PARLIAMENT OF NEW SOUTH WALES

COMMITTEE ON THE
HEALTH CARE COMPLAINTS COMMISSION

Report on Mandatory Reporting of Medical Negligence

November 2000

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FUNCTIONS OF THE COMMITTEE

The Joint Committee on the Health Care Complaints Commission was appointed in 1993. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint

COMMITTEE MEMBERSHIP

Legislative Assembly

Mr Jeff Hunter MP - Chairman
Ms Marie Andrews MP – Vice-Chairman
Mr Wayne D Smith MP
Mr Peter W Webb MP

Legislative Council

The Hon Dr Brian Pezzutti, RFD, MLC
The Hon Henry Tsang OAM , MLC
The Hon Dr Peter Wong AM, MLC

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Ms Catherine Watson, Director
Ms Christina Thomas, Project Officer
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Ms. Susan Want, Committee Officer
Ms Glendora Magno, Assistant Committee Officer

TERMS OF REFERENCE OF THE INQUIRY

Notification Of Medical Negligence Actions To The Commission

The Committee on the Health Care Complaints Commission was established by Parliament to monitor the functions and operations of the Commission and to report to Parliament on any issues pertinent to the effective running of the Commission.

> "Section 80(1)(j) of the *Health Care Complaints Act 1993 (NSW)* requires the Health Care Complaints Commission to investigate *the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners.*

The Joint Committee is considering how to facilitate the Commission in performing these functions and has resolved to inquire into:

(a) the barriers currently prohibiting the Commission from complying with the requirements of S80(1)(j);

(b) whether there should be mandatory reporting of all medical malpractice actions to the Commission;

(c) what would be the most appropriate method by which to achieve this;

(d) other methods by which the Commission can better gain access to information regarding malpractice actions which are either pending, on foot or settled;

(e) any other related issues.

Chairman's Foreword

There are those who will no doubt argue that mandatory reporting of medical negligence litigation to a regulatory authority is unnecessary. They will cite the examples of South Australia and the United States as justification as to why. However, following careful examination of the issue, it is not a view which this Committee shares. Nor is it, I believe, the prevailing view of the consumers of the New South Wales health system.

Quality assurance in our health system is paramount. It is erroneous to argue that litigation is somehow outside the general purview of quality of care. Medical negligence litigation is a clear indicator of consumer dissatisfaction with the health system and its nexus with adverse outcomes must surely be undisputed.

Of course not all claims for medical negligence litigation relate to real quality of care issues any more than do all complaints received by the Health Care Complaints Commission and the Area Health Services.

What is important is to gather as much information as possible about consumer unhappiness with the health system and where and why adverse events occur and to feed it back into the system in a meaningful way. This then allows for providers, practitioners and regulatory authorities to understand where the real problems are located and attempt to address them.

Other jurisdictions have acknowledged this for some time. The Committee was advised that the current South Australian system was introduced on the initiative of the South Australian branch of the AMA. The Victorian Medical Board also pushed for the introduction of mandatory reporting in the recent rewrite of its states legislation.

This is not to say that the effective collection of this information and the handling of it in a useful way is not a complex task. The Committee has undertaken a first hand study of jurisdictions which currently have mandatory reporting schemes. It is firmly of the opinion that none of these schemes are operating comprehensively enough to recommend their adoption in New South Wales. Hence, there is currently no one existing comprehensive adverse outcome reporting model which could be recommended for implementation in New South Wales.

This is why the Committee recommends the introduction of a two pronged approach. De-identified information about litigation claims received, settlements and adjudications against health practitioners and providers which can contribute to building a bigger picture of systemic issues and why and when people sue should be reported by indemnifiers and insurers to the Health Care Complaints Commission. This would be used for the purposes of meaningful correlation, analysis and external dissemination in areas of risk management.

Information which contains much greater detail concerning the facts of each claim received and any settlement or adjudication and identifies the parties concerned should be reported by indemnifiers and insurers to the New South Wales Medical Board. The Medical Board should undertake an initial assessment where it looks like there may be a public health and safety or professional issue which is of interest to the Board and/or the Commission. This would initially be undertaken as a two year pilot project. The Report recommends that extension of mandatory reporting to other health professionals be considered at a later stage after the results of the pilot project with doctors are known.

The Committee thanks people who provided submissions and those who appeared before the Committee particularly HCCC, Medical Board, AMA and United Medical Protection. Also thanks to go to those other jurisdictions both in Australia and overseas who gave their time to assist in this inquiry.

Finally my thanks go to the other members of the Committee and the hard working and dedicated Committee Secretariat.

JEFF HUNTER MP
Chairman

Summary of Key Issues

The Health Care Complaints Commission is currently required under Section 80 (1) (j) of the Health Care Complaints Act 1993 (NSW) to *investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care practitioners.* The Commission is presently unable to perform this function because there are no legal obligations on individuals and organisations which hold such information to report it to the Commission.

Mandatory reporting of "medical negligence" information to regulatory authorities is undertaken on both a State and National level in the United States. South Australia has had a scheme of mandatory reporting by doctors to the South Australian Medical Board since 1983.

Centralised knowledge of medical negligence litigation information by regulatory bodies is extremely important for a number of reasons. Firstly, combined with complaint information it can provide a powerful risk assessment tool by highlighting problems within particular areas of the health system. Secondly, behaviour by a medical practitioner which provides for disciplinary action, raises an issue of gross negligence or raises a significant issue of public health and safety may well form part of a medical negligence litigation. This may never come to the attention of either the HCCC or the Medical Board due to a confidential settlements of the same cases. The experience of other jurisdictions with mandatory reporting schemes is that patients who litigate do not also complain to a regulatory authority.

Thirdly, medical indemnity insurers openly admit that they have "frequent fliers". These are doctors who are sued regularly. Some of these "frequent fliers" are identified by their insurers to be in need of retraining and rehabilitation due to substandard levels of performance. It is against the public interest to leave such a task in the hands of insurers whose perspective is commercial rather than public safety.

While it is important to gather medical negligence litigation information, it must also be acknowledged that such information can be misleading and therefore prejudicial to doctors if not handled by bodies who are aware of the vast legal differences between what may constitute medical negligence litigation and what constitutes unsatisfactory professional conduct and professional misconduct in most cases. Similarly, such bodies need to be alert to the commercial realities of why negligence matters are settled rather than defended in the vast majority of cases.

As discussed in the report, other jurisdictions have undertaken mandatory reporting of medical negligence litigation with only limited success. Delegations of the Committee have visited all the jurisdictions discussed in the report and observed the drawbacks with their schemes first-hand.

While there are still many great unknowns in relation to "medical negligence" information, it is clear that any successful scheme must contain the following: notification of claims filed with an insurer at the time that they are received or at regular short intervals; notice of claims settled as close to the time of settlement as possible; and notice of claims adjudicated. Further, cross checking of information by requiring a number of agencies which hold information to report is desirable. At present, only insurers, practitioners involved and the New South Wales Supreme Court are in a position to report such information.

To fulfil the obligations of Section 80 (1) (j) the Health Care Complaints Commission does not need any information forwarded to it to identify the parties to the action. It is the Committee's firm opinion that the Health Care Complaints Commission should be able to provide important risk assessment and management information through the combination of complaint information and deidentified data regarding litigation. The Committee would then like to see this information produced in a detailed form for the Minister for Health, health providers, health practitioners and Medical Board and be publicly available in a summarised form in the HCCC's annual report.

The Committee believes that in order to properly act upon matters of public health and safety, matters which may provide grounds for disciplinary action, and matters involving gross negligence and consistent substandard performance of a medical practitioner, information should be provided to a Medical Board which does identify the doctor concerned.

Due to the lack of effective precedent schemes and the current lack of knowledge concerning the contents of litigation information, the Committee is of the view that a pilot project should be established within the New South Wales Medical Board to receive information about medical negligence litigation claims, settlements and adjudications from indemnifiers and insurers which cover doctors practising in New South Wales. The aim of this project would be to ascertain the most effective way of gathering and dealing with this information.

It is anticipated that such a project would need to be of at least two years duration at the end of which a report could be prepared for both the Minister for Health and the Joint Committee on the utility of gathering and assessing the information. Funding could be done jointly by NSW Health and the NSW Medical Board.

Matters which are considered by the Medical Board to fall under the jurisdiction of the Health Care Complaints Commission by virtue of Section 23 of the *Health Care Complaints Act* 1993 would be referred to the HCCC for investigation. Other matters of concern could be dealt with by the Medical Board under Section 50 of the *Medical Practice Act.*

SUMMARY OF RECOMMENDATIONS

1. That, in the public interest, mandatory reporting of medical negligence litigation be introduced into New South Wales.

2. That the NSW District Court consider establishing a Professional Negligence List (Health and Legal) in line with that established by the NSW Supreme Court .

3. That the Health Care Complaints Act (1993) be amended to require that de-identified data on claims filed, cases settled and cases adjudicated be made available to the Health Care Complaints Commission by indemnifiers and insurers covering medical practitioners, practising in the NSW health system, for the purpose of investigating the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners, as set out at section 80 (1)(j) of the Health Care Complaints Act 1993 (NSW).

4. That a working party be established of relevant stakeholders including representatives of major medical negligence litigation insurers and indemnifiers, relevant registration boards, health providers and the Health Care Complaints Commission to decide upon what de-identified data needs to be supplied to the Health Care Complaints Commission in order for it to most effectively carry out its Section 80(1)(j) objectives.

5. That the Health Care Complaints Commission establish a combined database of complaints and medical malpractice information for the purposes of providing information for risk assessment and quality assurance purposes to the NSW health system.

6 That the Health Care Complaints Act 1993 be amended to require that the Health Care Complaints Commission be required to publish in its annual report summary data on the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners.

7. That insurers be required to provide identified data on medical negligence litigation claims filed, cases settled and cases

adjudicated to the Medical Board of NSW for the purpose of identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-standard performance.

8. That a two year pilot project be undertaken by the NSW Medical Board to assess the utility of data received regarding medical negligence litigation actions from insurers for identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-standard performance.

9. That the two year pilot project by the NSW Medical Board be jointly funded by the NSW Medical Board and NSW Health.

10. That the NSW Medical Board confer with the Health Care Complaints Commission, in accordance with Section 49 of the Medical Practice Act, where it is of the opinion that a medical negligence litigation claim or case should be investigated, in accordance with Section 23 of the Health Care Complaints Act 1993.

11. That after initial assessment of a medical negligence litigation claim or case, if the NSW Medical Board has concerns about the performance of a medical practitioner, but which are not serious enough to warrant investigation under Section 23 of the Health Care Complaints Act 1993 , that the NSW Medical Board deals with the matter in accordance with Section 50 of the Medical Practice Act.

12. That at the conclusion of the pilot project, the NSW Medical Board provide a report to the Minister for Health and the Joint Committee on the Health Care Complaints Commission. This Report should provide findings on the costs and benefits of mandatory reporting of medical negligence, whether the scheme should be extended to other health practitioners and providers and, where relevant, propose a model for reporting and analysis of identified medical negligence litigation data.

Chapter One: Background

Introduction

Section 80(1)(j) of the *Health Care Complaints Act* 1993 (NSW) requires the Health Care Complaints Commission to *investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care practitioners.* The Commission is presently unable to perform this function due to the fact that there are no existing legal obligations on parties to an action, their insurers or indemnity funds or any other holders of litigation information to notify the Commission of details of cases either filed, settled or adjudicated.

The practice of reporting medical negligence litigation or malpractice information to independent investigative bodies which have a mandate to protect public health and safety is widespread in the United States and has been practised within South Australia since 1983.

In 1995, Dr Fiona Tito, in the Commonwealth Government review of professional indemnity in health care, *Compensation and Professional Indemnity in Health Care* recommended that more information be made available on the level of injury and medical negligence litigation claims in the Australian health care system.

Differences between civil and disciplinary actions

It must be made clear at the outset of this report that a finding or admission of professional negligence concerning a health practitioner may differ in many important ways from actions which normally attract the interest of the Health Care Complaints Commission under Section 23 of the *Health Care Complaints Act* 1993 or would attract a finding of professional misconduct or unprofessional conduct under a health registration act.

Professional negligence requires a breach of a duty of care between a practitioner and patient which results in some form of harm to the patient. Alternatively it can involve a practitioner's state of mind: either an inadvertence to the consequences of his/her conduct or the deliberate taking of a risk without necessarily giving proper consideration to the possible consequences of that risk. The action is decided in a civil court on the lesser evidentiary burden of the balance of probabilities.

Unsatisfactory professional conduct as defined under Section 36 of the *Medical Practice Act* 1992 (NSW) includes *any conduct that demonstrates a lack of adequate knowledge, skill, judgement or care by the practitioner in the practice of medicine* as well as falsifying records, failing to attend to patients and other actions which

contravene the requirements of several other related Acts such as the *Health Insurance Act* (1973). *Professional misconduct* as defined under the Section 37 of the *Medical Practice Act* 1992 (NSW) means *unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine.* Such matters are decided on the basis of peer reports by a Tribunal panel and a higher evidentiary burden of "comfortably satisfied" applies.

Why complainants take one form of action over another

Due to lack of public knowledge about medical negligence litigation there is little known about the overlap between complaints received by agencies charged with the task of public protection and civil litigation. Discussions with agencies in jurisdictions which receive both types of information appears to indicate that patients tend to take either one path or the other. The Medical Board of South Australia, for example, told the Committee that only a small number of medical negligence litigation cases it received were subject of a complaint about the same incident.

There have been a number of studies as to why patients choose to sue. The indications are that it is generally not just about financial compensation but about concerns regarding standards of care, the accountability of the provider, to obtain an explanation as to what went wrong or to ensure that the same incident does not happen to someone else. A study published in the *Lancet* in June 1994 noted that not all adverse incidents result in legal action and threatened lawsuits often do not involve actual adverse incidents. The study found that 71 per cent of threatened suits involved physician-patient relationship issues, such as the doctor sending a surrogate physician to attend or being perceived as unavailable, perceived devaluation of the views of the patient or the family by a physician, poor delivery of information and failing to understand the patient or family perspective.

Litigation may be perceived by many patients to be the most effective way of achieving results. It is undoubtedly the case that medical negligence litigation judgements have the potential to have enormous impact upon the system as a whole. The High Court decision of *Rogers v Whitaker (1992)* is a clear example of this. However, often litigation has the opposite effect as it is generally settled out of court with confidentiality orders applying.

Solicitors may also play a role in discouraging a patient to simultaneously pursue the dual paths of complaint and litigation if they are the first point of advice. This was certainly the view taken by the Health Care Complaints Commission in its submission to the Committee:

> *There is a growing trend of litigants (complainants and respondents) who have been involved in investigations by the Health Care Complaints Commission subpoenaing files from the Commission for medical negligence litigation claims. The Commission is aware that plaintiff lawyers usually advise a person who has little prospect of successful legal action to pursue the matter as a complaint to the Health Care Complaints Commission. In cases that are likely to proceed to claims for medical negligence, litigants are not usually encouraged to complain to the Commission as it may compromise the confidentiality and final closure of the matter in a settlement. This occurs even though the Health Care Complaints Commission has power to act concurrently with civil or criminal action.*
>
> *Submission pp1-2*

Similarly, evidence provided to the Committee by Medical Boards within the United States who received malpractice information indicated that "gag orders" as part of settlements have traditionally formed one of the major inducements to settling matters out of court and one of the largest battles fought over mandatory reporting of suits has been the reluctance of lawyers and their clients to erode the power of this bargaining tool.

Potential overlap between civil matters and those which fall within the HCCC's jurisdiction

Although the Health Care Complaints Commission has the power to investigate any complaint, it concentrates on matters which must be investigated unde Section 23 of the *Health Care Complaints Act* 1993. These matters are where the complaint:

(i) *raises a significant issue of public health or safety, or*

(ii) *raises a significant question as to the appropriate care or treatment of a client by a health service provider, or*

(iii) *provides grounds for disciplinary action against a health practitioner, or*

(iv) *involves gross negligence on the part of a health practitioner.*

As previously mentioned, there is a vast difference in most cases between what constitutes actions on the part of a practitioner which may result in a successful finding of medical negligence litigation and those which provide grounds for disciplinary action or involve public health and safety issues. Similarly, a finding of medical negligence litigation may not necessarily involve any of the Section 23 criteria, although it is clear that the Commission is given a legislative role here in investigating medical negligence litigation matters when they are of a "gross" nature.

Health practitioners make mistakes like everybody else and this does not necessarily indicate that they are incompetent or an ongoing risk to the public. There is a very distinct overlap between the negligence alleged in the litigation and the Section 23 criteria. The two are certainly not mutually exclusive. Under the current system there is no way of knowing. In particular, matters which are settled quietly out of court and subject to confidentiality agreements may arguably have been dealt with in this way because the mistake may have been serious and the liability of the practitioner not in dispute.

As the Health Care Complaints Commission argued in its submission to the Committee:

> *The nature of the legal system itself militates against a public hearing of the worst cases - the indefensible ones will probably never get to court. The identities of negligent doctors are also kept secret.*
>
> *Submission p4*

The South Australian Medical Board advised the Committee that it had successfully prosecuted a number of disciplinary actions based upon information received under its mandatory reporting requirements of civil litigation.

The Health Care Complaints Commission quoted a case in its submission which resulted in a finding of unsatisfactory professional conduct following civil litigation:

> *In one case the Commission was investigating, the complainant withdrew the complaint as part of the settlement agreement with the respondent doctor. The Commission continued with the matter and subpoenaed the complainant to attend the Medical Tribunal and give evidence about the complaint. The doctor was found guilty of unsatisfactory conduct for having a post therapy relationship with a patient.*
>
> *Submission p.5*

Further Arguments Concerning Mandatory Reporting

NSW lagging behind other jurisdictions

As previously mentioned, mandatory reporting of medical negligence litigation practised in a number of other jurisdictions. In the United States, apart from requirements for insurers, employers, courts and practitioners to notify individual State Registration Boards, there is also a National Practitioner Databank which keeps a wealth of information on medical practitioners including: disciplinary actions taken against a practitioner; civil suits filed against the practitioner for malpractice; any downgrading of hospital privileges or dismissals from employment etc. The Databank is a commercially run National Government Organisation which charges for information. Any current or prospective employer or registration board may apply for a doctor's complete record.

Eleven Medical Boards in the United States are either in the process of, or have passed, legislation to put complaint and litigation data about doctors on their websites. The Massachusetts Board of Registration in Medicine has been at the forefront with this issue. The argument in support of this has been that health consumers should be able to make an informed choice about which doctor they wish to attend.

South Australia has also had provisions in their *Medical Practitioners Act* since 1983 which requires doctors to report any medical negligence litigation settlements resulting from their actions.

Section 72 of South Australian Act requires medical practitioners to report details of cases involving settlements and court awards within thirty days to the South Australian Medical Board. The penalty for not doing so is five thousand dollars. A number of disciplinary actions have so far been taken against doctors arising from details of civil matters reported.

Litigation as an indicator of performance problems

Details of medical negligence litigation actions hold information which it is in the public interest to disclose to regulatory bodies. Cases involving gross negligence are well within the Health Care Complaints Commission's and Medical Board's legislative ambit. Further, patterns of behaviour, deficiencies in competencies and impairment may well be indicated in successive litigation claims against the one practitioner. Likewise there may be cross overs between complaints received by the HCCC and litigation settled concerning different, but similar, incidents with the one doctor which when added together may indicate a competency or behavioural problem.

As the New South Wales Medical Board told to the Committee:

> *Our feeling is that there must be some pretty interesting stuff in all that data,*
> *Mr. Dix, Transcript 16 March 2000*

United Medical Protection openly admits that it has doctors who are regularly sued and who have been identified as being in need of rehabilitation and remedial training.

Dr Richard Tjiong: *We do have independent doctors who become frequently sued. In house we label them as our frequent fliers, and we do have a frequent flier program and they are risk managed. Quite aside from our professional development program, which is proactive, educative, our frequent flier program is reactive when we recognise the doctors.*

Peter Webb MP: *They are flagged and continually monitored?*

Dr Richard Tjiong: *Yes, they are flagged and we have a special program for them, which is not meant to be punitive but rehabilitative.*

Transcript 30 November 1999 p.14

As the Health Care Complaints Commission has argued in its written submission, professional registration boards are increasingly taking a role in ensuring the clinical competence of their individual members. The New South Wales Medical Board is currently in the process of establishing a professional assessment program to identify substandard performance doctors and retrain them due to the fact that so may investigations conclude with findings of substandard performance.

In response to a question by Jeff Hunter, Committee Chairman, Professor McCaughan, President of the New South Wales Medical Board explained the new program to the Committee:

> *We are proposing a third pathway which is the doctor who is not bad in a moral sense, who is not impaired, but whose overall level of performance is substandard. Currently, there are two pathways of complaints, that of impairment and the issue of professional conduct. What we have identified in looking at those is that some 30 to 40 per cent do not really fit into either, and they fit into an overall performance. The same model that has been working so successfully with impairment is now being applied to performance. At the receipt of a complaint, if it is not impairment and it is not conduct, it will go to the performance arm, which will consist of the doctor being notified, asked to make a submission and prepare for an assessment. The assessment will be done by members of the medical profession, with at least one of them being in the same specialty or general practice. They will do a full assessment and report. The doctor will have a chance to address issues of fact that they may have got wrong and correct them before the performance review panel, and then the panel will consider all the information available, including evidence from other people. It will be done in a non-adversarial way. The doctor will not be represented. Recommendations will be made with regard to areas in which the doctor may need retraining.*
>
> *Transcript 16 March 2000 p.8*

The amendments to the Medical Practice Act were passed in June 2000.

Doctors in the United Medical Protection "frequent flier" program are clearly of interest to the Medical Board in terms of the levels of their performance. As pointed out by the Health Care Complaints Commission in its written submission, risk management should not be left exclusively in the hands of professional indemnity insurers. It is in the public interest that regulatory authorities also perform this task. Ultimately, they are responsible to the public for the clinical competence of their professions. Apart from individual competencies, it is also important that they have a clear picture of how the profession is coping with new procedures and technologies. Further, insurers are put in a difficult situation when they try to risk manage their clients and, ultimately, unlike a registration body, an insurer has no way of forcing a physician to undergo remedial retraining.

In response to a question by Peter Webb MP, United Medical Protection admitted as much:

> *We (UMP) have had two members opting out of our frequent flier programs because they will not comply, and they decided not to continue to be members, but we believe that they could have complied in the sense that the program we gave them was not so prohibitive as to drive them out of the organisation.*
>
> *Dr R, Tjiong Transcript, 30 November 1999 p.14*

Besides its role as a complaint handler, the Health Care Complaints Commission also has a clear role in maintaining health standards by making recommendations for improvements in the care and treatment of patients.

Section 3(a) of the Health Care Complaints Act 1993 gives the Commission the following statutory role:

> (a) *to facilitate the maintenance of standards of health services in New South Wales*

It was argued strongly by the Health Care Complaints Commission in its submission that competency of health professionals fell firmly under the ambit of the regulatory authorities:

> *The prevailing medical culture, until only relatively recently, believed that conduct which is "bad" is appropriate for the disciplinary pathway and complaints about clinical competence are best left to the civil courts. Complaints about incompetence or professional judgement have historically been quarantined from investigations by regulatory authorities. This has changed over the last five years. Most professional registration boards today would view clinical competence as their responsibility. In the past, people with complaints about clinical matters or incompetence were referred by the regulatory authorities to approach the professional bodies such as the AMA or seek legal advice. This would not happen today.*

> *Why should medical negligence litigation cases be quarantined from professional or independent scrutiny? Rapid technological development and growth in knowledge are creating problems for doctors in terms of maintaining competence and for boards in terms of increased complaints.*
>
> *The medical profession tend to be more sympathetic to those doctors facing medical negligence litigation actions in the civil courts than they are to doctors before disciplinary committees. This is understandable given the inexactitude of medicine and the potential for mistakes. All doctors can make them. But negligent doctors can also harm patients, and in that context any distinction made between negligence and professional conduct can be an artificial one. Failing to report negligence cases to an appropriate body is against the public and profession's interest. The purpose of regulation is protection of the public. Any information that identifies unprofessional or incompetent treatment irrespective of its origins should be made available to the responsible organisations.*
>
> *The purpose of civil and criminal law is not only to provide redress/justice for the plaintiff or victim but it is also to act as a deterrent for a future recurrence of the event. The present regulatory environment does not capitalise on its potential deterrent effect.*
>
> *Submission p.6*

Risk Assessment and Management

Litigation information, in tandem with complaint information could be an extremely useful way of indicating particular trends within specialties and diagnostic areas, new techniques and technologies, particular areas of a hospital etc. It could serve as an important indicator of problems occurring within the health system and what these problems are. Many of these may not be serious and may be relatively easily addressed if awareness is raised and systems reviewed. More serious problems also need to be recognised and reviewed. Such reporting could lead to active prevention strategies to be implemented. The Health Care Complaints Commission is about to receive a significant upgrade to its database capability. With the addition of medical litigation information a more complete picture may be drawn of problems in the NSW health system.

Possible prejudicial and misleading nature of such information

This need for better scrutiny of medical negligence litigation cases must be balanced with natural fairness to practitioners themselves. Litigation information gathered about practitioners must be looked at in context. We are living in a society which has become increasingly litigious and New South Wales is widely considered to be by far the most litigious of all the Australian States. Patients are more likely to know about their rights and options and therefore sue than in the past, solicitors advertise for work on a "no win no pay" basis and barristers take a significant amount of work "on spec".

Insurers operate on a commercial basis, cases are often settled for purely financial reasons and settled early before significant administrative and legal costs are incurred. Insurers may not even wait for an action to be commenced by a patient before they ofer a settlement in some instances. The fact that there has been no fault whatever on the part of the practitioner certainly does not prevent a matter being settled. The costs for an insurer dramatically increase the longer a matter progresses and taking a matter all the way to court takes many years. Even in circumstances where a plaintiff's case is found to be unsubstantiated in court and they are ordered to pay the defendant's costs, an individual plaintiff's inability to meet the significant legal costs incurred by the defendant will often mean that the insurer is left paying their own costs for an action which they have successfully defended.

Dr. Kerryn Phelps, President of the New South Wales Branch of the Australian Medical Association stressed the commercial realities of medical negligence litigation in both its written and verbal submissions to the Committee:

> *The majority of medical negligence litigation are settled out of court with the medical practitioners never given the opportunity to defend their actions. The reasons for settlement, often commercial, also include consideration of whether or not the medical practitioner is thought by his or her legal advisors to be a poor witness.*
>
> *Transcript 30 November 1999 p.41*

In response to a question by Dr. Peter Wong MLC, Dr Richard Tjiong from United Medical Protection similarly told the Committee:

> *Part of the litigation increases that we see on our books, no doubt, are due to the fact that we, as an organisation, are becoming more pro-active. That is, we are asking our members to report incidents, not waiting for them to be sued.....We want to go straight to the patient and settle the matter before the emotion surfaces and complicates the whole resolution factor.*
>
> *Transcript 30 November 1999 p.7*

Numbers of claims against a doctor and amounts of settlements and court awards also vary widely depending upon the specialty practised. United Medical Protection named cosmetic surgeons, for example, as the group which tends to have the highest frequency of claims made against it although the amounts paid out in compensation tend to be small because the injuries are generally not life threatening. At the high payout end of the spectrum are obstetricians followed by neurosurgeons. The potential impact of adverse outcomes on the lives of patients in these two categories means compensation will often be extremely substantial.

Further, some specialists are more willing than others to take on inherently risky procedures which their colleagues may not touch. A higher rate of adverse outcomes may have more to do with the nature of their caseload than their actual level of competency.

As Dr Richard Tjoing explained to the Committee:

> *We (UMP) have an ear, nose and throat surgeon who works in the base of the skull, a very difficult area. The injuries are a bit like neurosurgical injuries. If something goes wrong, it goes wrong bad (sic). He has been sued many times, but he is a very competent doctor. In fact, he is a world authority and a national ENT hero, as it were. We cannot punish this doctor because it is not a rehabilitative issue.*
>
> *Transcript 30 November 1999 p.14*

Also, as indicated by the *Lancet* study, the interpersonal skills of a doctor can have a large effect on why he or she is sued. Insurers both in Australia and overseas told the Committee that some doctors are regularly sued largely because they are preceived as uncommunicative, dismissive or rude. In contrast, there are doctors whose competency is probably worthy of scrutiny who will never face a lawsuit due to nothing more than personal charm.

The Health Care Complaints Commission in its submission acknowledged the vast differences that generally exist between medical neglience and what is of interest to the Commission under Section 23 of the *Health Care Complaints Act* 1993:

> *Many consumers think that negligent doctors automatically breach the Hippocratic Oath and are guilty of professional misconduct. Bad outcomes for patients though do not automatically mean that doctors are guilty of misconduct or are incompetent. A patient's condition may require treatment which has known risks and side effects and as long as proper consent was obtained from the patient there may not be a problem with the doctor. In such cases, doctors may have done all that was possible, but were unable to save the patient. Doctors also make mistakes. This does not necessarily mean that they are incompetent. While a doctor's mistake may result in the patient succeeding in a medical negligence litigation action it will not normally end in professional negligence charges.*
>
> *Submission p.5*

Conclusion

The extent of the usefulness of mandatory reporting of medical negligence litigation actions is currently a great unknown due to lack of information. However, there is a clear public interest in the regulatory authorities receiving information concerning claims which may indicate behaviour which could attract disciplinary proceedings or indicate gross negligence, concerning patterns of behaviour, substandard levels of competency or impairment. This must be seen also as an important risk assessment and

risk management tool for the health system. This public interest must be balanced against the potentially misleading and therefore prejudicial nature of such information if taken out of context. Therefore, the rest of this report is devoted to discussing the means by which medical negligence litigation information should be reported, held, reviewed, and acted upon, in the interests of all stakeholders.

Recommendation 1:

That, in the public interest, mandatory reporting of medical negligence litigation be introduced into New South Wales.

Chapter Two: Findings of the PIR and schemes in comparative jurisdictions

The Commonwealth Review of Professional Indemnity Arrangements for Health Care Professionals

The Professional Indemnity Review (PIR) was established by the Commonwealth Government in 1991 to examine the arrangements for patients who were injured through health care negligence or misadventure and to identify any problems with these arrangements and propose solutions.

The Review produced its Interim Report in 1994 and its Final Report, *Compensation and Professional Indemnity in Health Care,* in 1995.

Availability of information on medical negligence litigation

The Report notes that one of the claimed benefits of the tort system is to encourage the improvement of standards of care by providing compensation where a standard has not been met. This assumes, however, that there are feedback mechanisms between the legal and insurance industries and the health profession.

It was noted by the Review that consumers who took legal action often assumed that these links existed and that their litigation would lead to improvements of standards. Litigants commonly reported to the PIR that they took legal action primarily to compel medical practitioners and providers to make information public which had been withheld from them and to ensure that action was taken to prevent a recurrence.

Instead consumers often found that, rather than making information public which would improve standards of care, the tort system usually acted to silence the issue. The vast majority of cases were settled out of court and received no publicity and were often subject to a 'gag order'. Two participants were quoted in the Interim Report in relation to this issue:

> *It took me five or six days to bring myself to sign the settlement form as I had to deny all allegations [regarding negligence]. This went against everything I believed in. I had to accept a lie to get any money.(172:1994)*

> *The system of compensating for medical negligence litigation is poor. I do not feel that offering an indemnity so that doctors cannot be sued for damages does anything to address the problem of negligence. It cannot be compared to motor accident compensation. Drivers who break the road laws can still be prosecuted. There is no medical law, no policing of standards and a medical culture which thinks it is above it all (172:1994*)

The Review noted that whilst the tort system provides compensation for harm, by itself it does not improve standards of care. The PIR commented specifically on the lack of any feedback mechanisms to make use of litigation data:

> *There are currently no systematic feedback mechanisms from the tort system to service providers, funders or professional standards bodies about the kinds of cases that are giving rise to tort actions. (128:1995)*

The Final Report notes that indemnity arrangements for health professionals for negligence are *"surrounded by a surprising degree of secrecy*" (225:1995). As a result of this secrecy, there were many myths regarding litigation and very little useful information.

> *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. (29:1995)*

The PIR commissioned research to obtain any useful data on adverse events and undertook the 'Quality in Australian Health Care Study' of the Australian hospital population in 1992. (17:1995) By extrapolating the results of the Study, it was found that 30,000 people suffered a permanent disability of some kind and between 10,000 and 14,000 died because of a preventable adverse event. The total number of adverse events which were preventable was estimated to be around 230,000." (22:1995)

One of the myths dispelled by the Study was that Australia was extremely litigious and that as a result, medical negligence litigation costs were spiralling. The Inquiry found that medical negligence litigation in Australia were low by world standards.

> *When data from the Quality in Australian Health Care Study…..are compared to the frequency of negligence actions taken against health professionals, it is clear that few people suffering even a highly preventable adverse event with significant resultant disability ever sue their health care professional. (24:1995)*

Who needs the information?

The Review explains that consumer confidence in health providers and the health system depends upon consumers having information on the benefits and risks of treatment options and the financial costs of these options, upon which to make informed choices. (15:1995)

It is further noted that in order to provide this information to consumers, health care professionals need accurate, basic information about medical negligence litigation cases.

> *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 any integrated risk management strategy in any State health system and when it could not obtain comprehensive details of medical negligence litigation claims (16:1995)*

The Review notes that health care facilities also need information on:

- the standards of performance in their services;
- the nature and frequency of negligence actions;
- the size of damages awarded in cases where they or similar facilities are involved;
- the skill levels or competence of those health care professionals who are either employed by them, or who provide services for them as independent contractors; and
- ways of reducing the costs of any claims made against them.

It is also argued that manufacturers of health care products and equipment need to ensure that their products are safe and that they have adequate liability insurance:

> *Manufacturers of therapeutic goods also need information on 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. (16:1995)*

The Review also identifies governments, and policy makers who need information on adverse patient outcomes and costs to assess health outcomes and value for public monies spent.

Recommendations of the Review

The Review recommended the establishment of a risk management system to collect information on incidents, collection of de-identified data on medical negligence litigation claims and the collection of identified data from health professionals in cases in which they are a defendant.

Reactive Risk Management

The PIR recommended the broader use of reactive risk management strategies. Reactive risk management systems work by requiring reporting of certain notifiable events by staff within given time frames. The events may be near misses or incidents where errors

may lead to litigation. The data collected may also include complaints whether or not error is suspected. The identity of the professional concerned is kept confidential to encourage full and frank reporting. The data is a much richer source of information than medical negligence litigation claims because very few incidents result in litigation.

The PIR identified a number of benefits in the collection of incident reports including:

- addressing the patient's and family's needs in the post-injury period;
- ameliorating the consequences of the incident and making things right, wherever possible;
- identifying problems early to prevent their recurrence;
- providing counselling and support to the health care professional;
- collection of evidence while it is fresh and untainted;
- accurate and timely accounts of the incident which may be useful if there is litigation; and
- early determination and payment of liability, when costs are least

It was recommended that statutory protection be given to risk management activities in situations where legal professional privilege do not apply. (133:1995)

De-identified data

The PIR recommended the establishment of a national minimum data set of non-identifying data on health care negligence cases maintained by the Australian Institute of Health and Welfare with appropriate funding contributions from data users. This data would be used to examine trends in particular specialities and diagnostic areas, and to detect areas likely to benefit from active prevention strategies. It was proposed that the data set should be developed in conjunction with the complaints database, as well as other quality and benchmarking projects at that time.

It was recommended that the following agencies provide data:

- all MDOs;
- any insurers providing health care professional indemnity cover to either individual practitioners or facilities;
- all State Governments; and
- private sector self insurers (31:1995)

The proposal was for a phased introduction of a national data base.

Stage 1 involved the establishment of a national data set of claims against State Government health agencies including:

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

The Report recommends that de-identified data connects the date of the incident, the date of the claim and the date of payment or finalisation of the claim (29:1995)

Stage 2 involved the national collection of data by MDOs on each claim, including:

- speciality of the practitioner
- type of health care treatment;
- details of the clinical circumstances of the adverse event; and
- some patient characteristics

The inclusion in the national benchmarking data of:

- diagnostic related group
- location
- whether private or public hospital treatment
- some patient characteristics

Stage 3 involved the establishment of data sets on the incidence of adverse patient outcomes and development of hospital regional and practice specific measures that build on the preceding stages and can be used for differential funding and accreditation purposes.

The PIR stressed the need to collect data on both high-incidence low cost cases (eg failed sterilisation) and low-incidence high cost cases (eg brain -damaged infants). The former was considered particularly important because these incidents may be reduced by inexpensive preventive action.

The proposal for a national data base has yet to be implemented .

Identified data

Section 72 of the *Medical Practitioners Act* 1983 (South Australia), requires a doctor to provide details to the Medical Board of any finalised tort case, where he or she is a defendant. The PIR notes that the collection of identified data has the potential to improve the quality of care by detecting a number of claims against an individual health professional.

The PIR undertook an analysis of the data from South Australia between 1989 – 1994. It found the data useful in revealing patterns of claims. Smaller claims tended to show a pattern by range of payout with six out of eleven in the $250,000 - $499,999 range being in obstetrics and gynaecology. (32:1995). It is important to note that there was no discernable pattern to large claims.

It was recommended that similar legislation was enacted in other States and that legislation be considered for other health professionals "to provide a positive quality link between the tort system and the registration system." (129:1995)

The limitations of the South Australian model in terms of identifying claims close to the time of the event against an individual practitioner was discussed.

Conclusion

The comprehensive study undertaken by the Commonwealth government clearly supports the introduction of a mandatory reporting of medical negligence litigation system within each State. The benefits of the collection of both identified and de-identified data is recognised throughout the PIR's final report .

OTHER JURISDICTIONS

United States

The Joint Committee's 1999 Report, *Study of International Jurisdictions*, discusses its findings in relation to visits to a number of United States jurisdictions which collect and investigate medical malpractice information. In addition, a Committee delegation also visited the South Australian Medical Board in 1999 to examine their system of mandatory reporting.

Massachusetts Board of Registration in Medicine

The introduction of the *Medical Malpractice Act* 1986 (Mass) empowered the Massacusetts Board of Registration in Medicine to establish a system of mandatory reporting of malpractice information. Reports are received from a number of key sources:

- licence renewal applications;
- court proceedings;
- insurance carriers on changes to a practitioner's policy following closed claims;
- hospitals on certain disciplinary actions against medical practitioners with privileges in that facility; and
- health care providers on medical practitioners who they have reason to believe are in violation of the Medical Practice Act or the Board's regulations.

The receipt of data from a variety of sources is seen as essential for a robust system of reporting in that it provides cross checks, particularly as there is no requirement for out of state insurers to report to the Board. Further, the Board does not have any penalty powers in relation to non reporting or under reporting except against doctors. It is found that the least accurate information is received through the court system .

On receipt of the information, the Board has an attorney review any matters which have been settled for over US$300,000. As the Board only receives information following the closure of a case, the earliest it would receive notification would be around four years after the event.

In 1996 the introduction of the *Physicians Profile Bill* (Mass) allowed the Board to compile physician profiles on individual medical practitioners registered with the Board and these are publicly available on the Board's website. There are currently around 50,000 profiles of doctors there. The profiles include the following information:

- physician contact information;
- education and training;
- specialty, honours and awards;
- professional publications; and
- malpractice information and disciplinary action.

The Board told a Committee delegation in August 1999 that its Physician Profiling Internet Site received 175,000 hits per month and the Board received 65,000 phone calls per month relating to information about doctors.

Each doctor has two weeks to view his or her record and up-date and correct it before it is posted onto the website. The doctor can dispute any information on his or her record but the onus is on the physician to disprove the substance of the report. Amounts of settlements are characterised as either "average", "above average" or "below average", It should be noted that only litigation cases where there has been a financial settlement over $300,000 (US) are made public.

New York State Office of Professional Misconduct

New York State has had a system of mandatory reporting of medical malpractice cases since 1975. Insurers are required to report open and closed cases to the Office of Professional Medical Conduct (OPMC) within the New York Department of Health. Each case settled over the threshold of US$300,000 is assessed by an attorney employed by the OPMC to see whether there are issues of concern. Where disciplinary action seems appropriate, an investigation is commenced.

In 1999, the New York State Legislative Assembly was considering a proposal to establish physician profiling similar to the Massachusetts system.

National Practitioners Database, Washington DC

The National Practitioner Database was established in 1990 to improve the quality of health care by identifying and disciplining health practitioners who are incompetent or engage in unprofessional conduct. The data-base also ensures that health professionals with a record of incompetence do not simply move to other states to practise.

The Database contains data on licensure actions, clinical privileges actions, and professional society membership actions against physicians and dentists. It also collects reports of medical malpractice payments made on behalf of health care practitioners.

Authorised agents can access the Data-base on behalf of prospective employers and HMOs to check applicants for positions. A fee is levied for this access making the Database completely self-funded. The public can access aggregated data.

A fine can be levied on those who do not report.

South Australian Medical Board

As mentioned in Chapter One, Section 72 of the *Medical Practitioners Act* 1983 (SA) requires medical practitioners to provide details of any settlement or judgement relating to their performance. Section 72 states:

> *Where a person has claimed damages or other compensation from a medical practitioner for alleged negligence committed in the course of medical practice, the practitioner concerned shall within thirty days after-*
>
> *(a) he is ordered by a court to pay damages or other compensation in respect of that claim; or*
>
> (b) *he agrees to pay a sum of money in settlement of that claim(whether with or without a denial of liability), provide the board with prescribed information relating to the claim. Penalty five thousand dollars*
>
> ……. The prescribed information to be reported is set out in Regulation 12 of the *Medical Practitioners Regulations* 1983:
>
> *……the prescribed information is as follows:*
>
> a) *full details of the alleged negligence;*
>
> b) *the nature of the treatment or procedure which is alleged to have been carried out negligently;*
>
> c) *the address of the premises at which the alleged negligence took place;*
>
> d) *the time and date of the alleged negligence;*

e) *details of any judgement or settlement in respect of the claim including the amount of damages or compensation either awarded by a court or agreed to in settlement of the claim; and*

f) *details of the injury incurred by the claimant as a result of the alleged negligence including whether death, permanent incapacity or impairment occurred as a result.*

A Complaints Advisory Committee within the Board considers each of these notifications and may lay a complaint before the Board Unlike in NSW, the Medical Board does its own investigations and prosecutions.

The Board received 58 Section 72 notifications in the 1999/00 financial year. The majority of notifications do not generally raise professional competence issues although many involve poor communication by medical practitioners. Most notifications are dealt with by counselling, a minority have resulted in action for unprofessional conduct.

Drawbacks of the Existing Schemes

The experience from international jurisdictions with mandatory reporting of malpractice litigation schemes indicates that there are clear cross-overs between medical malpractice litigation and professional competence and conduct issues. This is important in the protection of public health and safety and in ensuring that professional quality issues are addressed.

However, there are significant problems with the existing models in both the United States and South Australia which greatly inhibit their effectiveness.

Firstly, nearly all existing models rely on reporting after a settlement or adjudication has occurred, which is far too long after the event to be an effective risk assessment tool or to identify performance and competency problems when they need to be addressed for quality assurance.

Due to very litigious nature of the United States, so many cases are reported that there is no real attempt made to effectively deal with the voluminous amount of malpractice information which is received. United States Medical Boards which are receiving malpractice reports are only scrutinising cases which are settled for significant amounts of money. Massachusetts and New York only consider cases involving settlements of US$300,000 or more. This is despite the fact that both of these parties agree that there is no direct correlation between the size of a payout and professional incompetence.

There are similarly several important limitations within the existing South Australian model. Like the United States, notification is required too far from the time of the event to be effective. This problem was acknowledged by the Medical Board of South Australia, in its 15th Annual Report.

> *The Board has expressed concern relating to the receipt of Notifications pursuant to Section 72 of the Act. It is clear that these Notifications refer to activity which in some cases is many years old and therefore may or may not be an indication of a practitioner's competence to practise in a particular area. (15th Annual Report of the Medical Board of South Australia, 10:1997/98)*

The Medical Board told a Committee delegation that in order to address issues of incompetence information would need to be received within 12 months of the incident occurring.

Another limitation of South Australian model is that Section 72 Notifications have been held not apply to health practitioners who are employees of providers as it is the institution, not the doctor, which is the defendant to the action given that the provider's insurer receives and deals with the claim. This significantly restricts the amount of reports the Board receives.

A further limitation of the system is that with no cross check reports from relevant agencies, it is impossible for the Board to ascertain if a doctor is being truthful in what he/she either reports or, in fact, doesn't report in relation to Section 72.

Conclusion

There is currently no one existing medical negligence litigation reporting model which could be recommended for implementation in New South Wales at this time.

While the United States schemes offer a strong precedent of detailed reporting from a number of the key agencies, the information received is so voluminous that it makes effective scrutiny of it impossible.

There has never been any real attempt to develop a wholistic reporting system which identifies which information is most relevant in a timely manner to identify performance problems. The current system used in the United States of only investigating matters involving large settlements is almost meaningless.

The South Australian model of only requiring doctors to report after settlements have occurred or cases adjudicated creates a time lag which effectively operates against the public interest. Further the lack of cross checks with other agencies makes the validity of much of the information reported questionable.

In addition, the fact that doctors who are covered by provider insurers are not required to report is inequitable and means that residents, career medical doctors and staff specialists working in hospitals are not open to the same level of scrutiny as their peers . This produces a very incomplete picture of medical negligence litigation within the State.

Caution therefore needs to be exercised in implementing a system of mandatory reporting of medical negligence litigation in NSW.

In order to realise any of the benefits for improving quality of care, information reported must be sufficiently detailed and timely. However, this needs to be balanced with the administrative realities and costs of collecting and filtering large amounts of data. There must also be sufficient cross checks on the information reported.

These matters are considered further in the next chapters.

Chapter Three: Who Should Report

When considering implementing a system of mandatory reporting of medical negligence litigation cases, it is important to clarify which organisations currently collect data, the privacy and legal issues that exist, and which agencies are currently in a position to supply information.

There are a variety of sources of medical litigation information amongst the interested parties. Those with the most comprehensive amount of information are the professional and provider insurers. Courts also hold data concerning actions filed, settlements registered with them and matters adjudicated. Lastly, practitioners themselves should hold information concerning actions taken against them. Currently, access from any of these sources is severely restricted.

Who currently holds information

During the course of the inquiry the Committee spoke to the major repositories of medical negligence litigation data in New South Wales. Each agency spoke to the Committee at length about what type of information they held and what they felt that they could realistically provide to an external source.

The Courts

Currently civil matters started in New South Wales claiming damages of under $1m can be dealt with either by the District or Supreme Courts. Matters claiming over this amount are dealt with only by the Supreme Court.

The New South Wales District Court told the Committee during the course of the inquiry that it is not currently in a position administratively or technically to separate out medical negligence litigation cases from the rest of its caseload.

In April 1999 the New South Wales Supreme Court introduced a *Professional Negligence List (Medical and Legal).* The List, an innovation of Justice Abadee, aims to reduce the cost and delay associated with the bringing and prosecuting of certain classes of professional negligence actions, introduce better management of such cases and to create an atmosphere conducive to early resolution of disputes by the parties. A requirement that the plaintiff file and service an expert's report, or reports, at the time of institution of proceedings is intended to eliminate claims which do not have merit.

Prior to the introduction of Professional Negligence List, all claims involving personal injury were recorded as "common law-personal injury" and were indistinguishable as medical or other personal injury claims.

The creation of the Professional Negligence List means that certain details of actions concerning medical negligence litigation are readily accessible. During his appearance before the Committee in response to a question by Marie Andrews MP, Mr Barry Walsh, Courts Administrator of the Supreme Court advised that:

> *"Generally we identify the names of the parties, the nature of the claim basically in a phrase, in this case it would be medical negligence, the details of the solicitors involved, contact details, and also the residential address of the parties involved ….. records of events that occurred during the conduct of the litigation, things like listing dates and various orders that the court makes…*
>
> *Transcript, 30 November, 1999, p37*

Details of actions which are settled before judgement will be included in the List if parties file the terms of settlement and seek the court's approval. It is expected that approximately 100 cases per annum will be lodged on the Professional Negligence List.

> *Mr. Barry Walsh:*
>
> *..I can report that on average since April we have had approximately eight to nine matters commence each month. That is the average over the seven months since the list was introduced.*
>
> *Transcript, 30 November, 1999, 37*

On 21 June 2000, Justice Abadee supplied the Committee with the following information and statistics from the Professional Negligence List:

> For the 12 month period ending 31 May 2000:

Claims Commenced	110
Existing claims transferred to List	571
Total no. of dispositions	184
Settled	59
Discontinued	89
Dismissed	7
Judgement	8
Transferred to other Court	17
Other disposal	4

Mr Walsh explained to the Committee that current Supreme Court rules restrict information being made available to people who are not a party to the litigation. *Practice Note No 97* of the *Supreme Court Procedure (NSW)* states that access to material will normally be granted to non-parties in respect of:

(a) *pleadings and judgements in proceedings that have been concluded, except in so far as an order has been made that they or portions of them be kept confidential;*

(b) *documents that record what was said or done in open court;*

(c) *material that was admitted into evidence; and*

(d) *information that would have been heard or seen by any person present in open court, unless the judge or register dealing with the application considers that the material or portions of it should be kept confidential. Access to material by non-parties would not normally be allowed prior to the conclusion of the proceedings.*

The Supreme Court provides limited statistical information to a number of agencies, notably the Attorney General's Department for incorporation into the Department's annual report, but is not required to report to any external agencies in relation to professional negligence actions. However, the registrar or judge may notify interested parties before dealing with an application they may apply for access.

In 1994 the Health Care Complaints Commission wrote to the Department of Courts Administration and informed them of the statutory requirement on the Commission to comply with section 80(1)(j) and to seek consultation relating to whether section 80(1)(j) of the Act meant that the Commission should be considered an interested party entitled to obtain access to court material. In reply the Director General outlined the practical barriers to accessing information which existed and expressed uncertainty about whether or not the Commission would be entitled to get access to relevant files including those cases which are settled with the terms of settlement not to be disclosed.

Professional Indemnity Insurers

United Medical Protection Limited (UMP) currently provides medical indemnity insurance to approximately 95 per cent of practising medical practitioners in NSW. UMP provides legal advisory services, legal defence to non-indemnity cases such as disciplinary matters and indemnity to doctors who require it for civil claims. A range of education programs aimed at improving medical practitioners' skills and knowledge have also been developed.

Doctors are encouraged to report adverse incidents as soon as possible and when reinsuring state whether they are aware of any incidents in the past 12 months that may give rise to an action.

During his appearance before the Committee, the Chairman of UMP, Dr Tjiong answered a question by Dr Peter Wong, MLC concerning claims and incidents reported to the Fund:

> *"In the current year in New South Wales we would receive something like 2,000 incident reports and we would have civil claims in the order of about 400 to 500. Now, the rest of these incidents which are not civil claims in due course could become civil claims.*
>
> *Transcript, 30 November, 1999, p6*

UMP's 1998/99 Annual Report indicates it received 2928 claims and reported incidents during the year. Of these, 532 were claims and the remainder were other matters, including disciplinary matters.

Dr Tjiong indicated that of the total claims UMP receives each year, around 30 per cent are discontinued by the plaintiffs. Another 60 per cent are settled out of court, usually on UMP's initiative. UMP consider that around half of these are indefensible cases in which the doctor has been negligent. The other half are cases where UMP believes that the doctor has acted appropriately and has met or exceeded the standards expected of him/her. However, UMP settle these because it is decided that they will have difficulty defending the doctor in a full adversarial common law setting:

> *Dr. Richard Tjiong::*
>
> *….either the doctor is going to make a bad witness in that he is arrogant or his medical record is not up to par, so from an evidentiary position we believe his case is a bit weak, so we settle these cases.*
>
> *Transcript 30 November 1999 p.6*

Only nine per cent of the initial claims received by UMP end up in court. Dr Tjiong told the Committee that court judgement trends are moving to UMP's disadvantage:

> *"Up to 1991 we (UMP) would have won about two-thirds of these cases and lost one third. …The figure since the early 1990s and certainly now is more fifty-fifty and the tendency is more towards a more sympathetic, dare I say that with the greatest respect, (attitude) to patients, with a greater tendency towards the court to award sympathetic findings and these findings, as I said, are not just a perception on our part, it is often articulated in judgements by the trial judge as to his reason for finding fault where there ought not to be fault.*
>
> *Transcript 30 November p.7*

On 29 May 2000 United Medical Protection provided the Committee with an analysis of trends in the level of incidents, the consequent number of claims, claim costs and the time between notification and settlement. This information is detailed in ***Schedule 1*** of this Report.

In response to a question put to him by Committee Chairman, Jeff Hunter MP, Dr Tjiong indicated to the Committee that he believed the Board of UMP would have no problem in providing de-identified statistical information on claims if it were deemed to be in the public interest:

> *Dr Richard Tjiong:*
> *we would welcome an independent external review, so long as it is on a deidentified basis, of course, because of confidentiality to our members.*
> *Transcript 30 November 1999 p.12*

The Treasury Managed Fund for Public Providers

The legal liabilities of the NSW Health Department are managed by the Government Insurance Office (GIO) under a Treasury Managed Fund. During the 1970s it was decided to bring all public hospitals under a master policy managed by the GIO which was then a government agency. The Fund operates as a self-insurance arrangement for public hospitals. It's current claim management and payout costs are over $50m annually. Ninety seven and a half per cent is paid for by a State Consolidated Fund appropriation with the remaining two and a half per cent being met by NSW Health. Hospitals are charged a $5,000 excess fee per claim.

Thirty eight per cent of this Fund relates to claims against public hospitals but until recently no breakdown was available between workers' compensation, public liability and medical negligence litigation cases. The insurance covers most accidents involving public hospitals including trips, falls and other misadventures to members of the public on public health facilities. All employees who work within the New South Wales hospital system are also covered, including junior and career medical officers on staff and staff specialists. The Fund does not cover Visiting Medical Officers (VMO's) with the exception of sessional VMO's in the profession of obstetrics and gynaecology when treating public patients under a sessional contract and staff specialists are not covered when exercising rights of private practice in public health facilities.

There has obviously been a real lack of analysis of claim trends within this scheme in the past. One of the problems of collecting data is that a number of claims relate to incidents which happened as long as 10 or 15 years ago due to the length of the statute of limitations. The Committee was informed that the Department of Health is currently working with GIO on a set of key performance indicators and is endeavouring to be more involved in cases.

Recently, GIO have re-won the contract to operate the NSW Treasury Managed Fund. The new contract specifies that the contractor will improve information and communication exchange on public liability for agencies participating in the Fund. The GIO have engaged a staff member for this task and work will commence in October 2000. This cooperation should improve the current system of monitoring claims. GIO currently holds data on all claims lodged with them and all potential incidents reported. The Department of Health encourages practitioners to report potential incidents which may or may not result in a claim, however there is no statutory obligation to do so.

The General Manager of Finance and Commerical Services of NSW Health informed the Committee that incident data is intended to provide information about trends and alert the Department of Health to potential problems:

> *Mr. Ken Barker:*
>
> *… we are working now with the GIO to get some better key performance indicators, but we have previously done some work in this area and we have not become aware of what you might call adverse trends which would focus on a particular hospital or a particular clinician.*
>
> *Transcript 30 November, 1999, p29*

While the GIO database holds comprehensive information about each individual claim, this information remains confidential.

Private Provider Insurers

Private providers insure through a number of different funds. During the Professional Indemnity Review in 1995, nine of Australia's largest private hospital organisations were contacted in an effort to seek information relating to public liability and professional indemnity and the claims and compensation experience of the private health sector. Much of the claims data provided by those institutions was provided on a "commercial-in-confidence" basis and not subsequently disclosed by the PIR. Information was provided, however, that as a matter of course, incidents which could give rise to a future claim are recorded and the insurer notified. The PIR found that from the data provided, it appears there has been an increase in both the claims made and the claims paid over the three years prior to the report.

The PIR found that it was even more difficult to get information on those claims made against private hospitals and other private health care facilities including nursing homes, mental health institutions, establishments for people with disabilities etc. There was no legislative requirement to maintain insurance records in relation to personal injuries sustained by patients.

Some private hospitals may obtain insurance which includes cover for medical negligence litigation as a consequence of securing public liability insurance as required by the *Corporations Act 1989.* The Australian Council on Healthcare Standards requires professional indemnity insurance cover for the activities of a private hospital's employees for accreditation purposes.

Defendants to an Action

The defendant in each civil action, be it a medical practitioner or a health provider, will generally be familiar with the details of their claim and any outcomes. The South Australian mandatory reporting of medical negligence litigation program relies solely upon the doctor to report details of claims against him or her to the South Australian Medical Board. During their appearance before the Committee UMP indicated that their members were kept up to date with any actions taken against them:

> *Dr. Richard Tjiong::*
>
> *…..I rather think that our members are well informed of settlement. In fact, company policy would be that their permission is sought and sometimes encouraged in various ways when settlement is the proper way to go.*
>
> *Transcript 30 November 1999 p.16*

Who Should Report

A number of organisations currently collect data on medical negligence litigation actions. These agencies include professional indemnity insurers, institutional insurers, courts and doctors themselves. There is a range of sophistication and comprehensiveness in the database systems. Further, different agencies receive information at different stages of the medical negligence litigation and complaint process.

In 1995, the Professional Indemnity Review recommended the establishment of a national minimum data set for health care negligence cases and proposed that the contributors to the database be: all MDOs; any insurers providing health care professional indemnity cover to either individual practitioners or facilities; and all state government and private sector self-insurers (Recommendation 9).

The Health Care Complaints Commission considered that the onus to report should fall on both the doctor and the insurer. This was in line with recommendations made by the Commission to the review of the *Medical Practice Ac*t that, on re-registration, doctors are required to provide a certain body of information about their claims history and complaints to the Medical Board.

> ***HCCC:***
>
> *Registered health practitioners should be required to notify the appropriate registration board of any claim filed with a court and details of any settlement or finalised tort cases, where he or she is a defendant.*
>
> *Submission p18*

However, the NSW Medical Board tended to support the view of the AMA that reporting would place an unreasonable burden on medical practitioners. Further, the Board considered that reports via medical practitioners may lead to under-reporting and that it would be more useful to receive data from insurers. In response to a question by Dr. Brian Pezzutti, MLC about the issue, Professor McCaughan said:

> *" I have not given it much thought, but my initial reaction, and it is not because the AMA says the doctors have a lot of obligations, is that it is just the under-reporting. My view would be to have it done in a sort of hands off way where it comes through the defence organisation under a statutory requirement, depending on whether you are reporting claims or settlements in court, but somewhere the data is being centralised and it is not that individual doctor or board. My personal view is that would be more reliable.*
>
> *Transcript, 16 March 2000, pp 18-19.*

The Committee agrees with this view. On the evidence it received it believes that insurers and Medical Defence Organisations are in the best position both administratively and technically to report comprehensive information.

In line with SA system of legislation requiring notification of settlements and adjudicated cases, the Committee considers that it would be a useful cross check to require medical practitioners to notify the NSW Medical Board of such cases on reregistration.

Conclusion

There are a number of options as to who should report. Principally, insurers, courts and practitioners are the most appropriate candidates. As is done in United States urisdictions, requiring more than one type of agency to report would provide a useful cross-check. Placing the onus to report merely on doctors is ineffective based on the South Australian experience. Requiring doctors to report on re-registration would be an option only as a cross check given time lags and their limited knowledge of details.

At the present time insurers keep the most up to date and andcomprehensive information and be administratively sophisticated enough to begin the task immediately

Courts are another potential source of litigation information. However, the District Court does not appear presently to be in a position to undertake such a task. The Professional Negligence Division of the Supreme Court appear to supply limited information on claims filed, judgements given and out of court settlements registered with the court.

Recommendation 2:

That the NSW District Court considers establishing a Professional Negligence List (Medical and Legal) in line with that established by the NSW Supreme Court.

Chapter Four: What Should Be Reported

Any information reported will depend upon the intended outcomes of collecting medical negligence litigation information. Monitoring of trends in malpractice litigation can be achieved with data which does not identify the plaintiff or defendant (de-identified data). However, a system which scrutinises competencies and general levels of performance of the profession will ultimately have to identify doctors and providers to be effective.

As discussed in the previous chapters there was much debate throughout the inquiry about this issue, in particular, whether identified information should go to the Health Care Complaints Commission or to some other agency .

De-Identified Data

At a minimum, the intention of Section 80 (1) (j) of the *Health Care Complaints Act 1993 (NSW)* is to empower the Health Care Complaints Commission to monitor trends in legal proceedings of malpractice against health care practitioners. As discussed earlier, the Commission is unable to implement this function as there is currently no requirement that any of the organisations which hold relevant data must provide it to the Commission.

The Health Care Complaints Commission believes that:

> *….section 80(1) (j) as it currently stands must be viewed as a monitoring function for identifying systemic issues.*
>
> *Submission p17*

The Committee found that there was a consensus that the Health Care Complaints Commission should receive de-identified data on medical negligence litigation actions for the purpose of monitoring, and reporting upon, trends. As discussed earlier, the organisations able to provide the most useful de-identified data are insurers of health practitioners and of public and private health providers. The Committee took evidence

from UMP, which covers 95 per cent of medical practitioners in private practice, and the Treasury Managed Fund, which covers employees of the NSW public health system, during the course of the inquiry. These bodies both supported the provision of de-identified data to the HCCC.

> *Dr. Richard Tjiong:*
>
> *….we would welcome an independent external review, so long as it is on a de-identified base, of course, because of confidentiality with our members.*
>
> *Transcript 30 November 1999*

Further, in relation to data held by the Treasury Managed Fund, NSW Health supported the recommendation of the Review Committee of the *Health Care Complaints Act* that Section 80 (1) (j) be extended to include malpractice actions about providers:

> *the wording of the provision [section 80 (1) (j) of the Health Care Complaints Act] be changed, replacing the word "investigate" with the word "monitor". The Committee also recommended that the terms of the provision be extended to cover "health service providers" not just "health practitioners.*
>
> *Submission, p1*

It was generally considered that the potential benefits of the Health Care Complaints Commission analysing and disseminating information could be to:

- reduce systems failures by establishing management strategies for high risk areas;
- identify topics to be included in training and on-going professional education ;
- reduce the costs of litigation;
- identify earlier risky devices and procedures.

The Health Care Complaints Commission proposed that de-identified data be provided to it annually by insurers and indemnifiers which would allow the analysis of trends and identification of areas of possible concern to public health and safety.

The Commission's function under the legislation as it currently stands is to report upon *"the frequency, type and nature of allegations made in legal proceedings of malpractice by health professionals"*. The Health Care Complaints Commission believes that:

- *The type of information that would be relevant to monitoring trends in medical negligence litigation include the following:*
- *any trends in the number and nature of claims against health practitioners and public hospitals in NSW;*

- *the proportion of adverse events notified to insurers that become claims;*
- *the medical speciality involved;*
- *the type of defendant (doctor, hospital etc);*
- *the type of plaintiff (gender, income, age, occupation);*
- *the causes of action on which the claim is based;*
- *the type of health care treatment;*
- *details of clinical circumstances from which the claim arose;*
- *the proportion of claims that go to trial or settle out of court;*
- *the amount of damages awarded in each claim.*

HCCC Submission p 17

Dr Richard Tjiong, Executive Chairman of United Medical Protection, considered that the following information which could be provided by his organisation would be useful:

> *"Things like de-identified data on sex, age, specialty of the doctor, sex age and the type of injury of the patient, whether this is a civil claim or settlement out of court. …….location would be one….and the nature of a doctor's practice whether he is a sole practitioner or group practitioner whether he is employed by the hospital, location of the patient.*
>
> *Transcript, 30 November, 1999, p 19*

Although it has been argued throughout this report that it is clearly in the public interest to report details of medical negligence litigation actions to a relevant external body, there may be negative consequences for both plaintiffs and defendants if this information was widely available. For this reason, the names of the plaintiff and defendant should be protected wherever possible.

In particular, in smaller rural communities and in some limited sub-specialties, inadvertent identification by disclosure of the facts of a case remains a real possibility. The Far Western Area Health Services addressed this issue in their submission to the Committee:

> *A process where identification of the person reporting can be protected needs to be addressed, as in small towns it is easy to work out who has made a complaint by means of deduction.*
>
> *Submission, p 1*

The issue of what is to be reported to the HCCC in a deidentified manner is a technical one and probably outside the scope of this Committee to decide. Information needs to be useful as well as compatible with parameters set in other types of health statistic reporting. At the same time it should be ensured that any information given does not compromise the parties involved by identifying them unnecessarily.

The Committee believes that a working party of the relevant stakeholders would be in the best position to decide this issue. It is therefore recommended that representatives of the major medical negligence litigation insurers, the HCCC, the relevant registration boards, health providers and the health professionals' associations confer upon this issue and decide what should be reported.

Identified Data

The intended outcomes of the collection of identified data

The major benefit of receiving identified data on legal proceedings of malpractice is to address professional competence or conduct issues arising from such cases to ensure that the problem is not repeated. Also as discussed earlier, some cases will involve lack of professional standards in clinical care or professional conduct issues which, had they been complaints to the Commission or to a registration board, would have led to investigation, professional counselling, remedial education, disciplinary action or even de-registration. As the Health Care Complaints Commission states:

> *The awarding of damages to the plaintiff does not address the professional standards and conduct issues and does not engage the practitioner in any processes which would redress the problem to prevent it recurring with other patients.*
>
> *Submission, p22*

In particular, successive claims against a practitioner may be an indication of professional performance problems. However, the issue of when a matter should be reported and what should be included is problematic. This will generally impact directly upon what is reported. There is a real danger of the recipient agency being swamped with information which ultimately becomes essentially useless because there is just too much of it to be adequately dealt with. It is also essential that there is not too much of a time lag between the date of the accident and the time it comes to the recipient's attention. As discussed in Chapter Two, this is a major problem with the South Australian and United States models.

The NSW Medical Board emphasised to the Committee that if data on medical malpractice litigation is found to be useful in public health and safety matters, it is only likely to be useful if the incident which gave rise to the litigation was fairly recent:

> *Prof. McCaughan:*
>
> *But the real trouble would be the disparity between time periods. That is our biggest problem with the legal processes that occur in a medical negligence litigation case……I can assure you that if something came to our attention in a timely way and posed a major threat to the protection of the public, it would be acted on.*
>
> *Transcript, 16 March 2000*

Stage of Legal Proceedings at which identified data should be provided

Claims filed

In its submission to the Committee, the Health Care Complaints Commission proposed that information should be reported at the time a claim is filed with an insurer and/or a Court:

> *Legislation should be introduced to require such bodies [insurance carriers and professional indemnity organisations] to report to the Commission annually……..Registered health practitioners should also be required to notify the appropriate registration board of any claim filed with a court and details of any settlement or finalised tort cases, where he or she is a defendant. The Registration Boards should also be authorised to provide this information to the Health Care Complaints Commission.*
>
> *Submission, p 18.*

The NSW Medical Board also emphasised to the Committee that in order to be useful for risk management purposes information would need to be provided at an early stage. The time lag between incidents and settlements is too long to be useful in addressing current practice issues.

The experience of international jurisdictions confirms that there is a huge time lag between the filing of a claim and closure. The average time for closure on a case in New York State is 7 –8 years.

The Committee is also of the view that any useful system of reporting should commence with the filing of a claim to ensure that actions involving possible instances of gross negligence, professional misconduct and unsatisfactory professional conduct or consistent substandard levels of performance are identified as soon as possible. It is clearly in the public interest to do so.

Settlements involving monetary compensation

Details of any settlement involving some form of payment to the plaintiff are also of keen interest to the recipient of medical negligence litigation information. As previously discussed, this will be the method by which the vast majority of the cases are handled by an insurer. The Medical Board of South Australia found that over 90 per cent of the cases reported to it have been settled without reaching a courtroom. While details of claims filed with insurers is a way of attempting to ensure that the most important cases are detected early on, details of settlements are particularly useful for a number of reasons:

1. Settlements are usually an indication of the fact that a claim is not frivolous and completely unsubstantiated;

2. In many instances insurers will approach a plaintiff with an offer before a claim is filed as a result of a doctor reporting an adverse incident to them;

3. A case which is settled usually involves some sort of previous investigation and peer review having been carried out by the insurer;

4. The amount settled may be an indication of the severity of the incident or mistake.

As discussed in Chapter One, there are valid arguments as to why settlement of a case does not necessarily indicate that a medical practitioner is at fault. The decision whether to settle a case is made by the insurer. Indemnity insurers choose to settle cases rather than contest them for purely commercial reasons. It may be less expensive to settle early than contest a case even where the insurer does not believe that there will be an adverse finding against a health practitioner.

However, for the reasons outlined above, any useful system of reporting must include timely reporting of cases which have been settled.

Cases adjudicated

Cases which have been adjudicated may be reported by the press, depending upon the level of interest they arouse. Further, District and Supreme Court judges may produce written judgements on a particular case. However, neither of these forms of reporting are assured and therefore details of medical negligence litigation matters which have been adjudicated would also need to be reported to the recipient of the information as a matter of course to serve as a useful cross-check.

Recommendation 3:

That the Health Care Complaints Act (1993) be amended to require that de-identified data on claims filed, cases settled and cases adjudicated be made available to the Health Care Complaints Commission by indemnifiers and insurers covering medical practitioners, practising in the NSW health system, for the purpose of investigating the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners, as set out at section 80 (1)(j) of the Health Care Complaints Act 1993 (NSW).

Recommendation 4:

That a working party be established of relevant stakeholders including representatives of major medical negligence litigation insurers and indemnifiers, relevant registration boards, health providers and the Health Care Complaints Commission to decide upon what de-identified data needs to be supplied to the Health Care Complaints Commission in order for it to most effectively carry out its Section 80(1)(j) objectives.

Recommendation 5:

That the Health Care Complaints Commission establish a combined database of complaints and medical malpractice information for the purposes of providing information for risk assessment and quality assurance purposes to the NSW health system.

Recommendation 6:

That the Health Care Complaints Act 1993 be amended to require that the Health Care Complaints Commission be required to publish in its annual report summary data on the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners

Chapter Five: Who Should Hold The Information

As discussed in the previous Chapter, there was a general consensus by stakeholders that mandatory reporting of de-identified information was desirable and that this information should be reported to the Health Care Complaints Commission. However, there were very different views on the most appropriate body to filter/hold identified information, should the Committee recommend that this was desirable.

The Health Care Complaints Commission

As it is currently set out the Act does not empower the Health Care Complaints Commission to investigate or take disciplinary action against individual health practitioners of its own volition without the receipt of a complaint. This would prima facie preclude it from acting upon information supplied under Section 80 (1) (j):

> *HCCC:*
>
> *Even though the term 'investigate' is used any such investigation must be differentiated from investigations defined by section 23 and Division 5 of the Health Care Complaints Act 1993. There is no provision in the Act to link the function of investigating allegations made in legal proceedings to functions concerning investigations of individual health practitioners. The Act presently only contains provisions which empower it to investigate written complaints against individual health practitioners and health services that must be verified by statutory declaration. Without amendments to the legislation there is no pathway for the Commission to investigate a matter that has been subject of civil proceedings in the absence of a complaint about the same matter.*
>
> *Submission p17*

However, the Commission is firmly of the view that Section 80 (1) (j) should be used for the purposes of initiating investigations against doctors, where warranted:

> *HCCC:*
>
> *…. Section 80 (1) (j) should be:*
>
> - *for the purpose of monitoring and reporting trends in medical negligence; and*
> - *for the purpose of investigating individual practitioners where the subject matter of the complaint raises significant public health and safety issues or requires disciplinary action…*
>
> *Submission pp 17-18*

The Commission believes that this is consistent with the intention of the Act which states that:

> *(1) The Commission must investigate a complaint:*
>
> *(b) if, following assessment of the complaint, it appears to the Commission that the complaint:*
>
> *(iv) involves gross negligence on the part of a health practitioner.*
>
> *(4) The Commission may investigate a complaint despite any agreement the parties to the complaint may have reached concerning the complaint."*
>
> *HCCC Submission, p 18.*

In their submissions to the Committee, many providers including: the New Children's Hospital, Far West Area Health Service, Northern Rivers Area Health Service, Hunter Area Health Service and South Western Sydney Area Health Service supported mandatory reporting of identified medical negligence litigation information to the Health Care Complaints Commission. However, the latter three organisations proposed that any identified data provided to the Health Care Complaints Commission be limited to cases in which there has been settlement or adjudication, given the low correlation of malpractice claims with professional incompetence or conduct concerns.

Other stakeholder organisations in the medical field such as United Medical Protection, the NSW Branch of the Australian Nurses Association and the NSW Branch of the Australian Medical Association were opposed to any expansion of the Health Care Complaints Commission's role to include receipt of identified information about medical negligence.

NSW Health referred the Committee to the *Final Report of the Statutory Review of the Health Care Complaints Act* chaired by Mr John Cornwall which comprised representatives from the Health Care Complaints Commission, Medical and Nurses Registration Boards, the Department of Health and the AMA and Nurses Association.

The Review Committee considered section 80 (1) (j) in its deliberations in 1997 and recommended that:

> *NSW Health:*
>
> *the wording of the provision be changed, replacing the word "investigate" with the word "monitor"…..It was clear from the terms of these recommendations that the Committee did not see the section as providing a basis by which the Commission would be required to investigate particular matters.*
>
> *Submission, p1*

The NSW Medical Board

Most stakeholder groups did concede that the NSW Medical Board would be an appropriate body to hold identified medical negligence litigation information.

United Medical Protection:

> *Dr. Richard Tjiong:*
>
> *We really would rather go the route of, firstly, the Medical Board should be the recipient of the information and, secondly, the information is not simply as widely constructed as in section 80 (1) (j) even if it were personalised to make it more workable for the Medical Board, given you have an indemnity organisation that is capable of delivering.*
>
> *Transcript, 30 November 1999, p 18*

This was also the view taken by the Australian Medical Association:

> *AMA:*
>
> *If there is to be mandatory reporting, the AMA would support mandatory reporting to the Medical Board and no other organisations*
>
> *Submission p55*

The role of the HCCC vis a vis the Medical Board

The Health Care Complaints Commission was established to ensure public confidence in the health system by providing for an independent investigator and prosecutor on matters which may raise concerns regarding public health and safety and disciplinary matters. Further, the Commission is empowered to be pro-active on matters of public health and safety.

Unlike the other jurisdictions within Australia, and throughout the world, the NSW Medical Board does not perform a self regulatory role in terms of investigation and prosecution of complaints against doctors.

The Committee considers the current model to be a robust way of ensuring that complaints about the health system receive independent scrutiny and does not doubt the capacity of the Health Care Complaints Commissioner or her staff to appropriately identify and deal with cases of medical malpractice litigation which raise concerns under Section 23.

However, in deciding which is the most appropriate body to receive and assess identified medical negligence litigation information, it is clear that both the NSW Medical Board and the Health Care Complaints Commission are equally appropriate recipients given the Medical Board's new pro-active stance on performance of doctors.

In assessing the body to deal with the information the Committee was hampered primarily by the great unknowns concerning the amount of, and most appropriate way of dealing with, any information reported as well as the extent to which outcomes will ensure better public health and safety.

While the Committee considered the exercise to be an essential one, it feels that such a task will have impact upon the Commission's primary functions.

Lengthy investigations of complaints have an undisputed impact upon the health and safety of patients in the NSW health system and place unnecessary stresses on both complainants and respondents. The Committee considers that investigation of complaints and prosecution of adverse findings should always remain the primary focus of the HCCC.

Stakeholder groups pointed out throughout the inquiry that they were unhappy with the time taken to finalise complaints.

The NSW Nurses Association commented that:

> *The Commission has persistently had difficulty in dealing within a reasonable time frame with those complaints which are already provided for under the Health Care Complaints Act 1993. The Commission is taking, on average, some 728 days to investigate complaints. This does not include any further time that may be required if the complaint is to be prosecuted (Health Care Complaints Commission, 1997/98 Annual Report, page 45)*
>
> *Submission, p3*

While the Committee has observed significant improvement in HCCC investigating timeframes over the years at this point in time, it is impossible to ascertain how much of the information reported will ultimately be of interest to the HCCC. It is probably a fair prediction that information which is of interest to regulatory authorities will relate to patterns of substandard performance and, as such, identify potential candidates for the Medical Board's performance assessment program. This is clearly within the ambit of the Medical Board.

The Committee would at this time, like to see the HCCC focus on providing risk management data via a combined complaints and litigation information data base which can be fed directly back into the health system. This, in itself, will be a large challenge.

Further, the current arrangements by which the HCCC and Medical Board confer on complaints would lend itself ideally to a situation whereby the Medical Board could be compelled to discuss cases which raise real concerns about possible instances of professional misconduct and unsatisfactory professional conduct which the HCCC could then investigate.

Pilot Project

As discussed in Chapter Two, the Committee considers that there are currently no optimum models of mandatory reporting of medical negligence litigation operating in any of the jurisdictions which have schemes. The NSW Medical Board has a valid argument when it states that it is difficult to propose a set of arrangements for mandatory reporting when it is not clear how useful the data will be and the burden upon the agency which collects it:

> *Mr. Dix:*
>
> *Our feeling is that there must be some pretty interesting stuff in all that data, but the haphazard nature of the system could lead to a point at which the reporting necessitated appointing a claims made time. There is a huge range to the scope of those claims, from totally fanciful to really serious ones….*
>
> *People talk about speculative claims, but we do not know whether they happen. If, on the other hand, at the other end of the process a judgement has been handed down, or there has been a settlement, if we are trying to be protective about something terrible that happened in 1996, I am not sure what we could achieve by that. Then, everybody gets up in arms about the judgement of half a million dollars, when the actual dollar value does not necessarily indicate much about the level of culpability. Of perhaps even more concern are the people who make a string of claims over a short period of time, even though the claims might not be so large, suggesting incompetence or something like that…..*
>
> *The difficulty is that there is a lot of information, but it is very jumbled. What we have proposed in our letter is that if this proposal is to go ahead, we believe it should be done as a staged process. First of all, one must work out what information must be collected, then collect that information for a given time, then determine what use can be made of that information, rather than referring matters on to the Commission or using it for disciplinary processes. We feel that a lot of work has to be done before getting to that point."*
>
> *Transcript, 16 March 2000, p 24*

The Committee therefore proposes that a pilot project be undertaken to assess the extent of the usefulness of litigation information and how best to identify these areas of concern. This pilot project would need to be of a minimum two year duration. It is recommended that it be jointly funded by the NSW Health and the NSW Medical Board.

Identified data should be supplied by all indemnifiers and insurers which hold claims concerning doctors. This information should include information at the time a claim is filed and at the time of any settlement, dismissal or adjudication. Substantial penalties should apply for non-reporting of information. The names of the parties to litigation

should be kept confidential. Substantial penalties already apply to the disclosure of confidential information in the *Medical Practice Act 1992* and the *Health Care Complaints Act 1993*.

At the conclusion of the project a report should be provided to the Minister of Health and Joint Committee on the Health Care Complaints Commission as to the benefits of collecting the data and proposed arrangements for mandatory reporting of medical malpractice, including consideration of whether insurers, medical practitioners or both should be required to report, what is to be reported and how often.

The Joint Committee proposes to then review this matter after receiving the pilot project report.

The Committee has proposed that these arrangements apply initially to medical practitioners, as the bulk of medical malpractice litigation appears to be against medical practitioners.

At the conclusion of the pilot project consideration should be given to extending the mandatory reporting scheme to other health practitioners and providers.

Recommendation 7:

That insurers be required to provide identified data on medical negligence litigation claims filed, cases settled and cases adjudicated to the Medical Board of NSW for the purpose of identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-standard performance.

Recommendation 8:

That a two year pilot project be undertaken by the NSW Medical Board to assess the utility of data received regarding medical negligence litigation litigation actions from insurers for identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-standard performance.

Recommendation 9:

That the two year pilot project by the NSW Medical Board be jointly funded by the NSW Medical Board and NSW Health.

Recommendation 10:

That the NSW Medical Board confers with the Health Care Complaints Commission, in accordance with Section 49 of the Medical Practice Act, where it is of the opinion that a medical negligence litigation claim or case should be investigated, in accordance with Section 23 of the Health Care Complaints Act 1993.

Recommendation 11:

That after initial assessment of a medical negligence litigation claim or case, if the NSW Medical Board has concerns about the performance of a medical practitioner, but which are not serious enough to warrant investigation under Section 23 of the Health Care Complaints Act, that the NSW Medical Board deals with the matter in accordance with Section 50 of the Medical Practice Act.

Recommendation 12:

That at the conclusion of the pilot project, the NSW Medical Board provides a report to the Minister for Health and the Joint Committee on the Health Care Complaints Commission. That the Report provides findings on the costs and benefits of mandatory reporting of medical negligence whether the scheme should be extended to other health practitioners and providers and, where relevant, proposes a model for reporting and analysis of identified medical negligence litigation data.