their tasks with the goals in mind and with a commitment to achieving them;

- there would be a uniform measure of performance by which individual courts might be assessed in relation to the speedy disposal of matters;

- the creation of appropriate objectives allows administrators to best allocate their resources;

- as the Report of the Commonwealth Access to Justice Advisory Committee (Sackville Committee) argued, "we would encourage the collection of comparable data on the

management and performance of all Australia courts with a view to identifying best practice procedures through the careful evaluation of all procedural reforms."

Possible disadvantages of such national case disposition guidelines were also listed:

- the legislature may interfere with the operation of the courts if they are not performing well eg. in some states in the U.S they have legislative deadlines for the disposal of criminal cases, the sanction for non-compliance being the dismissal of the prosecution case;
- courts not meeting the objectives might be subjected to unfair media comment; and
- the legal profession may be less than co-operative, unless they have been consulted with.

The authors recognised that there are vast differences in the workloads of the various courts in Australia and that the development of objectives for the disposition of civil cases is potentially complex. However, they argued that the standards developed by the National Conference of State Trial Judges in the United States provide sufficient flexibility to cover nearly all types of cases. The authors argued that they should go forward as the basis for discussion in the development of Australian objectives, that is:

- 90% of all cases should be settled, tried or otherwise concluded within 12 months of the commencement of the proceedings;
- 98% of all cases should be settled, tried or otherwise concluded within 18 months of the commencement of the proceedings; and
- all cases should be settled, tried or concluded within 24 months of the commencement of the proceedings: except for cases in which exceptional circumstances are shown to exist.

They noted that it may be necessary to consider whether different objectives should apply to specialised lists within the civil division. They suggested that the national objectives should include some broad definition of the critical steps to trial, but that the fine tuning of those broad steps should be left to individual courts.

It is suggested by the authors that the following be indicated as the basic, critical steps:

- close of pleadings (and an early conference with the parties where that is desired);
- a period for discovery, interlocutory applications, notices to admit facts etc;
- a pre-trial conference; and
- a listing directive.

Some cases will have a greater number of conferences and directions hearings than others. These matters should be left to the individual courts.

A possible timeline is outlined. It is flexible and long/complicated cases may require their own tailored timeline. In terms of the maximum number of days from the commencement of the proceedings:

1.	Service	90 days
2.	Close of pleadings	125 days
3.	An early (status) conference	150 days
4.	The period for interlocutory applications, notices to admit etc.	240 days
5.	Pre-trial conference and listing directive	240 days
6.	Commencement of trial	300 days
7.	Delivery of Judgement	365 days

Appendix H : Outcome standards for health care complaints mechanisms

The PIR drafted outcome standards for complaints mechanisms for health care consumers. The standards represent *best practice*, ascertained from relevant literature, and discussions and correspondence with a number of interested parties. The draft outcome standards were forwarded to a small group of organisations and to officers within the Commonwealth Department of Human Services and Health for comment.

The outcome standards are intended to serve as a starting point for those responsible for establishing or reviewing complaints mechanisms in the health system. For example, they may be of use in the context of the recommendations of the Justice Statement, and the work of the Health Services Commissioner of Victoria to develop *best practice* in this field.

Outcomes desired from complaints handling at all levels:

1.1 Information about health care consumers' rights, including how to comment or complain, is freely available in a variety of appropriate formats and locations.

1.2 Those health care consumers who comment or complain are treated with respect and dignity and are not disadvantaged in accessing health care services.

1.3 Opportunities for comment and complaint are not limited by the complainants' geographical location, socio-economic status, ethnicity, or the nature of any illness or the health/medical condition of the consumer.

1.4 The confidentiality of health care consumer information is preserved, where appropriate.

1.5 Subject to the requirement to maintain confidentiality of health care consumer information, comments and complaints are accepted from third parties.

1.6 All comments and complaints are taken seriously. Individual health care consumers' complaints are assessed and appropriate follow-up action taken. Consumers are informed of action taken as a result of the complaint, and of avenues of review or appeal if they are not satisfied with the action taken.

1.7 Health care professionals are encouraged to co-operate with complaints mechanisms and to treat comments and complaints as an opportunity to improve health care services.

1.8 Complainants are advised of options for dealing with their complaint and achievable outcomes of the complaints process.

1.9 Where possible, complainants are referred to an appropriate body/organisation which can assist the complainant if he or she desires an outcome that cannot be achieved by the body or process currently in contact with the complainant.

1.10 Complaints handling procedures are prompt, efficient, cost effective and accessible.

1.11 Staff at all levels who receive, assess, investigate or conciliate health care consumer complaints are adequately trained.

1.12 The rules of lawful decision-making are followed in complaints mechanisms.[1]

1.13 There are adequate and accessible referral and appeal mechanisms.

1.14 Deidentified information collated from comments and complaints is used to improve the quality of health services at all levels.

1.15 Regular reviews of complaints mechanisms are carried out.

Outcomes desired from complaints handling at point of service:

2.1 At the point of service, there is an accessible complaints handling mechanism able to receive, assess and act upon/refer health care consumer complaints, comments and

suggestions relevant to the service. To promote accessibility to the complaints mechanism in health care facilities, patient liaison/complaints officers are appointed.

2.2 Health care consumers are encouraged to use the point of service complaints mechanism, except where the nature of the complaint makes this inappropriate.[2]

2.3 For consumers who feel unable to complain at the point of service, there is information freely available and displayed in public areas on how to contact the State-wide complaints commission.

2.4 Point of service complaints mechanisms treat consumer complaints and comments as an opportunity to improve the quality of the service, and are appropriately resourced to provide complaints data to formal or informal quality assurance and/or risk management procedures operated by the service.

2.5 At the time of complaint or comment, consumers are advised of the options for dealing with the complaint the point of service complaints mechanism can offer. This could include an investigation of the complaint, an apology, an explanation of what happened, or referral to a more appropriate authority.

2.6 Consumer complaints, comments and suggestions are received orally or in writing.

2.7 The point of service complaints mechanism supplies a consumer with advice on other avenues to pursue a complaint that cannot be dealt with by the point of service mechanism.

2.8 Consumers are informed they may have the assistance of a friend, relative or patient advocate to provide assistance in dealing with the point of service complaints mechanism.

2.9 Consumers are assisted, where necessary, to explain their complaints and encouraged to state what they believe is an acceptable outcome to the complaint.

2.10 Consumers whose complaint involves a physical injury (such as an adverse drug reaction, wound or infection) are offered/referred to remedial treatment, whether this be at the original service or at another service. Consumers whose complaint involves psychological harm are referred for appropriate counselling.

2.11 Consumer complaints are investigated/assessed promptly. Contact is kept with the complainant and any delays are explained to the complainant.

2.12 Consumers are informed of the outcome of the complaint and offered the opportunity for a further interview if they wish further information or follow-up.

2.13 Where appropriate, information from consumers' complaints, comments and suggestions leads to consultation with other bodies about changes within the organisation to improve the quality of care.

2.14 Aggregate deidentified information on complaints and changes to service as a result of complaints is forwarded regularly to the State-based complaints commission for analysis.

2.15 The point of service complaints mechanism reports to, is accountable to, and has the support of senior management of the service.

2.16 Regular reports on complaints, comments and suggestions from consumers are forwarded to the management of the service, together with details of improvements made as a result of complaint, comments and suggestions.

Outcomes desired relating to referrals from point of service complaints handling:

3.1 Information is prominently displayed in all health services advising of the role and contact details of the State-wide complaints commission.

3.2 Consumers seeking a further investigation of their complaint, or who are unsure of the outcome they prefer, or who are seeking assistance with conciliation of the complaint, are referred to the State-wide complaints commission.

Outcomes desired from a State-wide complaints commission:

4.1 a) Complaints commissions are independent of government health departments, health care professionals and consumer groups and are responsible to the relevant Minister for Health.

b) Complaints commissions are funded independently and adequately to fulfil their responsibilities in a timely manner. They are not funded through a government department with discretion to alter the commissions' allocation.

4.2 Boards or committees with adequate consumer and health care professional representation advise complaints commissions on complaints handling policy, priorities for consumer and provider education about health care consumers' rights and responsibilities, and on linking complaints to improving the quality of services.

4.3 Complaints commissions receive, assess, investigate, refer and conciliate consumer complaints. Where appropriate, commissions are able to initiate disciplinary proceedings before a registration board.

4.4 Matters of public health and safety are not conciliated. Where appropriate, once resolution of public health and safety issues are finalised, conciliation may take place.

4.5 Subject to the requirement to maintain confidentiality of health care consumer information, complaints are accepted from third parties.

4.6 Consumer complaints are received in writing. Consumers who have difficulty in putting the complaint in writing are assisted to do this.

4.7 Consumers are informed they may have the assistance of a friend, relative or patient advocate to help them in contacts with the commission.

4.8 Consumer complaints are assessed promptly and delays are discussed with the complainant.

4.9 Consumers are advised in writing where a commission decides not to pursue a complaint and are offered an opportunity to discuss the decision.

4.10 Consumers are able to appeal against a commission's decision not to pursue a complaint, or over the action taken to investigate the complaint, to an appropriate internal and/or external review body.

4.11 Consumers are advised of the possible benefits of contacting a consumer advocate and/or counsellor in supporting them to pursue the complaint and understanding and adjusting to the consequences of the adverse outcome which is the subject of the complaint.

4.12 Complaints commissions are able to treat complex complaints flexibly, for example, by differentiating elements of a complaint and taking appropriate action on each element.

4.13 a) Where a commission receives a complaint concerning a registered health care professional, a copy of the complaint is forwarded to the relevant registration board. The board and the commission jointly consider the compliant and agree on appropriate action. Where agreement is not reached, the more serious view of the complaint prevails.

b) Where a registration board receives a complaint, the board refers a copy of the complaint to the complaints commission. The board and the complaints commission jointly consider the complai0nt and agree on appropriate action. Where agreement is not reached, the more serious view of the complaint prevails.

4.14 Complaints commissions across Australia use standard data definitions in data collection, analysis and dissemination to permit comparison and analysis on a national basis.

4.15 Complaints commissions in each State receive deidentified complaints data from health care providers and facilities in the State. The data include information on the nature of the complaint, the type of health care professional involved, the action taken to resolve the complaint, and any changes made to service delivery as a result of the complaint. The deidentified data are collated by the Australian Institute of Health and Welfare to form a national data set which is analysed and used for education and quality improvement activities. The data form part of the proposed yearly publication of the National Health Ministers' Benchmarking Working Group.

4.16 The Australian Health Ministers Advisory Council receives an annual report on complaints data from the Australian Institute of Health and Welfare, in consultation with the National Council of Health Complaints Commissioners.

4.17 Complaints commissions publish an annual report which contains details of complaints, action taken to resolve them and recommended changes to the health system.

4.18 Complaints commissions liaise with all relevant parties as necessary to improve the quality of health care services.

4.19 Complaints commissions provide advice to health care professionals and institutions on the establishment and operation of point of service complaints mechanisms.

4.20 Complaints commissions promote education for health care consumers on their rights, what to expect from health care professionals, how to obtain information and how to comment and complain.

4.21 Complaints commissions liaise with State and Commonwealth authorities responsible for administering anti-discrimination legislation regarding complaints involving discrimination in the provision of health care services.

4.22 Complaints commissions make recommendations to State health ministers on changes to the health system as a result of analysis of consumer complaints.

Outcomes desired from the investigation process of a complaints commission:

5.0 Investigations are carried out promptly and effectively by appropriately trained and experienced staff.

5.1 Investigations are carried out impartially and all relevant issues are examined.

5.2 The complainant is kept informed of the progress of the investigation and any delays are explained.

5.3 With the consent of the complainant, allegations of possible criminal matters which, after assessment and investigation, require follow-up, are referred to the Director of Public Prosecutions or equivalent officer.

5.4 At the conclusion of an investigation, a written report of the investigation is complied. The written report:

- contains details of any action taken or recommended to remedy the complaint or improve the health system;
- is provided to the complainant; and
- is provided to the health care professional or health care facility concerned. Where the complaint concerned a registered health care professional, the relevant registration board receives a copy of the report.

5.5 Health care professionals and health care facilities subject to recommendations in a complaints commission investigation report, are required to notify the complaints

commission promptly of action taken to comply with the recommendation, or of the reasons for non-compliance.

5.6 In publicly available annual reports, complaints commissions *may* name health care professionals or facilities who do not comply with its recommendations and also report the reasons for non-compliance and any comments, where these are available.

5.7 At the conclusion of an investigation, commissions may initiate disciplinary proceedings before a registration board/tribunal or require that such proceedings be initiated.

Outcomes desired from the conciliation process:

6.1 Conciliation of health care consumer complaints aims to facilitate communication between the parties, identify all issues, explore feasible solutions, and reach a consensual agreement which accommodates the needs and interests of the parties.

6.2 Conciliation of health care consumer complaints aims, wherever possible, to preserve a good relationship between the health care consumer and health care professional, if they wish.

6.3 Conciliators appointed by, or available to, complaints commissions are fully trained to ensure the effect of any power imbalance between the parties is minimised.

6.4 Conciliated agreements, where possible, facilitate the process of the complainant and the health care professional or facility being able to consider the matter resolved finally and in a mutually satisfactory manner.

Outcomes desired from registration boards:

7.1 Consumers and health care professionals are made aware of the purpose and function of registration boards.

7.2 Lay (non-professional) members are adequately represented on registration boards, at least two lay members are appointed and are encouraged to provide an independent assessment of the board's approach to complaints handling in each annual report of the board.

7.3 A publicly accessible register of health care professionals is maintained with a public listing of their qualifications, languages spoken, availability of interpreters and whether practice addresses have access for wheelchairs.

7.4 Registrants are required to notify the board of any settlements or judgements where money is paid to the claimant. This information is confidential and used by boards to protect public health and safety and for quality assurance activities.

7.5 Registration boards receive complaints about registrants from consumers or their representatives in writing and provide assistance where a consumer has difficulty in putting the complaint in writing.

7.6 a) Where a registration board receives a complaint concerning a registered health care professional, a copy of the complaint is forwarded to the state-wide complaints commission. The board and the commission jointly consider the complaint and agree on appropriate action. Where agreement is not reached, the more serious view of the complaint prevails.

b) Where a commission receives a complaint, the commission refers a copy of the complaint to the registration board. The board and the complaints commission jointly consider the complaint and agree on appropriate action. Where agreement is not reached, the more serious view of the complaint prevails.

7.7 The reason/s for a decision not to pursue a complaint are provided in writing to the complainant, together with notification of procedures for requesting a review of the decision, and details of any appeal avenues available.

7.8 Registration boards review decisions when requested to do so by complainants and the review is carried out by different members from those who made the original decision.

7.9 Where a complaint is not dismissed, investigated or conciliated by a complaints commission, registration boards carry out an investigation to determine if the complaint is substantiated. A copy of the written report of the investigation, containing conclusions and any recommendations, is forwarded to the complaints commission, the complainant and the registrant who is the subject of the complaint.

7.10 A range of options is available to a registration board to deal with registrants who are the subject of a complaint which is substantiated. The options include: referral to a complaints commission for conciliation; deregistration; suspension of registration; restricted practice; re-training and education; supervised practice, fines and participation in treatment programs.

7.11 Registration boards are adequately resourced to ensure registrants' compliance with its orders.

7.12 Disciplinary hearings are open to the public unless the need of a witness or a party to the hearing for privacy outweighs the public interest in having an open hearing, or the proper administration of justice would be compromised by an open hearing.

7.13 Complainants are able to attend board hearings relevant to their complaint, are invited to make a submission to the hearing and are advised of the outcome of the hearing promptly.[3]

7.14 Registration boards keep data on hearings and decisions for reference to promote consistency in the application of the legislation and associated procedures. This data is made available to the complaints commission to inform quality assurance activities.

Appendix I : Model contract clauses in relation to professional indemnity cover

Model Clause for Employees with No Private Practice Rights

1. Under this contract you are an employee of [name service/organisation]. As an employee of this service you are indemnified for activities undertaken in the course of, or arising out of, your employment. You will not be indemnified where your behaviour constitutes serious and wilful misconduct or a "frolic".

2. Either:

   State government legislation precludes [name service/organisation], as an employer, from recovering from you, as an employee, damages paid to a third person.

   or

   State government legislation does not preclude [name service/organisation], as an employer, from recovering from you, as an employee damages paid to a third person. However, where damages are paid to a third person by [name service/organisation], [name service/organisation] undertakes not to seek from you recovery of the damages paid.

3. Either:

   All reasonable legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will be met by [name organisation].

   or

   Legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will **NOT** be met by [name organisation].

Model Clause for Employees such as Staff Specialists with Private Practice Rights

1. Under this contract you are an employee of [name service/organisation]. As an employee of this service you are indemnified for activities undertaken in the course of, or arising out of, your employment and you are indemnified for those services you provide within the hospital in accordance with the private practice rights stipulated in this contract. You will not be indemnified where your behaviour constitutes serious and wilful misconduct or a "frolic".

2. Either

   State government legislation precludes [name organisation/service], as an employer, from recovering from you, as an employee, damages paid to a third person. [name organisation] also agrees not to seek to recover damages where those damages are paid as a result of private practice activities you undertake in accordance with this contract.

   or

   State government legislation does not preclude [name service/organisation], as an employer, from recovering from you, as an employee, damages paid to a third person. However, where damages are paid to a third person by [name service/organisation], [name service/organisation] undertakes not to seek from you recovery of the damages paid. [name service/organisation] also agrees not to seek to recover damages where those damages are paid as a result of private practice activities you undertake in accordance with this contract.

3. Either

   All reasonable legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will be met by [name organisation].

   or

   Legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will **NOT** be met by [name organisation].

Model Clause for Health Professionals Hired as Independent Contractors

1. You are contracted to [name service/organisation] as an independent contractor. This contract is **NOT** one of employment. As such, you should maintain appropriate professional indemnity cover at all times. Evidence for such cover should be provided with this contract.

2. Legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will **NOT** be met by [name organisation].

Model Clause for Health Professionals Hired as Independent Contractors where the Hospital wishes to adopt an enterprise liability approach

1. You are contracted to [name service/organisation] as an independent contractor. This contract is **NOT** one of employment. However, [name service/organisation] agrees to meet any damages payable in relation to negligence in the performance of [all your duties/specified duties] [under this contract/ where they are performed at this hospital/institution] during the course of this contract, whenever the claim is made. You may still be required to hold professional indemnity cover for duties outside the terms of this indemnity.

2. Either :

   All reasonable legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will be met by [name organisation].

   or

   Legal costs that you may incur in obtaining independent legal representation before a coronial hearing or a disciplinary board, or in obtaining independent legal advice where you are compelled by law to appear as a witness or an action has been brought against [name organisation] and it concerns your professional standing, will **NOT** be met by [name organisation].

ENDNOTES

Endnotes to Chapter 1

1. To check the availability of free copies of PIR publications from the Commonwealth Department of Human Services and Health, telephone (06) 289 7030.

2. The PIR defined *adverse patient outcomes* as those unfavourable outcomes for patients that result from, or through, the intervention of health care itself. For the purposes of the Quality in Australian Health Care Study, part of the PIR's sponsored research into the nature and frequency of adverse patient outcomes, adverse events are defined as unintended injuries that result in a disability which may include a longer hospital stay, or death, and which are caused by health care management rather than the patients' underlying disease. Both terms are used in this Report.

3. The PIR received correspondence indicating that use of the terms *health care consumer, client* or *patient* is an important issue for some groups. For example, the Medical Practitioners Board of Victoria noted that, from a medical practice point of view, patients are perceived as having additional rights and needs beyond those of a consumer (correspondence to the PIR from the Medical Practitioners Board of Victoria, 11 April 1995). In this Report the PIR has used both *health care consumer* and *patient. Health care consumer* is used to indicate people in general who may use health services or be interested in, or require, information about the health system. *Patient* is used generally in the context of interactions with health care professionals.

4. In this Report, the two terms, *common law system* and *tort system* are used interchangeably. *Common law* is a term that has a number of definitions, one of which is law evolved through judicial decision and practice as distinct from law laid down by statute. A *tort* is a civil injury, actionable by a private individual, as opposed to a criminal wrong. The tort system is that branch of law concerned with civil injuries and their remedy, including injury sustained through medical negligence. See Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* Australian Government Publishing Service (AGPS) February 1994 Canberra: 100 (Interim Report).

5. For brevity, *State* is used throughout this Report to refer to both the States and Territories of Australia.

6. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: a discussion paper.* HHCS February 1992 Canberra (Discussion Paper).

7. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on consultations on first discussion paper:* prepared by Purdon Associates. HHCS November 1992 Canberra (Consultation report).

8. Interim Report - see note 3.

9. Discussion paper - see note 5.

10. Consultation report - see note 6.

11. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on the feasibility study of an Australian hospitals' adverse health care incidents study*: prepared by Roy Harvey and John Goss, Australian Institute of Health and Welfare. HHCS December 1992 Canberra (Feasibility Study).

12. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical care injury case study project*: prepared by Garry Coventry, Jeanne Daly, Merilyn Evans, Cathy Lowy, Marilyn McMahon, Gail Roberts, the National Centre for Socio-Legal Studies, La Trobe University. AGPS February 1993 Canberra (Case study report).

13. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Survey of medical defence organisations*: prepared by Statistical Consultancy, Australian Bureau of Statistics. Unpublished material April 1993 (ABS MDO Survey).

14. Commonwealth Department of Health, Housing, Local Government and Community Services (HHLGCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra (Defensive Medicine Study).

15. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of the Relationship between Compensation and Health and Community Services Programs. *Compensation and Commonwealth health and community services programs: a discussion paper*: prepared by Tom Brennan and John Deeble, Australian National University. Commonwealth Government Printer June 1993 Canberra (Compensation discussion paper).

16. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *So you want to know more about the Commonwealth Quality Assurance Legislation*: booklet. July 1993.

17. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: background paper*. HHCS August 1993 Canberra.

18. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: a rural perspective*: prepared by Madonna McGahan. HHCS December 1993 Canberra.

19. Interim report - see note 3.

20. Commonwealth Department of Human Services and Health (HSH). Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on medical professional indemnity arrangements*: prepared by John Walsh and Jann Skinner, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd. HSH March 1994 Canberra (MDO Consultancy Report).

21. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Incident monitoring and risk management in the health care sector: conference proceedings*. Radisson President Hotel, Melbourne. 29–30 November 1994, HSH 1994 Canberra.

22. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Patient guidelines: Consultancy for the development of information guidelines for health care professionals and patients in the event of an adverse patient outcome*: prepared by the Victorian Health Services Commissioner and the Health Issues Centre Victoria. March 1995 (Patient Guidelines).

23. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Patient guidelines: Consultancy for the development of information guidelines for health care professionals and patients in the event of an adverse patient*

outcome: prepared by the Victorian Health Services Commissioner and the Health Issues Centre Victoria. March 1995 (Provider Guidelines).

24. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Structured settlements as payment of compensation for personal injury: a discussion paper*. HSH June 1995 Canberra (Structured Settlements Discussion Paper).

25. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on taxation treatment of compensation payments*: prepared by John Walsh, Neil Wilson and Ian Farmer, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd. HSH June 1995 Canberra (Structured Settlements Tax Report).

26. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensable and non-compensable people with disabilities: equal needs – unequal assistance: a discussion paper*. HSH August 1995 Canberra (Disability Discussion Paper).

27. Information on incident monitoring and the Quality in Australian Health Care Study is available from the Health Services Outcomes Branch of the Commonwealth Department of Human Services and Health, telephone (06) 289 7046.

28. Interim Report - see note 4: 132–3.

29. Interim Report - see note 4: 173.

30. Submission from Consumers' Health Forum of Australia, September 1994.

31. Interim Report - see note 4: 147.

32. *Rogers v Whitaker* (1992) 109 ALR 625.

33. Submission from Consumer Help Against Malpractice, 9 November 1994: 4.

34. Submission from the Association for Australian Rural Nurses, 1 September 1994.

35. Interim Report - see note 4: 161–171.

36. Interim Report - see note 4: 275–284.

37. Council of Australian Governments Taskforce on Health and Community Services. *Meeting people's needs better: a discussion paper*. January 1995.

38. Disability Discussion Paper - see note 26.

Endnotes - Chapter 2

1. Commonwealth Department of Human Services and Health. (HSH) Review of Professional Indemnity Arrangements for Health Care Professionals. *Professional indemnity and compensation in health care: an interim report*. Australian Government Publishing Service (AGPS) February 1994 Canberra: 12 (Interim Report).

2. Submission from the Committee of Presidents of Medical Colleges (CPMC), 6 July 1994. The submission stated: "[w]e note that provider related issues account for less than 20% of adverse medical

outcomes." When this was checked with the CPMC, it was agreed that data available make it difficult, if not impossible, to give a definitive answer (letter from CPMC dated 16 August 1994).

3. Interim report - see note 1:21–5.

4. Schimmel E. The hazards of hospitalisation. 1964 *Annals of Internal Medicine* 60(1): 100–10. For articles which outline other research directed at looking at the issues of adverse patient outcomes see:

Barr D. Hazards of modern diagnosis and therapy – the price we pay. 1955 *Journal of the American Medical Association (JAMA)* 159(15): 1452–6; and Leape L. Error in medicine. 1994 *JAMA* 272(23): 1851–7.

5. Interim report - see note 1: 22–3.

6. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on the feasibility study of an Australian hospitals' adverse health care incidents study*: prepared by Roy Harvey and John Goss, Australian Institute of Health and Welfare. HHCS December 1992 Canberra (Feasibility study).

7. The members of the consortium were: Professor John Hamilton, Dean of the University of Newcastle Medical School; Professor Bob Gibberd, Department of Statistics, New South Wales Health Research Group, University of Newcastle; Ms Liza Newby, Senior Lecturer in Law, University of Newcastle; Dr Ross Wilson, Intensive Care Physician and Director of QARNS Program, Royal North Shore Hospital; and Professor Bill Runciman, Head of Anaesthesia and Intensive Care, University of Adelaide. Dr Wilson served as Project Director and Ms Bernie Harrison as Project Manager. Dr Susan Merrett, formerly Administrator of Medico-legal Services, South Australian Health Commission, ceased her connection with the project when she left the position in mid-1994.

8. When the Commonwealth Government funded the study in the 1992–93 Budget, it was considered necessary to ensure that any data collected in this and other studies or activities directed at improving the quality of care should be protected from any identifying material being subpoenaed by a court or revealed in any other manner, except in very limited circumstances. Should protection not be provided, it was considered unlikely that the health care professionals would participate. The *Health Insurance (Quality Assurance Confidentiality) Amendment Act 1992* was passed in December 1992. For details of the legislation, see Interim Report (note 1: 125–7), and Chapter 5 of this Report.

9. Peritonitis is an inflammation of the peritoneum or the serous membranes lining the walls of the abdominal and pelvic cavities. It can be caused by inflammation of abdominal organs, irritation from a perforated gall bladder, rupture of a cyst or irritation from blood during internal bleeding. It produces immediate and intense pain at the site of the infection. Miller BF, Brackman Keane C. Ency*clopedia and dictionary of medicine and nursing*. WB Saunders Company 1972 Philadelphia : 722.

10. The Quality in Australian Health Care Taskforce comprises:

Chairperson: Dr B Armstrong, Australian Institute of Health & Welfare;

Commonwealth and State Governments: Dr J Loy(Cwlth); Dr G Rubin(NSW); Dr B Kearney (SA);

Consumers' Health Forum: Ms M Draper; Ms B Garrett MBE;

National Health and Medical Research Council: Professor R Smallwood;

Committee of Presidents of Medical Colleges: Mr J Royle, The Royal Australasian College of Surgeons; Professor G Duggin, The Royal Australasian College of Physicians; Dr L Reti, The Royal Australian College of Obstetricians and Gynaecologists;

Study Consortium: Professor J Hamilton; Professor B Runciman; Dr R Wilson;

Royal College of Nursing Australia: Ms J Manning; Miss L Lambert; and

Australian College of Health Services Executives: Ms J Westaway.

11. For example: submission from the Committee of Presidents of Medical Colleges, 6 July 1994. "We are concerned about publicising adverse outcomes which may increase tort actions and/or stimulate legal firms to take action against care givers."

12. Interim Report - see note 1: 144–6.

13. See for example: submission from the Private Doctors Association of Australia, 24 March 1992.

14. See submissions to the PIR from: Consumer Health Against Malpractice, 9 November 1994; Citizen's Commission on Human Rights (Psychiatric Violations) Inc., 21 October 1994; Medical Consumers Association of New South Wales, 28 September 1994; Australian Plaintiff Lawyers Association Inc., 14 October 1994; and Slater and Gordon, Barristers and Solicitors, 8 November 1994.

15. Interim Report - see note 1: Appendix D.

16. Seymour J. *Fetal welfare and the law*: a report of an inquiry commissioned by the Australian Medical Association and also sponsored by the Royal Australian College of Obstetricians and Gynaecologists, the National Association of Specialist Obstetricians and Gynaecologists, the Australian College of Paediatrics and the Medical Protection Association of Australia. April 1995 Canberra: 104 (Fetal welfare report).

17. See: "Fetal welfare report attacked" 1995 *Australian Medicine* 7(11) : 2. It was stated that the report drew sharp criticism at the Australian Medical Association Federal Council meeting of 25 May 1995.

18. Fetal welfare report - see note 1: 105.

19. Rights of the Terminally Ill Bill 1995 (Northern Territory). Section 4 allows a patient to request the assistance of a medical practitioner to terminate his or her life in certain circumstances where there is a terminal illness.

20. *Rogers v. Whitaker* (1992) 109 ALR 625, see especially 631 where the majority judgment quotes with approval *F v. R* (1983) 33 SASR at 193, "the paramount consideration is that a person is entitled to make his own decisions about his life."

21. See: From the President. 1995 *Australian Medicin*e 7(11) : 5. Dr Weedon criticises unnamed recent court decisions and writes: "[i]t reinforces my view that in some cases, the medical profession (through its various indemnity organisations) is being made a de facto social security system for medical misadventure, regardless of any negligence by the doctor. How many millions of dollars have been paid out over the years for brain-damaged neonates when the likely aetiology was an *in utero* event, unrelated to the medical care of patients?"

22. The connection between cerebral palsy and birth was first asserted by Dr William John Little in 1862. See Little WJ. The influence of abnormal parturition, premature birth and asphyxia neonatorum, on the mental and physical condition of the child, especially in relation to deformities. 1862 *Trans. Obsts. Soc*. London 3 : 293–304, quoted in Lipson T. Annotation. Cerebral palsy, brain damage, blame and defensive obstetrics: time for a u-turn? 1991 *Journal of Paediatrics and Child Health* 27 : 201–2.

23. Lipson stated: "[w]hen confronted by a child with cerebral palsy, many medical practitioners will readily accept that brain injury or damage at birth may have played a major part, especially if there was any hint of difficulties at that time ... Some recent studies are challenging the concept that hypoxic or anoxic damage to the brain during the birth process is a common cause of cerebral palsy". Lipson T. - see note 22: 201.

24. Stanley F, Blair E, Westaway J. *Cerebral palsy – the role of obstetric care in pregnancy and delivery: A monograph for lawyers, doctors and parents*: prepared by the Institute for Child Health Research in conjunction with the Confederation of Australian Medical Defence Organisations. November 1994 : 2–6. Indeed, until the late 1970s, articles in learned journals were still being published which indicated a belief that nearly half of the cases of cerebral palsy could have been prevented through better obstetric care. See for example: McManus F, Rang M, Chance G, Whittaker J. Is cerebral palsy a preventable disease? 1977 *Obstetrics and Gynaecology* 50 : 71–7.

25. See for example: Blair E, Stanley F. Intrapartum asphyxia: a rare cause of cerebral palsy. 1988 *Journal of Pediatrics* 112 : 515–9; Gaffney G, Sellers S, Flavell V, Squier M, Johnson A. Case-control study of intrapartum care, cerebral palsy and perinatal death. 1994 *British Medical Journal* 308: 742–50; and Richmond S, Niswander K, Snodgrass C, Wagstaff I. The obstetric management of fetal distress and its association with cerebral palsy. 1994 *Obstetrics and Gynaecology* 83(5) : 643–6.

26. See for example: *Howarth v. Adey*, Victorian Supreme Court, June 1994; and Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical care injury case study project*: prepared by the National Centre for Socio-Legal Studies, La Trobe University: authors Garry Coventry, Jeanne Daly, Merilyn Evans, Cathy Lowry, Marilyn McMahon, Gail Roberts. AGPS May 1993 Canberra. One of the participants in the study, Darren Moynihan, was born with severe mental and physical disabilities. Darren's mother was unsuccessful in obtaining compensation.

27. See : From the President. 1995 *Australian Medicine* 7(11) : 5.

28 See: Dr Alistair McLennan. Baby births crisis forecast. *Adelaide Advertiser* 30 March 1995.

29. The recent consensus statement on the origins of cerebral palsy acknowledges this issue. "What little evidence exists suggests that less than 2% of cerebral palsy could be attributed to suboptimal intrapartum care. It is the opinion of this conference that this figure could be lower." The Australian and New Zealand Perinatal Societies. The origins of cerebral palsy – a consensus statement. 1995 *Medical Journal of Australia* 162 : 85–9 (Consensus statement). Other studies suggest higher rates of preventable cerebral palsy. For example: Gaffney G et al - see note 25.

30 Information supplied by the medical defence organisations in Australia showed that in the five years 1988–93, compensation/damages was paid out in only around 5 cases of cerebral palsy per year on average (the range was 1–7, and it was not in an increasing pattern). The amounts paid averaged only $750,000 in that period, with the top amount at that time being between $2–3million.

31 Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra : 24 - Table 4.4.

32 There are some electronic-based judgement services available, which are used by law firms. However, these are generally costly and not readily available to members of the public.

33 See: Tito F. Mistakes ... the clash between law and medicine. 1995 *Australian Medicine* 7(4) : 18.

34 Certainly this would seem to be the case, if the experiences of one MDO in Australia bear true. 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.

35 *Locher v Turner*, Supreme Court of Queensland, Rockhampton, No 102 of 1994.

36 These aims are set out in Article 2 of the Draft Constitution of the Australian Institute for Health, Law and Ethics.

37 Interim Report see note 1: Chapter 8.

38 For example, the NSW Supreme Court was able to identify 524 medical negligence cases between 1 January 1992 and 30 June 1995, but no other data was readily available (correspondence from Ms Kay Blance, Acting Chief Executive Officer of the Supreme Court of NSW, 3 August 1995). Other courts do not keep separate data on these cases - they are included in other personal injury matters.

39 Information was provided by Ms Audrey Lee, Solicitor, General Insurance Law, GIO at the United Medical Defence Conference *Increasing Health Care Litigation - can Australia afford it?* 9 September 1995 Hilton Hotel Sydney.

Endnotes - Chapter 3

1. For example, the submission to the PIR from the Swan Hills Division of General Practitioners Ltd., 24 August 1994, expressed concern about the practicability of providing a patient with all necessary information.

2. This thought was expressed to the PIR as " in general practice, if you hear hoof-beats, you should look for horses not zebras, because most of the hoof-beats will indicate horses".

3. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. Australian Government Publishing Service (AGPS) May 1993 Canberra.

4. National Health and Medical Research Council (NHMRC). Quality of Health Care Committee. *Draft guidelines for clinical practice guideline development.* NHMRC May 1993 Canberra : 7 (NHMRC 1993 draft guideline guidelines). The 1994 draft of the guidelines has removed this comment – apparently because of a later awareness of high quality, scientific evidence for many elements of health care (NHMRC 1994 draft guideline guidelines). Copies of the draft guidelines and the final guidelines, which are expected to be out in late October 1995, are available from the Secretariat, Quality of Health Care Committee, NHMRC, Department of Human Services and Health, GPO Box 9848, Canberra, 2601.

5. Consumers Health Forum of Australia. *Casemix project: final report.* Unpublished report December 1994. Copies are available from the Consumers Health Forum of Australia, PO Box 52, Lyons, ACT 2606, telephone (06) 281 0811.

6. Health Issues Centre (for the Australian Consumers Council). *Why we need a charter of rights for health care consumers.* Unpublished report May 1994. Further information is available from the Australian Consumers Council's Executive Officer, telephone (06) 250 6327.

7. Davidoff F, Case K, Fried P. Evidence-based medicine: why all the fuss? 1995 *Annals of Internal Medicine* 122(9) : 727. The editorial was commenting on the introduction later in 1995 of a new journal called *Evidence-Based Medicine.*

8. Cochrane A L. *Effectiveness and efficiency. Random reflections on health services.* London: Nuffield Provincial Hospitals Trust 1972 United Kingdom. Quoted in The Cochrane Collaboration. Preparing, maintaining and disseminating systematic reviews of the effects of health care: booklet : 1 (Cochrane collaboration booklet). For further information on the Cochrane Collaboration contact The Australasian Cochrane Centre, Flinders Medical Centre, Bedford Park, SA, 5042, Telephone (08) 204 5255.

9. Cochrane collaboration booklet - see note 8: 3.

10. NHMRC 1993 draft guideline guidelines - see note 4: 20.

11. Kassirer J. Clinical trials and meta-analysis: what do they do for us? 1992 *New England Journal of Medicine* 327(4) : 273–4.

12. Cochrane collaboration booklet - see note 8: 3.

13. Cochrane collaboration booklet - see note 8: 3.

14. Kassirer J - see note 11: 273.

15. Kassirer J - see note 11: 274.

16. There are Cochrane Centres in the United Kingdom, Denmark, Italy, Canada, the United States of America and Australia.

17. Cochrane collaboration booklet - see note 8: 5.

18. Cochrane collaboration booklet - see note 8: 6.

19. Adapted from Cochrane collaboration booklet - see note 8: 2.

20. Cochrane collaboration booklet - see note 8: 5.

21. Cochrane collaboration booklet - see note 8: 7.

22. Cochrane collaboration booklet - see note 8: 7.

23. Cochrane collaboration booklet - see note 8: 9.

24. Cochrane collaboration booklet - see note 8: 4–5.

25. Cochrane collaboration booklet - see note 8: 11.

26. Information extracted from a briefing note for the 8 December 1994 meeting of the NHMRC's Quality of Care and Health Outcomes Committee (unpublished.)

27. See, for example, Brook R. Using scientific information to improve quality of health care. 1993 *Annals of New York Academy of Sciences* 703 : 74–84.

28. Bunker J. Is efficacy the gold standard for quality assessment? 1988 *Inquiry* 25 : 51–8.

29. Brook R. - see note 27: 74-6.

30. Runciman W. Qualitative versus Quantitative Research – balancing cost, yield and feasibility. 1993 *Anaesthesia and Intensive Care* 21(5) : 502-5.

31. Nechas E, Foley D. *Unequal Treatment*. Simon & Schuster 1994 New York : 21–2.

32. Working party on the development of a NHMRC Women's Health Strategy and Implementation Plan. *A Women's Health Strategy and Implementation Plan:* chaired by Judith Roberts. AGPS 1994 Canberra (Women's health strategy).

33. Women's health strategy - see note 32: 10, especially recommendations 4.1 and 4.2.

34. Information provided by Dr Cathy Mead, Office of NHMRC, Commonwealth Department of Human Services and Health.

35. Committee of Enquiry into Allegations Concerning Treatment of Cervical Cancer at the National Women's Hospital and into Other Related Matters. *The Report of the Committee of Enquiry into Allegations Concerning Treatment of Cervical Cancer at the National Women's Hospital and into Other Related Matters*. Government Printing Office July 1988 Auckland: 38 (Cervical cancer inquiry report). Carcinoma in situ is a symptomless condition. It is a lesion found on the surface of the lining or skin of the uterus or any area of the genital tract and that has not invaded or spread beneath that layer. It will develop into cancer in an unknown number of cases over an unknown period of years. To discover its presence, it is necessary to screen well women.

36. Cervical cancer inquiry report - see note 35: 53.

37. Cervical cancer inquiry report - see note 35: 53.

38. It is interesting to note that this work, which attracted considerable public scandal due to the death from invasive cervical cancer of some of the untreated women, was reported in various journals. The journal articles attracted comments, which the Committee of Enquiry noted were "... directed more at the minority nature of Dr Green's views, nonetheless they were also expressions of concern about the validity of his trial". Such comments should have been considered by the doctor or his colleagues when a working party was formed to review the 1966 Proposal. Cervical cancer inquiry report - see note 35: 91.

39. Cervical cancer inquiry report - see note 35: 69.

40. Editorial. Doctor knows best ... or not. 1995 *New Scientist* 1 July : 3; and Kiernan V. Patients confused by medical trials. 1995 *New Scientist* 1 July : 7.

41. NHMRC 1993 draft guideline guidelines - see note 4.

42. Bernard C. An introduction to the study of experimental medicine (trans. Green H.) Dover Publications 1985 New York, quoted in Runciman W. - see note 30: 503.

43. United States Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. *Medical treatment effectiveness research – summary.* August 1994 : 2.

44. National Health Strategy. *Making it better: strategies for improving the effectiveness and quality of health services in Australia.* National Health Strategy Background Paper No 8: by Roy Harvey. AGPS October 1991 Canberra : 30 (Making it better paper).

45. Commonwealth Department of Human Services and Health. Review of *Professional Indemnity Arrangements for Health Care Professionals. Professional indemnity and compensation in health care: an interim report.* AGPS February 1994 Canberra : 121.

46. Making it better paper - see note 44: 6.

47. The survey showed guidelines had been developed for diagnostic purposes by four colleges, four societies and one non-medical organisation. Thirteen organisations had developed treatment guidelines, while 16 had developed guidelines for education and 14 for accreditation purposes. Five organisations had evaluated the effects of their guidelines on practice. Three said their guidelines were effective in improving performance and two organisations did not answer. Making it better paper - see note 44: 30.

48. Submission to the PIR from Roy Harvey, Australian Institute of Health and Welfare, 14 September 1994.

49. NHMRC 1993 draft guideline guidelines - see note 4.

50. NHMRC 1993 draft guideline guidelines - see note 4: 1–4.

51. NHMRC 1993 draft guideline guidelines - see note 4: 5.

52. NHMRC 1993 draft guideline guidelines - see note 4: 4.

53. NHMRC 1993 draft guideline guidelines - see note 4.

54. NHMRC. *Clinical practice guidelines for the management of early breast cancer.* Draft first edition, 24 June 1995.

55. NHMRC 1993 draft guideline guidelines - see note 4: 7.

56. United States Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. *AHCPR Program Note: Clinical practice guideline development.* August 1993 : 1.

57. These guidelines, which are supported by the United States Agency for Health Care Policy and Research (AHCPR), are listed in the AHCPR publication catalogue for 1995, which is currently in print.

58. These additional areas for guideline development were listed in the January 1994 Profile of the AHCPR.

59. Parliament of the Commonwealth of Australia. House of Representatives Standing Committee on Community Affairs. *Report on the management and treatment of breast cancer*. AGPS February 1995 Canberra.

60. Ellrodt A, Conner L, Riedinger M, Weingarten S. Measuring and improving physician compliance with clinical practice guidelines. A controlled interventional trial. 1995 *Annals of Internal Medicine* 122(4) : 277–82.

61. Ellrodt A et al - see note 60: 277.

62. Ellrodt A et al - see note 60: 280.

63. Ellrodt A et al - see note 60: 281–2.

64. Ellrodt A et al - see note 60: 282.

65. Commonwealth Department of Human Services and Health. *Better health outcomes for Australians: national goals, targets and strategies for better health outcomes into the next century*. AGPS 1994 Canberra : 1 (National goals and targets report).

66. National goals and targets report - see note 65: 1.

67. National goals and targets report - see note 65: 3-4.

68. New South Wales Health (NSWH). *Getting it right – focusing on the outcomes of health services and programs*. NSWH April 1994 Sydney : 17–19 (Getting it right). Copies are available by telephoning (02) 391 9010, quote State Health Publication No. (PA) 94–041.

69. New South Wales Health. *Questions and Answers on Areas and District Health Outcomes Councils*. Pamphlet.

70. Getting it right - see note 68.

71. Best J. *Normaltown NSW*. NSWH October 1993 Sydney. Copies are available by telephoning (02) 391 9010, quote State Health Publication No. (PA) 93–130.

72. Correspondence to the PIR from Ms M Williamson, Epidemiology Branch, New South Wales Health, 7 July 1995.

73. National goals and targets report - see note 65.

74. National Health Strategy. *Enough to make you sick: how income and environment affect health.* Research Paper No 1. AGPS September 1992 Canberra : 14.

75. NHMRC. *NHMRC Statement on Human Experimentation and Supplementary Notes* supplementary note 7. NHMRC November 1992 Canberra. Copies of NHMRC reports are available from the Publications Officer, NHMRC, GPO Box 9848, Canberra ACT 2601, telephone (06) 289 7646.

76. Harvey R. Health outcomes, quality assurance and information. A presentation to a seminar titled An introduction to health outcomes, held at the Victorian Department of Health and Community Services, 26 May 1995 : 12.

77. Harvey R. - see note 76: 13.

78. Making it better paper - see note 44: 16.

79. NHMRC 1994 draft guideline guidelines - see note 4: 5. The PIR notes that in the NHMRC 1993 draft document it was stated that: "... strictly speaking [the NHMRC Statement on Human Experimentation and Supplementary Notes] should apply to interventions for which both consensus guidelines and non-consensus statements are issued." NHMRC 1993 draft guideline guidelines - see note 4: 7.

80. Making it better paper - see note 44: 41–42.

81. Making it better paper - see note 44: 42.

82. NHMRC 1993 draft guideline guidelines - see note 4: 7.

83. Making it better paper - see note 44: 42.

1. Wain G, Ward J, Towler B. Gynaecological care of women with abnormal Pap smears: how varied is current practice? 1995 *Medical Journal of Australia* 162 : 348–353.

2. Commonwealth Department of Human Services and Health. *Screening to prevent cervical cancer: Management of women with screen detected abnormalities.* The package includes a consumer information booklet, a summary of the NHMRC Guidelines for the Management of Women with Screen Detected Abnormalities and a desk reference chart summary, as well as Guidelines for referral for investigation of intermenstrual and postcoital bleeding. Copies can be obtained from the Queensland Cervical Screening Program, State Coordination Unit, Queensland Health, GPO Box 48, Brisbane Queensland 4001, fax (07) 3225 2629 (Cervical screening information package).

3. Parliament of the Commonwealth of Australia. House of Representatives Standing Committee on Community Affairs. *Report on the management and treatment of breast cancer.* Australian Government Publishing Service (AGPS) February 1995 Canberra.

4. The information concerning the Help for Health Trust was extracted from: Health for Health Trust. *Third annual report 1993–1994.* Copies are available from The Help for Health Trust, Highcroft Cottage, Romsey Road, Winchester, Hampshire, England, SO22 5DH; and Gann B. *Promoting choice: sharing decisions – consumer health information in the 1990s*. Unpublished paper, available from the Help for Health Trust at the above address.

5. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* AGPS February 1994 Canberra : 147 (Interim Report).

6. Submission from the Association for Australian Rural Nurses, 1 September 1994.

7. Submission from the Law Council of Australia, 2 September 1994.

8. Submission from the Pharmacy Guild of Australia, 1 September 1994.

9. Submission from the Public Interest Advocacy Centre, 19 September 1994.

10. *Rogers v. Whitaker* (1992) 109 ALR 625.

11. See for example: *Karpati v Spira*. Unreported, NSW Supreme Court (Spender AJ) No 15853 of 1992, 6 June 1995; *Berger v Mutton*. Unreported NSW District Court (Twigg DCJ) No 3584 of 1990, 22 November 1994; and *Bustos v Hair Transplant Pty Ltd and Peter Wearne*. Unreported, NSW District Court (Cooper DCJ) No 30978 of 1986, 20 December 1994.

12. National Health and Medical Research Council. *General guidelines for medical practitioners on providing information to patients.* AGPS 1993 Canberra (NHMRC patient information guidelines).

13. NHMRC. *NHMRC Statement on human experimentation and supplementary notes*. AGPS 1992 Canberra (NHMRC human experiment statement).

14. *O'Shea v Sullivan and Macquarie Pathology Services Pty Ltd* (1994) Aust Torts Reports ¶81–273.

15. HSH. National Cervical Screening Program. *Pap smear test results - a guide for women with an abnormal pap smear test.* AGPS August 1995 Canberra (Women's pap smear guide).

16. HSH. *Report of the Interim Evaluation Steering Committee. The interim evaluation of the organised approach to preventing cancer of the cervix 1991–95*. HSH May 1995 Canberra : 13–14 (Interim evaluation report).

17. HSH. *Report by the NHMRC for the Organised Approach to Preventing Cancer of the Cervix. Screening to prevent cervical cancer: guidelines for the management of women with screen detected abnormalities.* AGPS 1994 Canberra : 4 (NHMRC screening abnormalities guidelines).

18. Interim evaluation report - see note 16: 1.

19. Medley G. Failures in screening for cervical cancer: who is to blame? 1995 *Medical Journal of Australia* 162 : 342.

20. Report of the United States Preventive Services Task Force. *Guide to clinical preventive services: an assessment of the effectiveness of 169 interventions.* Williams & Wilkins 1989 Baltimore : 57–62.

21. Interim evaluation report - see note 16: 26–7.

22. Interim evaluation report - see note 16: 27.

23. Interim evaluation report - see note 16: 28.

24. NHMRC screening abnormalities guidelines - see note 17: 10.

25. Correspondence to the PIR from Dr Heather Mitchell, Deputy Director of the Victorian Cytology Service, 13 April 1995. Dr Mitchell cited information from published articles, but these original sources have not been followed up.

26. Wain G et al - see note 1.

27. NHMRC screening abnormalities guidelines - see note 17: 16.

28. Women's pap smear guide - see note 15: 14-18.

29. NHMRC screening abnormalities guidelines - see note 17: 17–18.

30. NHMRC screening abnormalities guidelines - see note 17: 5.

31. Wain G. et al - see note 1: 352.

32. This problem of an intervention rate that seems excessive and that still does not catch all cases of cervical cancer in women who are screened is not unique to Australia. In a recently published evaluation of its own service, the Bristol cervical cancer screening program in England noted that the numbers of colposcopies and abnormalities found are "excessively high in comparison with incidence of the malignancy we are trying to prevent". It also noted that the effect of screening on the death rates in Bristol has been too small to detect. The conclusions of the study were that "despite good organisation of the service, much of our effort in Bristol is devoted to limiting the harm done to healthy women and to protecting our staff from litigation as cases of serious disease continue to occur". Raffle A, Alden B, Mackenzie E. Detection rates for abnormal cervical smears : what are we screening for?. 1995 *Lancet* 345 : 1469-73.

33. NHMRC screening abnormalities guidelines - see note 17: 31 (see Appendix 2).

34. Interim evaluation report - see note 16: 21–4.

35. Cervical screening information package - see note 2.

36. *O'Shea v Sullivan and Macquarie Pathology Services Pty Ltd* (1994) Aust Torts Reports ¶81–273.

37. Royal Australian Colleges of Obstetricians and Gynaecologists and the Royal Australian College of General Practitioners, Australian Society for Colposcopy and Cervical Pathology and HSH. *Guidelines for Referral for Investigation of Intermenstrual and Postcoital Bleeding*. 1995. The guidelines themselves identify their genesis as the O'Shea case, in a footnote on page one.

38. The PIR would like to thank Dr Heather Mitchell, Deputy Director of the Victorian Cytology Service, and Dr Margaret Dorsch, Specialist Adviser, Department of Human Services and Health, for input to the PIR and for their time spent in assisting PIR staff to understand the issues surrounding screening to prevent cervical cancer.

39. HSH. Draft quality management plan for the National Cervical Screening Program. Unpublished material from Dr Margaret Dorsch, Specialist Adviser, HSH.

40. Baume P. *A cutting edge: Australia's surgical workforce - report of the Inquiry into the Supply of, and Requirements for, Medical Specialist Services in Australia, 1994*. AGPS 1994 Canberra : 118-119.

41. Interim report - see note 5: 158.

42. *Private Hospitals Regulation 1990 (NSW)*, Schedule 1, regulations 161–64; *Day Procedure Centre Regulation 1990 (NSW)*, Schedule 1, regulations 161–64; *Nursing Homes Regulation 1990 (NSW)*, Schedule 1, regulations 151–54.

43. Interim report - see note 5: 158–61.

44. Interim report - see note 5: 158-61; and HSH. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical care injury case study project*: prepared by the National Centre for Socio-Legal Studies, La Trobe University: authors Coventry G, Daly J, Evans M, Lowy C, McMahon M, Roberts G. AGPS February 1993 Canberra.

45. Submission from the Private Hospitals Association of Queensland, 22 December 1994 : 6.

46. Submission from the Private Hospitals Association of Queensland, 22 December 1994 : 6.

47. Submission from the Public Interest Advocacy Centre, 19 September 1994 : 15.

48. Submission from Ms A Richards, 26 August 1994 : 16.

49. Submission from the New South Wales Health Care Complaints Commission, 4 November 1994 : 2.

50. Submission from the Consumers Health Forum of Australia, September 1994 : 9.

51. Submission from Mr P McCarthy, 25 July 1994 : 5.

52. Submission from the Medical Protection Association of Australia, 19 October 1994 : 6.

53. Submission from the Australian Plaintiff Lawyers Association., 4 October 1994 : 3.

54. Submission from the Royal Australian & New Zealand College of Psychiatrists, 1 September 1994 : 2.

55. Submission to the PIR's discussion paper from the Medical Record Association of Australia, undated 1992 : 1.

56. Submission to the PIR's discussion paper from the Medical Record Association of Australia, undated 1992 : 2.

57. Australian Medical Association resolution of 29–30 October 1993.

58. Commonwealth of Australia. *Report of the Inquiry into the Use of Pituitary Derived Hormones in Australia and Cruetzfeldt Jakob Disease*: author Margaret Allars. AGPS June 1994 Canberra : 635–45 (Allars report).

59. Allars report - see note 58: second page of recommendations, unnumbered.

60. *Breen v. Williams* Unreported, Supreme Court of New South Wales Equity Division (Bryson J) No.2363/94, 10 October 1994 (Breen Supreme Court decision).

61. Breen Supreme Court decision - see note 60: 62.

62. See: the Canadian case of *McInerney v. MacDonald* (1992) 93 DLR (4th) 415; and the English case of *R v. Mid-Glamorgan Family Health Service Authority exparte Martin* (1993) 16 BMLR 81.

63. Breen Supreme Court decision - see note 60: 77.

64. The Privacy Commissioner was broadcast on radio station 2GB, 11 October 1994.

65. *The Australian*, 13 October 1994.

66. *Breen v. Williams*. Unreported, New South Wales Court of Appeal (Kirby P, Mahoney JA and Meagher JJA) No. CA 40600/94, 23 December 1994 (Breen Court of Appeal decision).

67. Breen Court of Appeal decision - see note 66- Mahoney JA : 13.

68. Breen Court of Appeal decision - see note 66- Mahoney JA : 13 -14.

69. Breen Court of Appeal decision - see note 66- Mahoney JA : 15–21.

70. Breen Court of Appeal decision - see note 66- Mahoney JA : 25–6.

71. Breen Court of Appeal decision - see note 66- Mahoney JA : 26.

72. Breen Court of Appeal decision - see note 66- Kirby P : 42–3.

73. Breen Court of Appeal decision - see note 66- Kirby P : 44.

74. Australian Law Reform Commission (ALRC) and Administrative Review Council. *Freedom of information. Issues Paper 12.* 1994 (FOI issues paper). See also ALRC and Administrative Review Council. *Freedom of information. Discussion Paper 59*. May 1995 (FOI discussion paper) : 1. Copies of these papers are available from the Australian Law Reform Commission, GPO Box 3708, SYDNEY NSW 2001, telephone (02) 284 6333.

75. FOI discussion paper - see note 74: 121.

76. FOI discussion paper - see note 74: 23.

77. FOI discussion paper - see note 74: 125.

78. *Harry Brandy v. Human Rights and Equal Opportunity Commission and Ors* (1995) 127 ALR 1. In this case, the Court was asked to rule on whether provisions of Part 111 of the *Racial Discrimination Act 1975* (Cwlth*)* were invalid. The question related to whether the commission exercised judicial power otherwise than in conformity with Chapter 111 of the Commonwealth Constitution. The Constitution requires judicial power to be exercised by a court established pursuant to s.71 and constituted in accordance with s.72 of the Constitution. The Court found that provisions providing for the registration of a determination of the commission and its enforcement as if it were an order of the Federal Court constituted an exercise of judicial power by the commission. As the commission is not a court established in accordance with the Constitution, the provisions of the Act that enable registration and enforcement of a commission determination were found to be invalid.

79. FOI discussion paper - see note 74: 126.

80. FOI discussion paper - see note 74: 126–7.

81. FOI discussion paper - see note 74: 127.

82. Medical Records Consortium, School of Community Medicine, University of New South Wales. *Regulations and guidelines for medical record creation, content, storage and disposal by medical practitioners: discussion paper for the Medical Board of New South Wales*. May 1995 : 4 and 24 (Medical records discussion paper).

83. Medical records discussion paper - see note 82: 15–16 and 24.

84. Medical records discussion paper - see note 82: 25.

Endnotes - Chapter 4

1. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* Australian Government Publishing Service (AGPS) February 1994 Canberra: 26–36 (Interim Report).

2. Interim report - see note 1: chapter 5.

3. Submission from Victorian Department of Health and Community Services, 6 October 1994.

4. Submission from the Public Interest Advocacy Centre, 19 September 1994.

5. Submission from the Law Council of Australia, 2 September 1994.

6. Submission from the Australian Institute of Health and Welfare, 14 September 1994.

7. Submission from the Northern Region, Department of Community and Health Services, Tasmania, 23 January 1995.

8. See Paget M. *The unity of mistakes : a phenomenological interpretation of medical work.* Temple University Press 1988 Philadelphia.

9. Leape L. Error in medicine. 1994 *JAMA* 272(23) : 1851-1857 at 1851-1852.

10. Christensen J, Levinson W, Dunn P. The heart of darkness: the impact of perceived mistakes on physicians. 1992 *Journal of General Internal Medicine* 7(July/August) : 424-431 at 430.

11. Tito F. Mistakes... the clash of law and medicine. 1995 *Australian Medicine* 7(4) : 18.

12. Christensen J, Levinson W, Dunn P. - see note 10: 430.

13. Leape L. - see note 9: 1852.

14. Van Santen J. Trainee docs work dangerously long hours. 1994 *Medical Observer* 28 October : 1, quoting from the evidence of Dr Drew Dawson, an expert on the effects of shift work on performance.

15. Currie M, Mackay P, Morgan C, Runciman W, Russell W, Sellen A, Webb R, Williamson J. The "wrong drug" problem in anaesthesia : an analysis of 2000 incident reports.1993 *Anaesthesia and Intensive Care* 21 : 596-601 at 598.

16. Van Santen J. - see note 14, where Dr Dawson states that for some senior medical administrators the issue was an emotional one rather than an economic one. "People feel you have to work these hours to become a real doctor. They think because they did it in their day, so should the new generation of trainee doctors." : 2.

17. Janssen E. Asleep on the job. 1995 *Australian Medicine* 7(5) : 11.

18. Zelcer, J. Fatigue - the Anaesthetist's dilemma. Paper to the conference Risks to the Anaesthetist, 12 August 1995, Carlton Radisson Hotel Melbourne.

19. Van Santen J. - see note 14: 2, quoting from the evidence of Dr Drew Dawson.

20. Australian Institute of Health and Welfare (AIHW). *A Survey of Complaints Handling Processes and Knowledge and Use of Quality Assurance Legislation in Australian Hospitals, 1993 - A Report to the Professional Indemnity Review*. unpublished (AIHW 1993 survey).

21. Renwick M, Harvey R. *Quality Assurance in Hospitals - Report of a Survey* : Australian Institute of Health. AGPS 1988 Canberra (1988 QA survey).

22. 1988 QA survey - see note 21: 19.

23. 1988 QA survey - see note 21: 26.

24. Interim report - see note 1: 173.

25. Submission from Consumers' Health Forum, September 1994.

26. Submission from the Medical Consumers Association of NSW, 28 September 1994.

27. Submission from the Maternity Alliance, undated.

28. Submission from Paul Maher, 29 August 1994.

29. Submission from Council of Retired Union Members Associations of New South Wales, undated.

30. Victorian Hospitals' Association Quality Review Working Party. *Report on the Role of Government in Monitoring and Ensuring Quality*. March 1995 : 15.

31. Congress of the United States, Office of Technology Assessment (OTA). *The Quality of Medical Care - information for consumers*. US Government Printing Office June 1988 Washington DC : see especially Chapter 11 - "Patients' Assessments of their Care" (OTA report).

32. OTA report - see note 31: 245.

33. OTA report - see note 31: 246.

34. OTA report - see note 31: 10.

35. Report from the Cochrane Exploratory meeting 2 May 1995 - Communicating Effectively with Consumers, 12 July 1995 Melbourne, Appendix 5, List of participants (Cochrane meeting notes).

36. Cochrane meeting notes - see note 35: 1.

37. Interim report - see note 1: 133.

38. Submission from the Private Hospitals' Association of Queensland, 22 December 1994.

39. Submission from the Committee of Presidents of Medical Colleges, 6 July 1994.

40. Submissions from the National Rural Health Alliance, 20 June 1994 and Victorian Department of Health and Community Services, 6 October 1994.

41. The numbering of the sections of the legislation were modified, where the Health Insurance Act provisions were renumbered. Section 106N is now section 124Z. Part VC on Quality Assurance Confidentiality now covers sections 124V to 124ZC.

42. Submission from the Australian Dental Association (Victorian Branch), 26 July 1994.

43. For example, section 124V sets out the object of the Part - "to encourage efficient quality assurance activities in connection with the provision of certain health services."

44. See for example, regulations 23E (2) and 23F(2)-(4).

45. 5 in NSW/ACT, 15 in Victoria, 1 in Queensland, 7 in South Australia and 2 in Tasmania : AIHW 1993 survey - see note 20, Appendix 2.

46. 3 in NSW/ACT, 4 in Victoria : AIHW 1993 survey - see note 20: Appendix 2.

47. Runciman W, Sellen A, Webb R, et al. Errors, incidents and accidents in anaesthetic practice. 1993 *Anaesthetic and Intensive Care* 21(5) : 506-519.

48. Reason J. The human factor in medical accidents. Chapter in *Medical Accidents*, edited by Vincent C, Ennis M, Audley R. Oxford University Press 1993 England : 5.

49. Eagle et al. (1992) cited in Reason J. - see note 48: 10.

50. Australian Patient Safety Foundation. *Australian Anaesthesia Incident Monitoring Study - A report for the Professional Indemnity Review*, December 1994 : 16. For copies of this report, contact the Department of Human Services and Health on 06-289-7030. The Australian Patient Safety Foundation can be contacted at GPO Box 400, Adelaide on 08 224 5544.

51. Flanagan J. The critical incident technique. 1954 *Psychology Bulletin* 51: 327–58.

52. Webb R, Van der Walt J, Runciman W, Williamson J, Cockings J, Russell W and Helps S. Which monitor? An analysis of 2000 incident reports . 1993 Anaesthesia and Intensive Care 21: 529-542.

53. Webb R et al. - see note 52: 537 and Figure 3.

54. Webb R et al. - see note 52: 541.

55. Australian Patient Safety Foundation. *Australian Anaesthesia Incident Monitoring Study - A report for the Professional Indemnity Review*, December 1994. For copies of this report, contact the Department of Human Services and Health on 06 289 7305. The Australian Patient Safety Foundation can be contacted at GPO Box 400, Adelaide on 08 224 5544.

56. The conclusions of this part of the pilot (that is, the first 34 incidents) were presented to the PIR in the following report : Campbell J and Ryan M. *Final Report on the Pilot Project on Incident Monitoring in Obstetrics and Gynaecology* (undated).

57. The results summarised here were presented to the PIR in the following report: Wright M, Parker G. Final Report : *RANZCP Critical Incident Pilot Study* (undated).

58. Vinen J, Gaudry P, Ashby R, Epstein J and Blizard P. *Critical Incident Monitoring Study (CIMS) in Emergency Medicine: an interim report.* October 1994: 1 - see paragraph 3.

59. Vinen J, Gaudry P, Ashby R, Epstein J and Blizard P. *Critical Incident Monitoring Study (CIMS) in Emergency Medicine: A second report.* May 1995 : 4.

60. Vinen J et al - see note 59: 6-7 and table 2.

61. Vinen J et al - see note 59: 4-5.

62. Vinen J et al - see note 59: 8-9 and table 3.

63. Vinen J et al - see note 59: 9.

64. Vinen J et al - see note 59: 9-13.

65. The conclusions of this pilot were presented to the PIR in two reports. Beckmann U. *Development, introduction and evaluation of an anonymous voluntary incident reporting system in intensive care - report for pilot study and national study to 30th June 1994*. September 1994. Beckmann U. *Development, introduction and evaluation of an anonymous voluntary incident reporting system in intensive care*. 24 February 1995.

66. The results of this pilot were provided to the PIR in an attachment to a letter dated 22 November 1994 from the project head, Dr Gregory Lockrey.

67. This pilot provided two reports to the PIR: Miller G, Britt H, Steven I, Howarth G, Nicholson P, Reid S, Bhasale A and Norton K. *Incident Monitoring in General Practice: A pilot study* - report to the Professional Indemnity Review, Commonwealth Department of Human Services and Health. September 1994 . Miller G, Britt H, Steven I, Howarth G, Nicholson P, Reid S, Bhasale A and Norton K. *Incident Monitoring in General Practice: A pilot study* - Final report to the Professional Indemnity Review, Commonwealth Department of Human Services and Health. June 1995 (GP second report).

68. GP second report - see note 67: 181-182.

69. A report on the study thus far was presented to the Department. Australian Patient Safety Foundation. *The Australian Health Care Incident Monitoring Study (AHCIMS)* - draft final report. May 1995.

70. Australian Patient Safety Foundation. *Australian Anaesthesia Incident Monitoring Study - A report for the Professional Indemnity Review*, December 1994 : 17-18 (AIMS report).

71. AIMS report- see note 70: 18.

72. Australian Patient Safety Foundation. *The Australian Health Care Incident Monitoring Study (AHCIMS)* - draft final report. May 1995 : 14-15 (AHCIMS report).

73. AHCIMS report - see note 72: 12, see especially figure 2.

74. Interim report - see note 1: 132–133.

75. Interim report - see note 1: 264–272.

76. Submission from the National Rural Health Alliance, 20 June 1994.

77. Submission from the Private Hospitals' Association of Queensland, 22 December 1994.

78. Submission from F and A Richards, 26 August 1994.

79. Submission from the Royal Australasian College of Surgeons, 12 August 1994.

80. Submission from Faulkner Street Medical Practice, 16 August 1994.

81. Baume P. *A Cutting Edge - Australia's surgical workforce. Report of the Inquiry into the Supply of, and Requirements for, Medical Specialist Services in Australia, 1994*. AGPS 1994 Canberra : see eg recommendations in relation to competence certification 102-103; and chapter 9, especially 120-121.

82. Commonwealth Department of Health, Housing, Local Government and Community Services. *Screening to prevent cancer of the cervix*. A handbook compiled by Dr Alison Free, Medical Adviser, Cervical Cancer Prevention Task Force, November 1991.

83. Commonwealth Department of Health, Housing, Local Government and Community Services. *Making the Pap smear better*. Report of the Steering Group on Quality Assurance in Screening for the Prevention of Cancer of the Cervix. AGPS April 1993 Canberra (reprinted May 1994).

84. National Pathology Accreditation Advisory Council. *Guidelines for Gynaecological (Cervical) Cytology*. AGPS 1993 Canberra.

85. In a study of the correlation between histological diagnosis of CIN1 and corresponding smear results, it was found that the smear result was negative in 42% of cases, borderline in 14%, and in the remaining 44% various grades of CIN were predicted. The results of the histology review revealed that in 10% of positive cases the classification of CIN1 was not justified; 22% fell into the borderline category and the remaining 68% were (probably) genuine cases of CIN. AI Al-Nafussi, MK Colquhoun. Mild cervical intraepithelial neoplasia (CIN1): a histological overdiagnosis. 1990 *Histopathology* 17 : 557–61.

86. Spice Management Consulting Services. *The interim evaluation of the Organised Approach for Preventing Cancer of the Cervix*. Final Report of the Evaluation Steering Committee. 8 February 1995 : 37-38.

87. Victorian Department of Health and Community Services Committee on Quality. *Towards a New Framework for Quality in Victoria's Hospitals - Issues and Options: A Discussion Paper*. June 1995: 1

88. Interim report - see note 1: see especially pages 40-52.

89. Interim report - see note 1: 203 - paragraph 7.127.

90. US studies show that broad analysis of tort cases can indicate areas where error rates are high and where quality improvement efforts could be targeted. Kravitz R, Rolph J, McGuigan K. Malpractice claims as a quality improvement tool - I. Epidemiology of Error in Four Specialties. 1991 *JAMA* 266(15) : 2087-2092.

91. OTA Report - see note 31: 140-141.

92. OTA Report - see note 31: 133-138.

93. OTA Report - see note 31: 141.

94. See for example: Bovbjerg R, Petronis K. The Relationship Between Physicians' Malpractice Claims History and Later Claims - Does the Past Predict the Future? 1994 *JAMA* 272(18): 1421-1426. See also: Rolph J, Pekelney D, McGuigan K. Amending the National Practitioner DataBank Reporting Requirements: Are Small Claims Predictive of Large Claims? 1993 *Inquiry* 30: 441-446. See also: Morlock L, Malitz F. *Utilization of Maryland Data to examine the Possible Impact of Proposed Changes to the Reporting Requirements of the National Practitioner Data Bank*. Department of Health Policy and Management, Johns Hopkins University 1993 Baltimore Maryland.

95. Kravitz R, Rolph J, McGuigan K. *Malpractice claims as a quality improvement tool - II. Is targeting effective?* 1991 *JAMA* 266(15) : 2093-97.

96. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra. See also Interim Report - see note 1: 44-45.

97. See judgment of Kirby P in *Breen v Williams*, NSW Court of Appeal, 23 December 1994 : 43.

98. Further information on the operation of the Healthcare Insurance Reciprocal of Canada (HIROC) and its risk management services can be obtained from Barry Leithhead and Associates, (07) 231 1973 - the PIR acknowledges Mr Leithhead's assistance in providing us with contacts and information, as well as arranging several visits from HIROC, including Ms Eleanor Morton, HIROC's Risk Management Manager and the President, Mr Michael McNeil.

99. HIROC. Annual Report 1994 : 9.

100. For further detailed information on Mr Bowden's work, please contact Merrett Health Risk Management, 60 West Street, Brighton BN1 2RB, England. Phone (0273) 747272, FAX (0273) 206450. The PIR acknowledges Mr Bowden's important contribution to the PIR's conference and expresses appreciation for the additional information provided to Ms Tito while in England in 1994.

101. Bowden D. Managing Risk in Healthcare. Paper in HSH. *Incident Monitoring & Risk Management in the Health Care Sector - Conference Proceedings* held 29-30 November 1994 Radisson President Hotel, Melbourne: 42-46 at 43.

102. Mr Bowden produced an excellent report, setting out a comprehensive risk management program for the National Health Service Management Executive: Merrett Health Risk Management. *Risk Management in the NHS*. UK Department of Health 1993 London. Copies of the report may be obtained for ten British pounds from Heywood Stores, Health Publications Unit, No 2 Site, Manchester Road Heywood, Lancashire, OL10 2PZ. Telephone 1100 44 706 366287.

103. Information provided by Trudy Scott, Risk Manager, United Medical Defence (UMD) and Dr Peter Taylor, Chairman, UMD Risk Management Committee in presentations to seminar "*Increasing Health Care Litigation - Can Australia Afford it?"* 9 September 1995 Hilton Hotel Sydney.

104. The PIR was advised that Steeves Lumley recently merged with Rollins Hudig Hall, which has increased their risk management focus.

105. Risk management is partly managed "in house", as discussed later in the description of the South Australian Risk Management Pilot, and partly on contract with the claims management function privatised in 1994-95. The firm managing this part of the process is LADD Risk Management Pty Ltd in Adelaide. For further details of their work, contact Dr S Merrett at 08 362 9224.

106. Professional Risk Management can be contacted in Australia through Mr Brian Gurry at the Melbourne Office of Corrs, Chambers & Westgarth, 600 Bourke St, Melbourne Victoria 3000, phone (03) 0672-3000. The head office can be contacted through Mr Gus von Bolshwing, President, Professional Risk Management Group, 493 Bridgeway, Sausalito, California 93965 USA, FAX 415-331-6334. The PIR would like to extend its gratitude to PRM, particularly its Director of Special Projects, Dr Orley Lindgren, who assisted in organising visits to a number of relevant sites in the US and England, to see various risk management operations in progress.

107. Additional information on the University College London's risk management program can be obtained from Dr Jonathon Secker-Walker, 40 Woodland Gardens, Muswell Hill, London N10 3UA, FAX 0181 883 4982, or Quality and Risk Management Ltd, 52 Trafalgar Court, Wapping Wall, LONDON E19TF England.

108. Hooper J. *South Australian Risk Management Study Report - Royal Adelaide Experienc*e. 1995. For further details of the study and the risk management initiatives operating at Royal Adelaide Hospital, Mr Hooper can be contacted through the Royal Adelaide Hospital on 08 224 5723.

109. Hooper J. - see note 108: 19.

Endnotes to Chapter 6

1. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Professional indemnity and compensation in health care: an interim report.* Australian Government Publishing Service (AGPS) February 1994 Canberra: 36 - paragraph 2.106 (Interim Report).

2. Interim report - see note 1: 61-64.

3. Interim Report - see note 1: 61 - paragraph 3.117.

4. See Submission from Victorian Cytology Service, 19 July 1994: paragraph 2.9.

5. Interim report - see note 1: 47-51, 313-322.

6. The recent consensus statement on the origins of cerebral palsy acknowledges this issue. "What little evidence exists suggests that less than 2% of cerebral palsy could be attributed to suboptimal intrapartum care. It is the opinion of this conference that this figure could be lower." The Australian and New Zealand Perinatal Societies. The origins of cerebral palsy – a consensus statement. 1995 *Medical Journal of Australia* 162: 85–9. Other studies suggest higher rates of preventable cerebral palsy. For example: Gaffney G, Sellers S, Flavell V, Squier M, Johnson A. Case-control study of intrapartum care, cerebral palsy and perinatal death. 1994 *British Medical Journal* 308: 742–50.

7. Gaffney G et al. - see note 6 and Richmond S, Niswander K, Snodgrass C, Wagstaff I. The obstetric management of fetal distress and its association with cerebral palsy. 1994 *Obstetrics and Gynaecology* 83(5): 643–6.

8. Submission from the Public Interest Advocacy Centre, 19 September 1994.

9. Submission from the Human Rights Committee, Disabled Peoples' International, Australia, 13 September 1994.

10. Submission from Law Council of Australia, 2 September 1994.

11. Submission from the Consumers' Health Forum of Australia, September 1994.

12. Submission from Slater & Gordon, Barristers & Solicitors, 8 November 1994: 8.

13. Submission from Slater & Gordon, Barristers & Solicitors, 8 November 1994: 8.

14. Interim report - see note 1: 67-113.

15. Interim report - see note 1: 134-139.

16. Commonwealth Department of Health, Housing, Local Government and Community Services (HHLGCS). Review of the Relationship between Compensation and Health and Community Services Programs. *Compensation and Commonwealth Health and Community Services Programs - a Discussion Paper*: prepared by T. Brennan and J. Deeble. HHLGCS June 1993 Canberra (Compensation discussion paper).

17. Commonwealth Department of Human Services and Health (HSH). Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensable and non-compensable people with*

disabilities: equal needs – unequal assistance: a discussion paper. HSH August 1995 Canberra (Disability discussion paper). Copies of this paper are available by phoning the Commonwealth Department of Human Services and Health, telephone (06) 289 7030.

18. Disability discussion paper - see note 17: section 4.

19. This is detailed in Section D of Chapter 1 of this Report.

20. Commonwealth Department of Human Services and Health. *Working solutions. Report of the Strategic Review of the Commonwealth Disability Services Program*: prepared by P. Baume and K. Kay. AGPS 1995 Canberra (Working solutions report).

21. Commonwealth Department of Human Services and Health. *Coordinated care trials.* Unpublished paper for the Health and Community Services Ministerial Council meeting, 15 June 1995: 2.

22. Interim report - see note1: 60.

23. Duckett S. Opening Address to the Third National Rehabilitation Convention. Rehabilitation: investing in the future. Wednesday 17 May 1995: 10.

24. Disability discussion paper - see note 17.

25. *Motor Accidents Act 1988* (NSW): section 72.

26. *Common law (Miscellaneous Actions) Act 1986* (Tasmania): section 5.

27. *Motor Accidents Act 1988* (NSW): section 72A allows additional damages in such cases for respite care, presumably at market rates, but this would not assist where the person was unable to continue their gratuitous provision of the majority of the services.

28. *Van Gervan v Fenton*, High Court, full court 92/041, 28 October 1992.

29. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical injury case study project*: prepared by: Coventry G, Daly J, Evans M, Lowy C, McMahon M and Roberts G, National Centre for Socio-Legal studies, La Trobe University. AGPS May 1993 Canberra: 60–9.

30. Interim report - see note 1: 138.

31. Interim report - see note1: 136–9.

32. Industry Commission. *Workers' Compensation in Australia*: report number 36. AGPS February 1994 Canberra.

33. *Motor Accidents Act 1988* (NSW): Part 4, especially section 38(1) and 38(2).

34. *Motor Accidents Act 1988* (NSW): section 38(1A).

35. *Motor Accidents Act 1988* (NSW): section 39.

36. Commonwealth Department of Human Services and Health. *Better health outcomes for Australians. National goals, targets and strategies for better health outcomes into the next century.* AGPS 1994 Canberra: see especially 236 - 239 (Better health outcomes report).

37. Better health outcomes report - see note: 236-237.

38. Compensation may be inadequate because of: a reduction in the amount due to the plaintiff's contributory negligence; statutory limits on amounts a court can award; poor negotiating on the claimant's part; and difficulties in estimating the cost of long-term care needs.

39. See for example: Commonwealth Department of Human Services and Health (HSH). Office of Disability. *Commonwealth Disability Strategy: a ten year framework for Commonwealth Departments and Agencies*. HSH December 1994 Canberra.

40. Disability discussion paper - see note: 39-41.

41. Invalid pensions were listed in clause 51 (xxiii) of the Australian Constitution in 1901. The first invalid pensions were first provided by the Commonwealth Government in 1910, one year after the Age pension in 1909. The invalid pension was replaced by the Disability Support Pension, as part of the Disability Reform Package announced in the 1990-91 Commonwealth Budget.

42. The establishment of the Human Rights Commission in 1981 and subsequently the Human Rights and Equal Opportunity Commission in 1986 by the Commonwealth Government is one example of many, where the Commonwealth government has sought to act in support of its international human rights obligations.

43. In his recent Strategic Review of the Commonwealth's Disability Services Program, Professor Baume said :" In this Report, the point is made that rhetoric and reality in the area of disability do not match. To move from good intentions to good outcomes for people with a disability will require a paradigm shift..." Working solutions report - see note 20: 33.

44. See commentary in Working solutions report - see note 20: 33, where Professor Baume refers to the House of Representatives Second Reading Speech by the Minister for Health Housing and Community Services on the Health, Housing and Community Services Legislation Amendment Bill 1992.

45. Working solutions report - see note 20: 3.

46. Working solutions report - see note 20: 2.

47. *Christensen v Pannikote and St George Hospital*, unreported, NSW Supreme Court, Justice Sharpe, 9 August 1993, No. 12016/88. See also: Interim report - see note 1: 81-83.

48. Interim report - see note 1: 67-68.

49. Justice Murphy's statements to this effect in *Jaensch v Coffey* (1983-84) 155 CLR 549 were quoted extensively in the Interim report - see note1: 85.

50. Submission from Committee of Presidents of Medical Colleges, 6 July 1994: 4 & summary point 9.

51. The titles of the bills are: *Health and Other Services (Compensation) Bill 1994; Health and Other Services (Compensation) Care Charges Bill 1994; Health and other Services (Compensation)*

Administration Fee Bill 1994; and Health and Other Services (Compensation)(Consequential Amendments) Bill 1994.

52. The *Health and other Services (Compensation) Administration Fee Bill 1994* was defeated by a combined vote of the Democrats and the Opposition in the Senate.

53. *Motor Accidents (Liabilities and Compensation) Act 1973* (Tas), section 27A(1).

54. *Motor Accidents (Liabilities and Compensation) Act 1973* (Tas), section 27A(3).

55. *Motor Accidents (Liabilities and Compensation) Regulations 1980* (Tas), Part II - Medical Benefits, clause 1(1A).

Endnotes to Chapter 7

1. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - A Discussion Paper*. HHCS February 1992 Canberra : see especially Chapter 5 (Indemnity discussion paper).

2. Indemnity discussion paper - see note 1: chapter 8.

3. Indemnity discussion paper - see note 1: chapter 7 and appendixes 6 and 7.

4. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* Australian Government Publishing Service (AGPS) February 1994 Canberra : 61-62.

5. This concept derived its name from the English case, which first enunciated it - *Bolam v. Friern Hospital Management Committee* (1957) 1 WLR 582.

6. Mrs Maffei, who recently died from breast cancer, was unsuccessful in a negligence action against two of her doctors, Mr Macleish and Mr Russell. She claimed they had breached their duty of care to her by failing to diagnose her cancer. Her case was heard with a jury before Justice Ashley in the Victorian Supreme Court in March 1995.

7. Lilienthal C. Editorial - Excellent Value. 1994 *Journal of the Medical Defence Union* 8(4) : 49.

8. Gillies R. Negligence and Anaesthetic Practice. Statement in relation to the claims experience of the Medical Defence Association of Victoria made in oral presentation delivered at *Risks to the Anaesthetist Conference* held 12 August 1995 at the Carlton Radisson Hotel, Melbourne.

9. This proposal was strongly argued for by the Royal Australian College of Obstetricians and Gynaecologists in the Birthing Issues Sub-committee.

10. *O'Shea v Sullivan & Anor* (1994) Aust Torts Reports 81-273.

11. Pochon J. The stress of litigation. 1993 *Australasian Journal of the Medical Defence Union* 4 : 53-54.

12. Charles S. Appraisal of the event as a factor in coping with malpractice litigation. 1988 *Behaviour Med* Winter : 150.

13. Charles S. The Psychological trauma of a medical malpractice suit: a practical guide.1991 *American College of Surgeons Bulletin* 76(11).

14. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra.

15. For example, some recently established medical defence organisations show rapid increases in the number of claims. However, such a pattern is to be expected in the growth to maturity of an occurrence based claims profile. It may have little to do with an underlying upward trend in claims numbers, or it may be amplified from both sources.

16. The United Medical Defence made this claim at a recent conference, but has been unable to supply supporting data to the PIR to back up its assertions.

17. For example, the Court accepted Ms O'Shea's evidence at various points against that of Dr Sullivan in *O'Shea v. Sullivan* (1994) Aust Torts Reports 81-273, and in *Burnett v. Kalokerinos*, Justice Spender accepted the evidence of Ms Burnett (and other corroborating evidence) over that of Dr Kalokerinos about Ms Burnett's advice to him that it was not possible for her to attend a specialist in a distant town, and that she wanted a referral to a closer specialist. Unreported, NSW Supreme Court No 11138 of 1993, 22 March 1995.

18. Kinney E. Malpractice reform in the 1990s: Past disappointment, future success? 1995 *Journal of Health Politics, Policy and Law* 20(1) : 99-135.

19. Commonwealth Attorney-General's Department. *The Justice Statement*. Attorney-General's Department May 1995 Canberra : 3 (Justice statement).

20. Access to Justice Advisory Committee. *Access to Justice - an Action Plan. 1994*. This committee was chaired by Mr (now Justice) Ronald Sackville QC.

21. Justice statement - see note 19.

22. Justice statement - see note 19: 1-2.

23. Justice statement - see note 19: 49.

24. See for example submission from the Australian Dental Association (Victorian Branch), 26 July 1994 : 6.

25. Justice statement - see note 19: 49.

26. 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.

27. Interim report - see note 4: 167 - paragraph 6.107.

28. Justice statement - see note 19: 49.

29. A similar criticism was recently made in relation to the provision of evidence by doctors against their colleagues in medical board proceedings: Ann Treweek "Weak doctors attacked", 1995 *Sunday Times (WA)* 2 April : 10, quoting the WA Medical Board Registrar Kim Bradbury.

30. 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. 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.

31. Interim Report - see note 4: 162-165 - paragraphs 6.86-6.98; see especially paragraph 6.86.

32. Brebner Justice and Foster R. *A Discussion Paper on the Development of National Objectives or Goals for the Disposition of Cases in the Higher Trial Courts*. Unpublished, undated.

33. Interim Report - see note 4: 164.

34. Submission from the Medical Protection Association of Australia, 19 October 1994.

35. Submission from the Australian Plaintiff Lawyers Association, 14 October 1994.

36. Submission from the Victorian Department of Health and Community Services, 6 October 1994.

37. Justice statement - see note 19: 59.

38. Zeisel H, Kalven H, and Bucholz B. *Delay in the Court.* Little Brown 1959 Boston.

39. Flanders S. *Case Management and Court Management in U.S. District Courts*. Federal Judicial Center 1977 Washington. Church T et al. *Justice Delayed: The Pace of Litigation in Urban Trial Courts.* National Center for State Courts 1978 Williamsburg Va.

40. See: Brebner, Justice - see note 32. Also: Scott I.R. Is Court Control the Key to Reduction in Delays. (1983) 57 *Australian Law Journal* 16.

41. Brebner, Justice - see note 32: 62.

42. NSW Department of Courts Administration. *Key Performance Summary*. March 1994.

43. Interim Report - see note 4: 231.

44. Interim Report - see note 4: 232.

45. Generally, a Statute of Limitations does not commence until a person gains his or her "legal majority", that is, turns 18 years of age. If a person is unable to attain this legal competence, for example a person with an intellectual disability, then in New South Wales and South Australia there is a maximum 30 year limitation period; in the other States and Territories there is no limitation period which means that an action can be commenced at any time. In the case of a child, the limitation period commences from the date of reaching legal majority. Interim Report - see note 4: 231.

46. MDO consensus submission from the Medical Defence Union, the Confederation of Australian Medical Defence Organisations, the Medical Protection Society, the Medical Protection Association of Australia and the Medical Protection Society of Queensland, 17 November 1994 .

47. Submission from the Maternity Alliance, undated : 2.

48. Submission from Public Interest Advocacy Centre, 19 September 1994: 10.

49. Submission from Victorian Department of Health and Community Services, 6 October 1994 : 15.

50. Submission from Citizens' Commission on Human Rights (Psychiatric Violations), 21 October 1994: 3.

51. Submission from the Australian Plaintiff Lawyers' Association, 4 October 1994.

52. Submission from Slater & Gordon, Barristers & Solicitors, 8 November 1994.

53. Submission from Slater & Gordon, Barristers & Solicitors, 8 November 1994.

54. Submission from Medical Consumers Association of New South Wales, 28 September 1994.

55. Submission from Insurance Council of Australia Limited, 8 December 1994.

56. Submission from the Medical Protection Association of Australia, 19 October 1994; and the MDO consensus submission from the Medical Defence Union, the Confederation of Australian Medical Defence Organisations, the Medical Protection Society, the Medical Protection Association of Australia and the Medical Protection Society of Queensland, 17 November 1994.

57. Submission from F & A Richards, 26 August 1994.

58. *Motor Accidents Act 1988 (NSW)*, section 79-80. The sum was originally $15,000, with a graded payment scale between $15,000 and $55,000, after which a full amount is payable up to $180,000. These sums are indexed. In 1995, then floor had been indexed to $18,500.

59. The floor, below which no non-economic loss is payable, has been increased from $18,500 to $31,000.

60. Sharp M. Govt cuts green slip claims. *Sydney Morning Herald* 27 September 1995 : 5.

61. The plaintiff Mr Tom Papic sued Geelong Hospital for damages related to his quadriplegia, which resulted from a mistaken injection of a cancer drug into his spine last August. Liability was admitted, and an out of court settlement was made, after several days of hearing before the Victorian Supreme Court, reported to be around $6 million plus legal costs. See "Paralysed patient $6m settlement" 1995 *Sydney Morning Herald* 6 May: 8 .

62. *Crossman v Le Fevre & Port Adelaide Community Hospital*, unreported, SA Supreme Court (Matheson J) JNS4899, 22 December 1994.

63. Interim Report - see note 4: pages 99-107 - Chapter 4, paragraphs 4.134-4.166.

64. Commonwealth Department of Human Services and Health (HSH). Review of Professional Indemnity Arrangements for Health Care Professionals. *Structured settlements as payment of compensation for personal injury: a discussion paper*. HSH June 1995 Canberra: see especially chapter 2.

65. For example, the Tasmanian Law Reform Commission considered this issue and in Report Number 67, 1991 entitled *Damages for Personal Injury*, it was recommended that legislation be enacted to allow courts to award all or any damages for personal injury or death by way of structured judgements or periodic payments, so long as the assessment is still once and for all and non-reviewable: 11-17.

Extensive references and discussion on this topic can be found in the Interim Report - see note 4: 99-105.

66. English Law Commission. *Structured settlements and interim and provisional damages*. Law Com No 224. HMSO September 1994 London - see especially Part II: 9.

67. Submission from National Rural Health Alliance, 20 June 1994.

68 Submission from Private Hospitals' Association of Queensland, 22 December 1994.

69. Submission from the Association of Australian Rural Nurses, 1 September 1994.

70. Submission from Welfare Rights Centre, 13 September 1994.

71. Submission from the Human Rights Committee, Disabled Peoples' International, Australia, 13 September 1994.

72. Submission from the Public Interest Advocacy Centre, 19 September 1994: 10.

73. Submission from Slater & Gordon, Barristers & Solicitors, 8 November 1994.

74. Submission from the Medical Protection Association of Australia, 19 October 1994.

75. MDO consensus submission from the Medical Defence Union, the Confederation of Australian Medical Defence Organisations, the Medical Protection Society, the Medical Protection Association of Australia and the Medical Protection Society of Queensland, 17 November 1994.

76. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on taxation treatment of compensation payments:* prepared by John Walsh, Neil Wilson and Ian Farmer, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd, June 1995: 51 (Tax report).

77. Tax Report - see note 76.

78. Interim Report - see note 4: 64.

79. For example, submissions from Myrtleford District War Memorial Hospital, 12 September 1994; Australian Physiotherapy Association, 27 September 1994; Tasmanian Department of Community and Health Services 19 September 1994; Australian Plaintiff Lawyers Association 4 & 14 October 1994; NSW Nurses Association, 10 October 1994; and Citizens' Commission on Human Rights (Psychiatric Violations), 21 October 1994.

80. For example, submissions from the Prince Henry Hospital, 14 June 1994; National Centre for Epidemiology and Population Health, 25 May 1994; Australian Perinatal Society, 7 July 1994; Committee of Presidents of Medical Colleges, 6 July 1994; Royal Melbourne Hospital Department of Gastroenterology, 26 July 1994; Southern Pathology, 25 August 1994; Anti-cancer Council, 22 August 1994; University of Melbourne - Department of Surgery, 4 August 1994; and Maternity Alliance, undated.

81. Submission from Myrtleford District War Memorial Hospital, 12 September 1994.

82. Submission from Australian Physiotherapy Association, 27 September 1994.

83. Submission from the Australian Plaintiff Lawyers Association, October 1994.

84. For example, submissions from Medical Consumers' Association of NSW, 28 September 1994 and Chelmsford Victims Action Group, 28 September 1994.

85. Submission from The Prince Henry Hospital, 14 June 1994: 2.

86. Submission from The Prince Henry Hospital, 14 June 1994: 3.

87. Submission from the Australian Perinatal Society, 7 July 1994.

88. Submissions from the Victorian Cytology Service, 19 July 1994; Southern Pathology, 25 August 1994; Ant-Cancer Council, 22 August 1994; and University of Melbourne - Department of Surgery, 4 August 1994.

89. Submission from University of Melbourne - Department of Surgery, 4 August 1994.

90. Submission from University of Melbourne - Department of Surgery, 4 August 1994: 1.

91. Submission from the Victorian Cytology Service, 19 July 1994.

92. Submission from the Victorian Cytology Service, 19 July 1994.

93. Submission from Southern Pathology, 25 August 1994.

94. Submission from Southern Pathology, 25 August 1994: 2.

95. Submission from Southern Pathology, 25 August 1994: 3.

96. Submission from Southern Pathology, 25 August 1994.

97. Interim Report - see note 4: 53-54 - recommendation 8, also paragraph 3.84 - 3.88.

98. Interim Report - see note 4: 52-53 - paragraphs 3.78-3.83.

99. Interim Report - see note 4: paragraph 3.88.

100. Tancredi L and Bovbjerg R. Advancing the Epidemiology of Injury and Methods of Quality Control: ACEs as an Outcomes-Based System for Quality Improvement. 1992 *QRB* June: 201-209.

See the following list of articles which also relate to this work:

Bovbjerg R. Lessons for tort reform from Indiana [comment]. 1991 *Journal of Health Politics, Policy and the Law* 16(3).

Bovbjerg R. Medical malpractice: folklore, facts, and the future [editorial]. 1992 *Annals of Internal Medicine* 117(9): 788-791.

Bovbjerg R, Tancredi L, Gaylin D. Obstetrics and malpractice: evidence on the performance of a selective no-fault scheme. 1991 *JAMA* June : 2836-2843.

Rosenblatt R, Bovbjerg R, Whelan A, Baldwin L, Hart L, Long C. Tort reform and the obstetric access crisis: the case of the WAMI states. 1991 *West J Med* 155: 693-699.

Slone F, Mergenhagen P, Bovbjerg R. Effects of tort reforms on the value of closed medical malpractice claims: a microanalysis. 1989 *Journal of Health Politics, Policy and Law* 14(4): 663-9.

Slone F, Mergenhagen P, Bovbjerg R. Medical malpractice experience of physicians. 1989 *JAMA* December: 3291-7.

Tancredi L. Identifying avoidable adverse events in medicine. 1974 *Medical Care* November: 935-943.

Tancredi L. Designing a no-fault alternative. 1986 *Law and Contemporary Problems* 49(2): 277-286.

Tancredi L. Malpractice and tardive dyskinesia: a conceptual dilemma. 1988 *Journal of Clinical Psychopharmacology* 8(4): 71S-76S.

Tancredi L, Barondess J. The problem of defensive medicine. 1978 *Science* May: 879-882.

Tancredi L, Bovbjerg R. Rethinking responsibility for patient injury: accelerated compensation events, a malpractice and quality reform ripe for a test. 1991 *Law and Contemporary Problems* Spring: 147-177.

Tancredi L, Bovbjerg R. Creating outcomes-based systems for quality and malpractice reform: methodology of accelerated compensation events (ACEs). *Millbank Quarterly* 70(1): 183-214.

Zuckerman S, Bovbjerg R, Slone F. Effects of tort reforms and other factors on medical malpractice insurance premiums. 1990 *Inquiry* Summer: 167-182.

101. The PIR understands that the Robert Wood Johnson Foundation's IMPACS program for improving malpractice prevention and compensation systems in the US will be funding the further trialing of ACEs in the obstetrics area.

102. Interim Report - see note 4: 62-64.

103. (1957) 1 WLR 582.

104. *Sidaway v. Governors of Bethlem Royal Hospital* (1985) AC 871 at 880 per Lord Scarman.

105. *F v. R* (1983) 33 SASR 189

106. (1983) 33 SASR 189 at 194.

107. *Rogers v. Whitaker* (1992) ALR 625 at 631

108. *Woods v. Lowns & Ors*, unreported, NSW Supreme Court (Badgery-Parker J) No 14259 of 1988, 9 February 1995.

109. *Woods v. Lowns & Ors* - see note 108: 26-27.

110. *Woods v. Lowns & Ors* - see note 108: 31.

111. *Woods v. Lowns & Ors* - see note 108: 86.

112. Wain G, Ward J, Towler B. Gynaecological care of women with abnormal Pap smears: how varied is current practice? 1995 *Medical Journal of Australia* 162: 348-353.

113. Mertz S. Clinical practice guidelines: policy issues and legal implications. 1993 *Journal on Quality Improvement* 19(8): 306-312 at 308.

114. Hyams A et al. Practice guidelines and malpractice litigation: a two way street. 1995 *Annals of Internal Medicine* 122(6): 451–5.

Endnotes to Chapter 8

1. Submission from Public Interest Advocacy Centre, 19 September 1994.

2. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an Interim Report.* Australian Government Publishing Service (AGPS) February 1994 Canberra : see Chapter 8 - Medical practitioners and indemnity arrangements (Interim Report).

3. See, for example, *Locher and Anor v. Turner*, Unreported, Supreme Court of Queensland Court of Appeal (Pincus JA, McPherson JA and Byrne J) no 14 of 1995, 21 April 1995. In this case a doctor was sued for negligence for failing to diagnose cancer of the colon. The court found for the plaintiff, but reduced the damages by 20% because the plaintiff did not inform the doctor of the nature and extent of her rectal bleeding (contributory negligence). The Court of Appeal upheld the original decision.

4. Submission from Committee of Presidents of Medical Colleges, 6 July 1994: 4.

5. As at end July 1995, the following States had published Charters: New South Wales, Queensland, Victoria, the Northern Territory, and Western Australia. These Charters incorporate core elements developed by the Commonwealth Government and State Governments with interested parties.

6. Gregory G (Ed.) *The politics of rural health: how far have we come?* Proceedings of the 3rd National Rural Health Conference, Mt Beauty, 3–5 February 1995. National Rural Health Alliance, May 1995 Canberra: 5.

7. Interim Report - see note 2: 142.

8. Unpublished draft health consumers charter, July 1995.

9. For example, see submissions from the Public Interest Advocacy Centre, 19 September 1994; and Consumers' Health Forum of Australia, September 1994.

10. See submission from the Public Interest Advocacy Centre, 19 September 1994.

11. Interim Report - see note: 9–11.

12. Submission from Myrtleford District War Memorial Hospital, 12 September 1994.

13. Submission from Swan Hill Division of General Practitioners, 24 August 1994.

14. Submission from Mr John Germov, University of Newcastle, Department of Sociology and Anthropology, 8 June 1994.

15. Interim Report - see note 2: 153.

16. Submission from Dr Peter Arnold, 6 March 1994.

17. Submission from Swan Hill Division of General Practitioners, 24 August 1994.

18. Submission from Consumer Help Against Malpractice, 9 November 1994: 3.

19. Submission from Consumer Help Against Malpractice, 9 November 1994: 4.

20. Redelmeier D, Rozin P, Kahneman D. Understanding patients' decisions: cognitive and emotional perspectives. 1993 *Journal of the American Medical Association* 270(1): 72–6.

21. Buchan H. *Communicating effectively with consumers*: report from the Cochrane exploratory meeting 2 May 1995: 7. Unpublished material (Cochrane consumer exploratory meeting report). For further details contact, Dr H Buchan, Meeting Convenor, Manager, Health Care Evaluation, Public Health Branch, Health & Community Services, GPO Box 4057, Melbourne, Victoria, 3001.

22. Cochrane consumer exploratory meeting report - see note 21: 7.

23. Submission from the Public Interest Advocacy Centre, 19 September 1994.

24. For example, see submissions to the PIR from: the Consumers' Health Forum of Australia, September 1994; Consumer Help Against Malpractice, 9 November 1994; Disabled Peoples' International, Australia, 13 September 1994; and Dr Paul Maher, 29 August 1994.

25. Submission from the Committee of Presidents of Medical Colleges, 6 July 1994.

26. Submission from Simon Blair, Regional Director, Community & Health Services, Northern Region Tasmania, 19 September 1994 (Tasmanian Community & Health Services Department).

27. Submission from Tasmanian Community & Health Services Department, 19 September 1994: 3.

28. Interim Report - see note 2: Chapter 7 - Grievance handling and maintaining standards.

29. Interim Report - see note 2: 189–283.

30. *Health Complaints Amendment Act 1994*, No 89 of 1994. Notified in ACT Gazette S280: 15 December 1994.

31. Commonwealth Attorney-General's Department. *The Justice Statement*. Attorney-General's Department May 1995 Canberra: 144 (Justice statement).

32. The dispute schemes as have been established vary according to the circumstances of the industry. For example, the insurance schemes comprise a panel with an independent chair and consumer and industry representatives who consider disputes with companies. The banking and telecommunications industries have established industry ombudsman schemes which comprise a board of directors, a council with an independent chair, and consumer and industry representatives, with an Ombudsman responsible for the day-to-day operation of the scheme. Justice Statement - see note 31: 144.

33. Correspondence to the PIR from Albertje Gurley, Registrar, Health Conciliation Registry, 1 May 1995: 2.

34. Interim Report - see note 2: 145–6.

35. Interim Report - see note 2: 181–2.

36. The PIR notes that in some States, a medical tribunal provides a judicial forum to address matters deemed *more serious*, while those deemed *less serious* are examined by the medical board. Changes to State medical acts would be required to implement this model in States which do not currently have a medical tribunal. The PIR also notes advice from the Australian Medical Council to the effect that it is usually a difficult and slow process to effect changes to State medical acts.

37. Interim Report - see note 37: 122.

38. Perhaps as a sign of this concern, the First Australian and New Zealand Conference on Sexual Exploitation by Health Professionals, Psychotherapists and Clergy, is to be held in Sydney, 12–14 April 1996. Further information on the conference can be obtained from telephone (02) 557 8290, or from the Committee Against Health Professionals and Clergy Abuse PO Box 674, Rozelle NSW 2039.

39. The PIR drafted a paper on sexual misconduct in early 1994. The paper was based on: published articles and books; annual reports of registration boards and health care complaints commissions; data supplied by health care complaints commissions; judgements from courts and medical tribunals; and correspondence from individuals who wrote to the PIR detailing their experiences of sexual misconduct on the part of health care professionals. Draft copies were distributed for comment to the health care complaints commissions and to those who contributed their experiences. The PIR would like to thank all those who contributed.

40. See, for example, Section 30 of the *Health Services (Conciliation and Review) Act 1987* (Vic), and Section 98 of the *Health Care Complaints Act 1993* (NSW).

41. The New Zealand model refers to The Health Advocates Trust which operates in Auckland. The service is fully funded by the Ministry of Health and reports on progress on complaints every three months to the Ministry. Advocacy services are provided free of charge to consumers of health services. The Trust aims to: provide support and assistance to health and disability services consumers; raise the awareness and encourage acceptance by health professionals and health services consumers of complaints mechanisms and procedures; and try to resolve conflict/complaints locally and promptly before the dispute escalates. The Trust empowers consumers, believing health and disability advocacy must be consumer-focused. Direct communication between the consumers and medical practitioners is promoted. Information is available from Ms Janine Abernathy, Manager, Health Advocates Trust, 97 Manukau Road, Epsom, Auckland, New Zealand. The PIR thanks Ms Aberanthy for information relating to the Trust.

42. Submission from Tasmanian Community & Health Services Department, 19 September 1994.

43. Consumers Health Advocacy. *Submission to the Health Rights Commission.* Toowong, Queensland, Unpublished, March 1995: 2. Copies available from Consumers Health Advocacy Association Inc., PO Box 1302, Toowong QLD 4066.

44. Consumers Health Advocacy - see note 43: 12.

45. Health Rights Commission (HRC). *Code of health rights and responsibilities: a discussion paper*. December 1994: 50. Copies available from HRC, GPO Box 3089, Brisbane QLD 4001.

46. Health Care Complaints Commission (HCCC). *Complaints unit: annual report 1993–94*: 8. Copies available from HCCC, Locked Bag 18, Strawberry Hills NSW 2012.

47. Information on the proposal was supplied to the PIR by the NSW Health Complaints Commissioner.

48. The College of Physicians and Surgeons of Ontario. CPSO *Sexual abuse recommendations*. September 1992 (Ontario physician sexual abuse proposals).

49. Ontario physician sexual abuse proposals - see note 48: 14–5.

50. Correspondence to the PIR from Ms Merrilyn Walton, Health Care Complaints Commissioner, 18 April 1995: 4.

51. Community advocates are statutory office holders in the States who promote and protect the interests of persons who are disadvantaged. Generally community advocates represent interests, investigate, enquire and report to government, courts, tribunals and other relevant bodies. See for example, Office

of the Community Advocate: pamphlet, available from telephone (06) 207 0707, or from 2nd Floor, GIO House, City Walk, Canberra ACT 2601.

52. Winefield H, Murell T, Clifford J. *Process and outcomes in general practice consultation: problems in defining high quality of care.* University of Adelaide, South Australia, undated: 5.

53. Plueckhahn V, Breen K, Corder S. *Law and ethics in medicine for doctors in Victoria*. 1994: 59–63.

Endnotes to Chapter 8

1. Commonwealth Department of Health, Housing and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Survey of medical defence organisations*: prepared by Statistical Consultancy, Australian Bureau of Statistics. Unpublished material April 1993.

2. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an Interim Report.* Australian Government Publishing Service (AGPS) February 1994 Canberra (Interim Report): Chapter 8 relates to medical defence organisations (MDOs), Chapter 9 to the arrangements of other health professionals, and Chapter 10 to public sector and institutional liability issues.

3. Commonwealth Department of Human Services and Health (HSH). Review of Professional Indemnity Arrangements for Health Care Professionals. *Report on medical professional indemnity arrangements*: prepared by John Walsh and Jann Skinner, Coopers & Lybrand Actuarial and Superannuation Services Pty Ltd. HSH March 1994 Canberra (MDO consultancy report).

4. Some examples where MDOs have exercised their discretion against a doctor or class of doctors has been the retrospective exercise of the discretion after Dr Harry Bailey's death by suicide in relation to claims arising from his activities at Chelmsford by the NSW Medical Defence Union, and the refusal by the Medical Protection Society to pay claims incurred but not reported at the date of cessation of membership for past members who transferred to the Medical Defence Association of Victoria or the Medical Defence Association of Western Australia.

5. Public statements by Dr Megan Keaney, United Medical Defence.

6. Interim Report - see note 2: Chapter 8.

7. The Medical Defence Union of NSW recently changed its name to United Medical Defence.

8. For example, the submission from the Australian Dental Association (Victorian Branch), 26 July 1994, indicated that they had a scheme for their members with the Medical Protection Society/Dental Protection Society, which also covered dental hygienists.

9. While the various different market shares of the various MDOs are closely guarded, the MDO consultancy report gave estimates of membership numbers which indicated that Australia-wide the two overseas based MDOs individually had larger market shares than the individual Australian based ones, though the Australian based ones collectively held over one-third of the market. MDO consultancy report - see note 3: 11 - paragraph 4.4.3.

10. The Medical Defence Association of Western Australia, the Medical Defence Association of Victoria and the United Medical Defence are the three MDOS with captive insurers.

11. Interim Report - see note 2: 288-290.

12. Commonwealth Department of Human Services and Health (HSH). *Statistical Overview 1993-94.* AGPS 1995 Canberra: 55 - Table 6.1 (Statistical overview).

13. Statistical overview - see note 12: 104 - Table 9.2.

14. The Quality in Australia Health Care Study estimates were not based on all public hospital admissions - they excluded public psychiatric hospitals, day-only admissions and veteran's admissions. Their estimate was that 16.6% of admissions were associated with an adverse event - see Chapter 2 for more details.

15. MDO consultancy report - see note 3: 14.

16. Submissions from the Australian Physiotherapy Association, 27 September 1994; and the Committee of Presidents of Medical Colleges, 6 July and 16 August 1994.

17. Johns L. $7m claim forces sale of hospital. 1994 *Adelaide Advertiser* 30 March 1994: 1. The damages payable was overestimated in this report by a considerable amount. No further investigation was undertaken to determine whether the $2 million cover was correct. Anecdotes indicated the cover could have been as low as $1 million.

18. *Crossman v. Le Fevre & Port Adelaide Community Hospital*, unreported, SA Supreme Court (Matheson J) JNS4899, 22 December 1994.

19. See for example: *NSW Medical Defence Union v. Crawford; NSW Medical Defence Union v. Bailey (as executrix of the Estate of Harry Bailey); Bailey v. Crawford*, unreported, NSW Supreme Court of Appeal (Kirby P, Mahoney JA and Sheller JA) CA 40127/92, CA 40128/92, CA 40134/92, 3 September 1992.

20. Submission from the Chelmsford Victims Action Group, 28 September 1994.

21. Submission from the Insurance Council of Australia, 8 December 1994.

22. Interim Report - see note 2: 232.

23. See for example: submission from the Australian Association of Occupational Therapists, 3 September 1994.

24. See for example: submission from the Australian Physiotherapy Association, 27 September 1994, Australian Dental Association (Victorian Branch), 26 July 1994.

25. See for example: submission from the Alcohol and Other Drugs Council of Australia, 27 July 1994.

26. Submission from the Australian Physiotherapy Association, 27 September 1994.

27. MDO consensus submission from the Medical Defence Union, the Confederation of Australian Medical Defence Organisations, the Medical Protection Society, the Medical Protection Association of Australia and the Medical Protection Society of Queensland, 17 November 1994 (MDO consensus submission).

28. Submission from the NSW Nurses Association, 10 October 1994.

29. Submission from the Dietitians Association of Australia, 5 September 1994.

30. Submission from the Institute of Ambulance Officers (Australia), 5 August 1994.

31. Submission from Darwin Homebirth Group, 20 December 1994.

32. Submission from the Institute of Hospital Engineering, 26 August 1994.

33. Interim Report - see note 2: 290-292.

34. Davis J. *Inquiry into the Law of Joint and Several Liability - Report of Stage 2.* Commonwealth Attorney-General's Department January 1995 Canberra : 7 (Joint and several liability report).

35. Joint and several liability report - see note 34: 10.

36. Joint and several liability report - see note 34: 34-38.

37. Joint and several liability report - see note 34: 33.

38. Joint and several liability report - see note 34: 32.

39. The PIR wishes to thank Mr Frank Earl, Managing Director, Minet Australia; Mr Michael Dangelo, Executive Vice-President, Minet Risk Services; and Mr Peter Sasson, Chief Executive Officer, National Insurance Advisory, for their significant assistance to the PIR and on the time spent discussing the operation of health professional indemnity insurance in the US and other professional indemnity products in the Australian market.

40. This distinction underlies the recommendations in the Joint and several liability report - see note 34.

41. Information provided by Mr Eric Chalmers, Assistant Commissioner - General Insurance, Insurance and Superannuation Commission.

42. Interim Report - see note 2: 284-287.

43. *Woods v. Lowns & Ors*, unreported, NSW Supreme Court (Badgery-Parker J) No. 14259 of 1988, 9 February 1995: 51-62.

44. Submission from St John Ambulance Australia, 12 May 1994.

45. Interim Report - see note 2: 285 - paragraphs 10.43-10.44.

46. MDO consultancy report - see note 3: 15.

47. MDO consultancy report - see note 3: 28-29.

48. MDO consultancy report - see note 3: 26.

49. The returns required by an authorised insurer are set out in the MDO consultancy report - see note 3: 24-25 and Appendix C. The report also indicated that the reporting requirements are currently being revised to reduce the number of forms and simplify them. Appendix D to the MDO consultancy report provides details of these proposed changes.

50. MDO consultancy report - see note 3: 26-27.

51. Self-regulation was detailed in the MDO consultancy report - see note 3: 56-58, and 89.

52. MDO consensus submission from the Medical Defence Union, the Confederation of Australian Medical Defence Organisations, the Medical Protection Society, the Medical Protection Association of Australia and the Medical Protection Society of Queensland, 17 November 1994.

53. Interim Report - see note 3: 279-284 and recommendations 44 and 45.

54. Interim Report - see note 2: 263-264 and recommendation 41.

55. Interim Report - see note 2: 275-279 and recommendations 42 and 43.

56. Submission from the Australian Association of Pathology Practices, 25 August 1994.

57. Submission from the Tasmanian Department of Community and Health Services, 19 September 1995.

58. Submission from the National Rural Health Alliance, 20 June 1994.

59. Interim Report - see note 2: 277-279.

60. Interim Report - see note 2: 279.

61. Submission from the National Rural Health Alliance, 20 June 1994.

62. Submission from the Private Hospitals' Association of Queensland, 22 December 1994.

63. Submission from the Association for Australian Rural Nurses, 1 September 1994.

64. Submission from Dr Malcolm Traill, 22 August 1994.

65. Submission to the PIR Discussion Paper from the Australian Council of Trade Unions: 4.

66. Submission to the PIR Discussion Paper from the Australian Council of Trade Unions: 4.

67. Submissions to the PIR Discussion Paper from the Australian Nursing Federation: 6; and Queensland Nurses' Union: 4.

68. Submission to the PIR Discussion Paper from the Australian Nursing Federation: 6.

69. Submission to the PIR Discussion Paper from the Australian Nursing Federation: 6.

70. *Ellis v. Wallsend District Hospital* (1989) 17 NSWLR 553 at 566.

71. Interim Report - see note 2: 26.

72. Interim Report - see note 2: 288-290.

73. Submission to the PIR Discussion Paper from GIO Australia: 2.

74. Correspondence to the PIR from Amos B. (then) Director-General, New South Wales Health Department, undated: 2.

75. Submission to the PIR Discussion Paper from the New South Wales Department of Health: 5.

76. Correspondence to the PIR from P. Davidge Executive Director, Finance and Information Division, South Australian Health Commission. Attachment I: South Australian Health Commission indemnity basis for medical malpractice & public liability risk exposures, 24 September 1991:5.

77. Interim Report - see note 2: 277-279 and recommendations 42 and 43.

78. For example, New York state law now required every hospital to purchase excess insurance to cover liability costs above the doctors' compulsory $1 million cover. New York State Insurance Department. *Report on Medical Malpractice: A Balanced Prescription for Change.* New York State insurance 1985 New York State: 30.

79. American Law Institute. *Enterprise Responsibility for Personal Injury - Reporters' Study - Volume II Approaches to Legal and Institutional Change*: chief reporters Paul C. Weiler (from 1989) and Richard B Stewart (to 1989). American Law Institute 1991 Philadelphia: 111-126.

80. Petersen K. No-Fault and Enterprise Liability: the View from Utah. 1995 *Annals of Internal Medicine* 12(6): 462-463.

81. American Law Institute - see note 79: 114.

82. American Law Institute - see note 79: 119.

83. American Law Institute - see note 79: 125.

84. American Law Institute - see note 79: 125.

85. Submission to the PIR from the Medical Protection Association of Australia, 19 October 1994:1.

86. Submission from the Medical Protection Association of Australia, 19 October 1994: 2.

87. MDO Consultancy report - see note 3.

88. Interim Report - see note 2: 209 - recommendation 31.

89. MDO consultancy report - see note 3: 21.

90. MDO consultancy report - see note 3: 22.

91. Submission from the Australian Perinatal Society, 7 July 1994.

92. Submission from the Australian Dental Association (Victorian Branch), 26 July 1994.

93. Submission from the Royal Australian and New Zealand College of Psychiatrists, 1 September 1994.

94. Submission from Westmead Hospital Staff Specialists Association, 3 August 1994.

95. American Law Institute - see note 79: 116.

96. Diekman, J. What price medical defence? 1993 *Journal of the Medical Defence Union* 7(3): 34 - 35.

97. MDO Consultancy report - see note 3: 49.

98. Nisselle P. Professional protection: the way forward? 1995 *Australian Medicine* 7(14): 16.

99. What is a reciprocal insurance exchange? Leaflet: available from Reciprocal Insurance Management Limited, 4100 Yonge Street, Suite 412, North York, Ontario, M2P 2B5, Canada.

100. In Canada, a further advantage is that mutuals do not pay income tax. A similar position applies to mutuals in Australia as well. See MDO Consultancy report - see note 3: 62.

101. The HIROC story. Brochure: available from Healthcare Insurance Reciprocal of Canada, 4211 Yonge Street, Suite 210, Willowdale, Ontario M2P 2A, Canada.

102. Risk management. Leaflet: available from Reciprocal Insurance Management Limited. 4100 Yonge Street, Suite 250, North York, Ontario, M2P 2B5, Canada.

103. Claims management. Leaflet: available from Reciprocal Insurance Management Limited. 4100 Yonge Street, Suite 250, North York, Ontario, M2P 2B5, Canada.

104. Correspondence to the PIR from Mr R J Falzon, Director/General Manager of Jardine Australian Insurance Brokers Pty Ltd, 468 St Kilda Road, Melbourne, Victoria 3004, 22 February 1995.

105. Correspondence to the PIR from Mr R Falzon - see note 104: 2–4.

106. Correspondence to the PIR from Mr R Falzon - see note 104: 4.

107. Toltz P. The "no" case. 1995 *Open road* March/April: 10. Paciullo G. "The yes" case. 1995 *Open road* March/April: 11.

Endnotes to Chapter 10

1. The members of the Birthing Issues Sub-committee were: Ms Fiona Tito (Chair) PIR; Dr Craig Lilienthal, the Medical Defence Union; Dr Paul Nisselle, Medical Protection Society of Australia; Dr Gordon Clowes, Confederation of Australian Medical Defence Organisations; Dr Ross Sweet, Committee of Presidents of Medical Colleges (Royal Australian College of Obstetricians and Gynaecologists); Dr Chris Maxwell, Committee of Presidents of Medical Colleges (Royal Australian College of Obstetricians and Gynaecologists); Dr Richard McKinnon, Committee of Presidents of Medical Colleges (Faculty of Rural Medicine of the Royal Australian College of General Practitioners); Ms Ann Grieve, Australian College of Midwives; Ms Catherine Maxwell, Australian College of Midwives; Mrs Elaine Smallbane, Australian College of Midwives; Mr Iain Birtwhistle, Insurance Council of Australia; Mr Greg Brown, Insurance Council of Australia; Ms Karen Crawshaw, NSW Department of Health; Dr Andy Cumming, Western Australian Department of Health; Dr Ian Pryor, Australian Medical Association; Dr Michael Sedgley, National Association of Specialist Obstetricians and Gynaecologists; Ms Di Beveridge, Australian Nursing Federation; Ms Bethne Hart, Consumers' Health Forum of Australia; Mr Max Palmer, Medicare Benefits Branch, Commonwealth Department of Human Services and Health (HSH); Ms Ruth Parslow, Workforce Policy Branch, HSH; Ms Merrilyn Woodward, Health Development Branch, HSH. Secretariat support was provided by Ms Madonna McGahan, PIR, HSH.

2. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: background paper*. HHCS August 1993 Canberra.

3. Commonwealth Department of Health, Housing and Community Services (HHCS). Review of Professional Indemnity Arrangements for Health Care Professionals. *Birthing issues: a rural perspective*: prepared by Madonna McGahan. HHCS December 1993 Canberra (Rural issues paper).

4. Commonwealth Department of Human Services and Health. Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and professional indemnity in health care: an interim report.* Australian Government Publishing Service (AGPS) February 1994 Canberra: 62-65 (Interim Report).

5. Interim Report - see note 4: 258 and 206-207.

6. Submission from the Australian Perinatal Society, 7 July 1994: 2.

7. Submission from the Australian Perinatal Society, 7 July 1994: 4.

8. Submission from Maternity Alliance, 1994.

9. Submission from the Association for Improvements in the Maternity Services, 29 August 1994.

10. Submission from Darwin Homebirth Group, 20 December 1994.

11. Submission from the Committee of Presidents of Medical Colleges, 6 July 1994.

12. Submission from Disabled Peoples' International (Australia), 13 September 1994.

13. This figure may be subject to some adjustment upwards in final figures, which are not yet available. This is due to adjustments required when a doctor bills separately for antenatal care and then tries to claim a global fee for delivery as well. The delivery claim is initially disallowed, and then an adjustment is later made to the Medicare data to remove the claims for ante-natal care only and put it back into the global delivery item number. It is unlikely that this adjustment would increase this figure by more than 1%.

14. Medicare data - numbers of providers of confinements - number of providers and number of services by item number and specialty 1989-90 to 1994-95.

15. Medicare Benefits Schedule 16517 - antenatal care, confinement with delivery by any means (including caesarean section) and post natal care for 9 days. In 1994-95, 81 319 confinements were funded under this item number, with 9% of confinements being paid to GPs, 87% being paid to specialist obstetricians and gynaecologists and 4% being paid to IVF practitioners.

16. Bastian H, Lancaster P. *Homebirths in Australia 1988-1990.* AIHW National Perinatal Statistics Unit 1992 University of Sydney: 11-14.

17. This figure may be a little lower, when final figures are available - see note 13 for explanation.

18. Medicare Benefit Schedule item numbers 16500 and 16503.

19. The Medical Protection Society of Tasmania's subscription for an obstetrician or gynaecologist is $5,500 for 1995, while the Medical Protection Society of NSW is $29,000. Others vary between these.

20. Hope Island Insurance Brokers can be contacted through Mr B McKenna (075) 77 5050 - different prices apply to different states because of different rates of stamp duty.

21. Data on premiums provided by Mr B McKenna to Ms F Tito, 15 September 1995.

22. National Health and Medical Research Council (NHMRC). *Options for Effective Care in Childbirth*: report submitted by an Expert Panel to the Women's Health Committee. NHMRC July 1993 Canberra.

23. NHMRC. *Draft report on options for effective care in childbirth - consultation document 2nd stage.* NHMRC October 1994 Canberra (NHMRC 2nd stage draft report).

24. See for example: Department of Health Victoria. Ministerial Review of Birthing Services in Victoria. *Having a Baby in Victoria.*1989 Victoria, where it was said that "although the majority were satisfied with the present provision of maternity services, there is also a desire in the community for new options in the provision of maternity care in Australia."

25. Medicare Benefits Schedule Item Number 16517.

26. Commonwealth Department of Human Services and Health (HSH). *Statistical Overview 1993-94.* AGPS 1995 Canberra: 72-73.

27. NHMRC 2nd stage draft report - see note 23: 51.

28. Stanley F, Blair E, Westaway J. *Cerebral Palsy: the role of obstetric care in pregnancy and delivery. A monograph for lawyers, doctors and parents prepared by the Institute for Child Health Research in conjunction with the Confederation of Australian Medical Defence Organisations.* November 1994: 3.

29. Australian and New Zealand Perinatal Societies. The origins of cerebral palsy - a consensus statement. 1995 *Medical Journal of Australia* 162: 85-89 at 86.

30. Lamb B, Lang R. Aetiology of cerebral palsy. 1992 *British Journal of Obstetrics and Gynaecology* 99(3): 176-178 at 177.

31. Stanley F et al - see note 33: 6.

32. Stanley F et al - see note 33: 6.

33. Stanley F et al - see note 33: 7.

34. Table entitled "Cerebral palsy in pre-term (<37 weeks) and term (>= 37 weeks) infants: Western Australia, 1970-1989" supplied by Professor Stanley in correspondence to Ms Tito - 8 March 1995.

35. For example, the third most expensive AN-DRG in Australia relates to neonates with a birthweight below 750g (AN-DRG 705) at average cost of $58 972. In fact 25% of the top twenty highest average cost AN-DRG relate to neonates weighing less than 2 kg at birth (AN-DRGs 705 - 709). HSH Statistical Overview - see note 26: 115 - Table 9.10. Recent studies have shown that, of babies born before 29 weeks of pregnancy, 50% die before leaving hospital, 13% survive with a severe disability, 6% survive with a moderate disability, 14% have a mild disability and 17% are normal. Those who were classified as severely disabled, 26% had cerebral palsy, 17% were blind, 9% were hearing impaired, 20% had significant intellectual impairment and 29% had a combination of cerebral palsy and other problems. World Review. Disability likely in preterm babies who survive. 1993 *Australian Doctor* 23 July.

36. The connection between cerebral palsy and birth was first asserted by Dr William John Little in 1862. See Little W. The influence of abnormal parturition, premature birth and asphyxia neonatorum, on the mental and physical condition of the child, especially in relation to deformities. 1862 *Trans. Obsts. Soc*. London 3: 293–304, quoted in Lipson T. Annotation. Cerebral palsy, brain damage, blame and defensive obstetrics: time for a u-turn? 1991 *Journal of Paediatrics and Child Health* 27: 201–2.

37. McManus F, Rang M, Chance G, Whittaker J. Is cerebral palsy a preventable disease? 1977 *Obstetrics and Gynaecology* 50: 71-7.

38. Stanley F et al - see note 28: 2.

39. Stanley F et al - see note 28: 5.

40. Naeye R, Peters E, Bartholomew M, Landis R. Origins of Cerebral Palsy. 1989 *AJDC* 143: 1154-1160.

41. Nelson K, Ellenberg J: Antecedents of Cerebral Palsy - multivariate analysis of risk. 1986 *New England Journal of Medicine* 315 (2): 81 - 86.

42. Blair E, Stanley F. Intrapartum asphyxia: a rare cause of cerebral palsy. 1988 *Journal of Paediatrics* 112: 515-519. See also Stanley F et al - note 28: 3.

43. Naeye R et al - see note 40: 1159. Gaffney G, Susan Sellers, Flavell V, Squier, Johnson A. Case-control study of intrapartum care, cerebral palsy and perinatal death. 1994 *British Medical Journal* 308: 743-750.

44. Richmond S. Niswander K, Snodgrass C, Wagstaff I. The obstetric management of fetal distress and its association with cerebral palsy. 1994 *Obstetrics and Gynaecology* 83(5): 643-646 at 646. See also Lipson T. - see note 36: 202, where he states that "Many dysmorphological syndromes such as the Prader-Willi Syndrome are often not diagnosed until beyond the age of 1 year and associated with significant perinatal asphyxia. This type of situation is an indication that lower apgar scores and birth asphyxia may be an early sign of cerebral palsy itself, decreasing the ability of these babies to respond to intrapartum stress. The baby's brain is not damaged by the birth process but abnormal in its development."

45. Stanley F et al - see note 28: 5.

46. Both instrumental and caesarean birth involve risks to the mother and the baby, ranging from various soft tissue injury, skull damage and nerve injury in the baby and the obligatory use of an episiotomy on a mother where forceps are to be used, to much more serious mortality and morbidity. While these risks may be considered appropriate when the danger to the baby of non-intervention is high, where intervention is not necessary to protect the baby or the mother, the risks may not be considered acceptable. For some discussion of various birth traumas - some of which are iatrogenic, see Levine M, Tudehope D, Thearle J. *Essentials of Neonatal Medicine.* Brooks Waterloo 1987 England: 47-54.

47. Henderson-Smart D. Throwing the baby out with the fetal monitoring? Obstetric care, birth asphyxia and brain damage. 1991 *Medical Journal of Australia* 154: 576-577.

48. Henderson-Smart D. - see note 47. Gaffney G et al - see note 43: 748.

49. See for example, Lumley J, Wood C. *Caesarean section in Australia. in the Report of the Working Party to Investigating Variations in Caesarean Section Rates in Australia.* NHMRC 1984 Canberra.

50. Henderson-Smart D. - see note 47: 577, where Dr Henderson-Smart comments on the different clinical practices used in different studies comparing electronic fetal monitoring and intermittent auscultation as techniques for accurately predicting birth asphyxia. He notes that some of these trials used much more intensive monitoring than is usual in routine obstetric practice, and included one-to-one midwife care throughout labour, additional auscultation and additional testing for scalp pH in certain circumstances. He also notes the different monitoring needs when labour is induced, where the pregnancy is high risk and where there are other indicators.

51. See for example: MacDonald D, Grant A, Sheriden-Periera M, Boylan P, Chamber I. The Dublin randomised controlled trial of intrapartum fetal heart rate monitoring. 1985 *American Journal of Obstetrics and Gynaecology* 152: 524-39.

52. *Howarth v. Adey*, Victorian Supreme Court, June 1994.

53. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *The health/medical care injury*

case study project: prepared by the National Centre for Socio-Legal Studies, La Trobe University: authors Garry Coventry, Jeanne Daly, Merilyn Evans, Cathy Lowry, Marilyn McMahon, Gail Roberts. AGPS May 1993 Canberra. One of the participants in the study, whose pseudonym was *Darren Moynihan*, was born with severe mental and physical disabilities. Darren's mother was unsuccessful in obtaining compensation.

54. *Crossman v. Le Fevre & Port Adelaide Community Hospital*, unreported, SA Supreme Court (Matheson J) JNS4899, 22 December 1994.

55. Australian and New Zealand Perinatal Societies - see note 29: 87.

56. Gaffney G et al - see note 43: 743-750 at 748.

57. See, for example: Stanley F. Litigation versus Science: What's driving decision making in medicine? August 1995.

58. Confidential data provided by various MDOs shows that most unresolved claims and most payments relate to claims and incidents which occurred in the early-mid 1980s. This was before the current scientific data on cerebral palsy was available for use by either plaintiffs or defendants.

59. Confidential data provided by MDOs in 1993 showed that most recent cases where payments was made to a plaintiff were settled for much smaller sums, presumably because of the difficulties of demonstrating causation eg one MDO paid 3 such cases in 1992 for an average of $480,000; another paid only one in 1992 and one in 1993 each for less than $100,000; while another paid out only $12,000 in 3 cases in 1992. There have been very few payouts in the multi-million dollar range, but nonetheless, the increased levels of high verdicts is likely to impact on these (rising from around $2 million in the late 1980s to $5-7 million for a young ventilator dependent quadriplegic in 1992). It takes only one or two cases to increase in such a way, as to reflect significantly in MDO premiums.

60. Nisselle P, Murray J. Obstetrics in crisis? 1993 *Medical Journal of Australia* 159: 219 - 221 at 220.

61. For example, Dr John Vallentine of the Medical Defence Union claimed that in Australia, obstetricians and gynaecologists accounted for 2% of membership and 40% of indemnity dollars, with probably 90% of these costs relating to the very small number of "brain damaged baby" claims: MDU Conference *Obstetric litigation options for reform*, November 1991. MPS analysis indicated that "brain-damaged baby" cases accounted for 81% by value of all claims paid in relation to obstetrics and gynaecology since 1988. Correspondence from Dr Paul Nisselle 26 May 1993.

62. Commonwealth Department of Health, Housing, Local Government and Community Services. Review of Professional Indemnity Arrangements for Health Care Professionals. *Defensive medicine and informed consent: a research paper*: prepared by Dr Linda Hancock, Deakin University, Victoria. AGPS May 1993 Canberra (Defensive medicine study).

63. This data on claims made between 1980 and 1993 was kindly provided by the Medical Protection Society - other MDOs were unable or unwilling to provide this information, though none have provided any contrary information to this. The view has been conveyed by several that this is broadly similar to their experiences.

64. The Medical Defence Union, for example, decreased its premium for obstetricians from $28,200 in 1994 to $19,950 in 1995. There have also been decreases in some MDOs for specialist anaesthetists - for example, United Medical Defence has decreased its premium for anaesthetists from $10,460 in 1993 to $9,250 in 1995, and the Medical Defence Union has decreased their premiums from $13,950 in 1993 to $9,500 in 1995.

65. Interim Report - see note 4: 220.

66. Interim Report - see note 6: 222.

67. The promotion of an environment of fear and suspicion in relation to litigation rather than open consideration of all the issues has been a strategy adopted by some MDOs presumably for their own purposes. For example, a recent conference held by the United Medical Defence entitled "Increasing Health Care Litigation - Can Australia afford it?" on 9 September 1995 focussed strongly on the increased incidence of incidents being reported by doctors, rather than on providing data on actual claims commenced, as a reason for doctors to be afraid of current arrangements. Notwithstanding a follow-up letter requesting this claims information, and an undertaking by the President of the organisation at the Conference to provide it and other information, as well as several earlier attempts to obtain claims information from that organisation, no such information had been produced by 19 September 1995, when this chapter was completed.

68. Nisselle P et al - see note 60: 219.

69. Medicare data shows there were only 1705 GPs providing 1 or more private confinements in 1994-95, while the number of GPs (recognised or other) billing at least one Medicare service in 1993-94 was 23 791. HSH statistical overview - see note 26: 67 at table 6.9.

70. Medicare data shows the number of specialist obstetricians and gynaecologists delivering one or more babies per year (including IVF specialists) to a private patient was 754 in 1994-95, while the number of specialists (defined as medical practitioners other than GPs) billing one or more services to Medicare in 1993-94 was 14 960. HSH statistical overview - see note 26: 67 at table 6.9.

71. Nisselle P et al - see note 60: 220.

72. HSH statistical overview - see note 26: 67.

73. Data derived from numbers in Table 10.4 compared to total numbers of obstetrician/gynaecologists disclosed in HSH Statistical overview - see note 26: 67 at table 6.9.

74. Defensive medicine study - see note 62: see chapter 5, especially 37-42.

75. Only some of these would be borne by the doctors MDOs, because a proportion will relate to public patients in states where no recovery is sought from a doctor, where a public patient is treated by them. However, because of the difficulty of determining how many of the 5 successful cases a year involve public patients and possibly split liability, we have used a figure double that to give the range.

76. For the purposes of Medicare data analysis, a full-time specialist is one who had a schedule fee income of $68,834 in 1994-95. Of the 754 specialist obstetricians and gynaecologists who delivered one or more private confinement in 1994-95, 77 were considered part-timers, using this definition. Many part-timers may well qualify for low-income premiums from MDOs, most of whom have such provisions as discussed later in this chapter.

77. Communications with Dr Michael Sedgley of the National Association of Specialist Obstetricians and Gynaecologists, March 1994.

78. A full-time specialist is one who has a schedule fee income of $68,834 or more in 1994-95. This data was provided by the Medicare Estimates and Statistics Section - Table DW4022B.

79. This data is for Peer group 219 - defined as a specialist who concentrates on Group T1-subgroup 3 services (Assisted reproductive services) in the Medicare Benefits Schedule.

80. This group includes: peer group 53, who are specialist obstetricians and gynaecologists, defined as those with specialist qualifications and with a substantial proportion of their work in Group T4 (obstetrics) and T8 - subgroup4 (gynaecological) of the Medicare Benefits Schedule; and peer group 218, who are non-specialist obstetricians and gynaecologists - these are thought to be specialists in training - advice from Medicare Estimates and Statistics Section.

81. HSH statistical overview - see note 26: 52-53.

82. See for example, Tjong R. The American litigation crisis is already here. 1995 *Australian Medicine* 7(10): 4.

83. See for example, the data revealed by the Medical Protection Society in Nisselle P et al - see note 60.

84. NHMRC 2nd stage draft report - see note 23: 11.

85. The procedural MBS items which are included in this calculation are 16506, 16507, 16510, 16513, 16516, 16517 and 16520. It excludes those which are exclusively antenatal, that is 16500 and 16503.

86. Rural issues paper - see note 3: Table 2.2 at 3.

87. Rural issues paper - see note 3.

88. Defensive medicine study - see note 62: 19 - see Table 4.2.

89. In 1993-94, the average income of full-time non-specialist medical practitioners was just under $159 241. HSH statistical overview - see note 26: 81.

90. The other MDO operating in these States does not have a State by State variable premium, categorising States only into high and low cost, with both of these States in its high cost category.

91. Waterford J. ACT caesarean rates: it's time for answers. 1995 *Canberra Times* December 17: 15. The total caesarean section rate varied from 24.5% for those with 300 plus deliveries, 19.4% for those with 100-299, and 13.4% for those less than 100.

92. Rural issues paper - see note 3: 10-11.

93. World Health Organisation, Regional Office for Europe, International Differences in the Use of Obstetrical Interventions, Report on a Study by Stephenson P.A., Sweden, 1992:28.

94. See for example, Lumley J, Wood C. *Caesarean section in Australia. in the Report of the Working Party to Investigating Variations in Caesarean Section Rates in Australia.* NHMRC 1984 Canberra.

95. Stanley F t al - see note 28: 5.

96. NHMRC 2nd stage draft report - see note 23: 15.

97. Defensive medicine study - see note 62: 35 - 46, especially 40.

98. NHMRC 2nd stage draft report - see note 23:16.

99. Fisher J, Smith A, Astbury J. Private health insurance and a healthy personality: new risk factors for obstetric intervention? 1995 *J Psychosom. Obstet. Gynecol* 16: 1-9 at 7.

100. Fisher J et al - see note 99: 7.

101. World Review. Assessment programs lower caesarean rates. 1994 *Australian Doctor* 24 June: 42. The PIR was also informed of similar success at Toowoomba base hospital in Queensland, though no details were supplied.

102. Chalmers I, Enkin M, Keirse M. *Effective Care in Pregnancy and Childbirth*. Oxford University Press 1989 Oxford.

Endnotes to Appendix G

1. Practice Note 81 of the Supreme Court of NSW.

2. Goal 3: Encourage early resolution of disputes by providing a range of appropriate dispute resolution services (draft). NSW Department of Courts Administration, 12/9/94.

3. Goal 3: Encourage early resolution of disputes by providing a range of appropriate dispute resolution services (draft). NSW Department of Courts Administration, 12/9/94.

4. Practice Note 39, Paragraph 11.

5. Supreme Court of NSW. Practice Note 81, Appendix E.

6. At the first directions hearing the Court may request that the parties file a statement of agreed issues (ie. issues in contention): Practice Note 39.

7. NSW Department of Courts Administration. *1992/1993 Annual Report* : 25.

8. NSW Department of Courts Administration. *Key Performance Summary*. March 1994.

9. NSW Department of Courts Administration. *Key Performance Summary*. March 1994.

10. NSW Department of Courts Administration. *1992/1993 Annual Report* : 26.

11. NSW Department of Courts Administration. *Key Performance Summary*. March 1994.

12. Mediation is undertaken pursuant to Rule 56A of the Supreme Court and District Court Rules.

13. Arbitration is undertaken pursuant to Rule 49 of the Supreme Court and District Court Rules.

14. Rule 38

15. SCR 54.09

16. Foster R. *Case Management and Delay Reduction in the District Court of SA*. A paper presented at the Third Annual AIJA Conference of Australian Higher Courts on Case Management and Delay Reduction, 1993.

17. E.2.04.3 and E.4.07

18. Supreme Court of Victoria. *Guide to Commercial List Practice* : D.3.08. 1992.

19. Supreme Court of Victoria. *Guide to Commercial List Practice*. D.3.10. 1992

Endnotes to Appendix H

1. Following these rules is expected to result in outcomes such as:

- all parties affected by a decision have an opportunity to put their case and to hear the opposing case before a decision is made;
- all decision-makers are unbiased;
- decisions are based on sufficient evidence;
- all relevant information is taken into account and irrelevant information is not taken into account;
- the decision-making body has the power/authority to make the decision;
- decisions made are reasonably open to be made on the evidence available;
- policy is not applied inflexibly;
- decisions are not made for improper purposes; and
- a discretionary power is not exercised at the direction of another person.

2. Circumstances where this is inappropriate include those where the relationship of trust between consumer and health care professional has broken down; where a criminal matter is suspected; or where an issue of public health and safety is suspected which overrides the personal complaint.

3. The PIR notes, in some circumstances, in may not be appropriate for a complainant to attend a hearing, for example, it might be necessary to ensure complainant confidentiality.