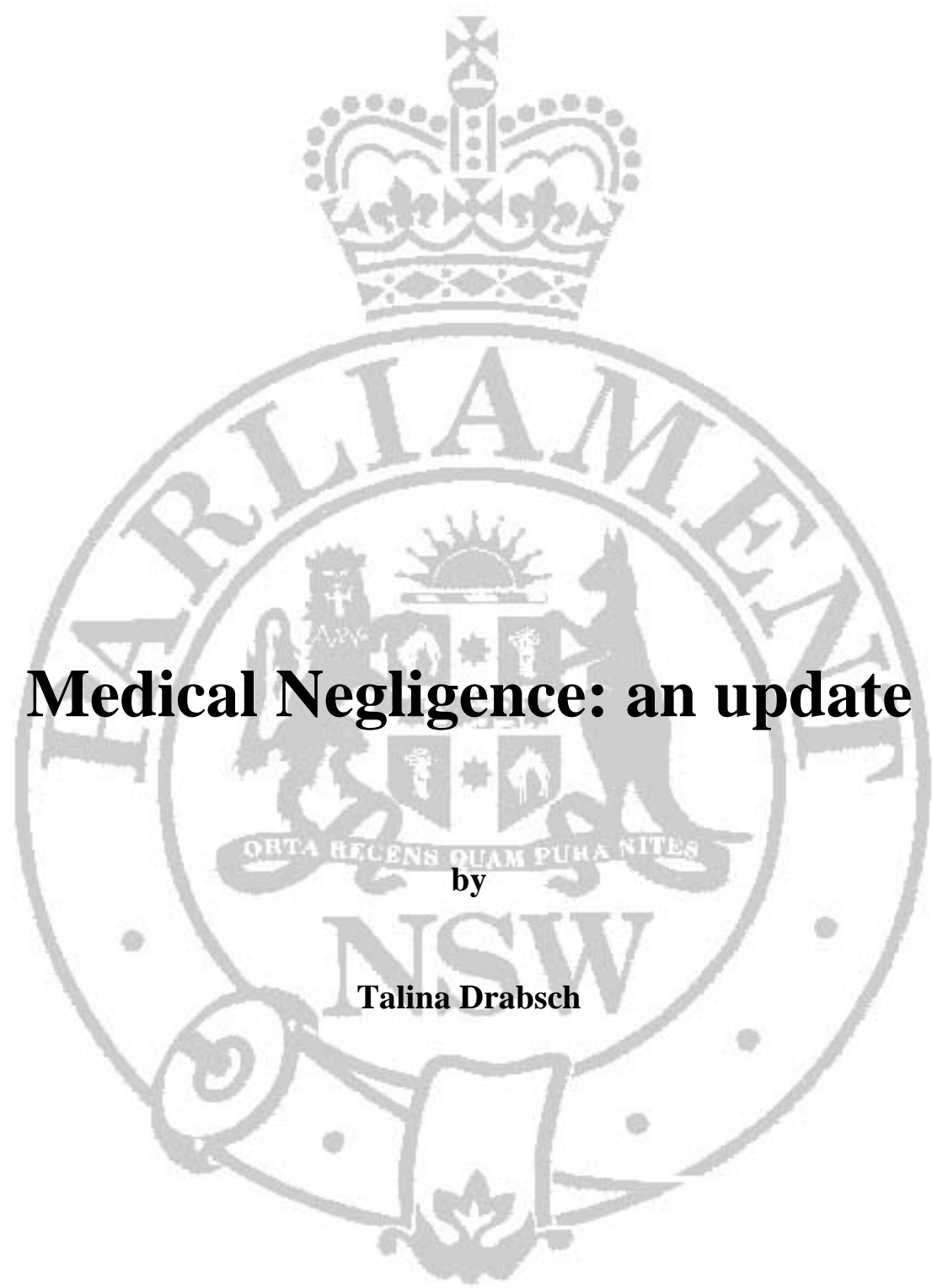


**NSW PARLIAMENTARY LIBRARY
RESEARCH SERVICE**



Medical Negligence: an update

by

Talina Drabsch

Briefing Paper No 2/04

RELATED PUBLICATIONS

- Medical Negligence and Professional Indemnity Insurance by Rachel Callinan, Background Paper No 2/01
- Public Liability by Roza Lozusic, Briefing Paper No 7/02
- Public Liability: An Update by Roza Lozusic, Briefing Paper No 11/02

ISSN 1325-4456

ISBN 0 7313 1754 8

February 2004

© 2004

Except to the extent of the uses permitted under the *Copyright Act 1968*, no part of this document may be reproduced or transmitted in any form or by any means including information storage and retrieval systems, without the prior written consent from the Librarian, New South Wales Parliamentary Library, other than by Members of the New South Wales Parliament in the course of their official duties.

NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE

David Clune (MA, PhD, Dip Lib), Manager (02) 9230 2484

Gareth Griffith (BSc (Econ) (Hons), LLB (Hons), PhD),
Senior Research Officer, Politics and Government / Law (02) 9230 2356

Talina Drabsch (BA, LLB (Hons)), Research Officer, Law (02) 9230 2768

Rowena Johns (BA (Hons), LLB), Research Officer, Law (02) 9230 2003

Stewart Smith (BSc (Hons), MELGL), Research Officer, Environment ... (02) 9230 2798

John Wilkinson (BA (Hons), MA), Research Officer, Economics (02) 9230 2006

Should Members or their staff require further information about this publication please contact the author.

Information about Research Publications can be found on the Internet at:

www.parliament.nsw.gov.au/WEB_FEED/PHWebContent.nsf/PHPages/LibraryPublications

Advice on legislation or legal policy issues contained in this paper is provided for use in parliamentary debate and for related parliamentary purposes. This paper is not professional legal opinion.

CONTENTS

EXECUTIVE SUMMARY

1	INTRODUCTION	1
2	SIGNIFICANT EVENTS SINCE 2001.....	2
3	NSW REFORMS.....	8
3.1	The Government’s rescue package	8
3.2	Health Care Liability Act 2001.....	8
3.3	Review of the Law of Negligence (the Ipp Report).....	11
3.4	Civil Liability Act 2002.....	13
3.5	Civil Liability Amendment Act 2003	18
4	COMMONWEALTH REFORMS	20
4.1	Medical indemnity package	20
4.2	IBNR Scheme	21
4.3	Medical Indemnity Policy Review Panel.....	22
5	THE SITUATION ELSEWHERE.....	25
5.1	New Zealand.....	25
5.2	United Kingdom	27
5.3	United States of America.....	28
6	HAVE THE REFORMS BEEN EFFECTIVE?	31
6.1	Overview of reforms.....	31
6.2	What was driving the increase in insurance premiums?.....	31
6.3	What has changed?	34
6.4	Remaining concerns	36
7	CONCLUSION.....	38

EXECUTIVE SUMMARY

This paper updates Background Paper No 2/01, *Medical Negligence and Professional Indemnity Insurance* by Rachel Callinan. In early 2001 there were frequent media reports of a doctors' crisis in NSW. Professional indemnity insurance premiums had risen substantially, attributed to an increase in medical litigation. The doctors' crisis has continued since then, intensifying in late 2003, when more than 100 doctors in NSW and Queensland handed in their resignations, in protest of bills for the IBNR levy issued by the Commonwealth Government. The current furore over Camden and Campbelltown hospitals again brings issues of medical negligence to the fore.

This paper examines the many events that have occurred since 2001 that have had an impact on medical litigation. There have been numerous legislative changes in NSW, including an overhaul of health care and civil liability law. United Medical Protection (UMP), the principal medical defence organisation (MDO) in NSW, has entered provisional voluntary liquidation and emerged again, the first body to do so in Australian corporate history. The debate surrounding medical indemnity insurance has become a national issue, evidenced by the development of a comprehensive rescue package by the Commonwealth Government. The Negligence Review Panel, chaired by Justice Ipp, published its review of the law of negligence in 2002, with many of its recommendations subsequently implemented by the states, including NSW. Medical defence organisations are now required to operate as insurers under the supervision of APRA, rather than as mutual indemnity societies. This paper examines these changes, analyses the effectiveness of the reforms, and highlights the concerns that still exist.

Section 2 (pp 2-7) contains a timeline of events from 2001 onwards that have influenced both the shape and effectiveness of reforms.

Details of the reforms themselves may be found in section 3 (pp 8-19). It examines action taken by the NSW Government, from the *Health Care Liability Act 2001*, through the *Civil Liability Act 2002*, *Civil Liability Amendment (Personal Responsibility) Act 2002*, and *Civil Liability Amendment Act 2003*. This section also discusses the findings of the Negligence Review Panel published in the Ipp Report. The extent to which the Panel's recommendations have been implemented in New South Wales is noted.

The Commonwealth Government has developed an extensive medical indemnity rescue package. Section 4 (pp 20-24) explores the details of this package, paying particular attention to the IBNR Scheme and the controversy which surrounded it. It also discusses the findings of the Medical Indemnity Policy Review Panel and the extent to which the Commonwealth Government has accepted the Panel's recommendations.

Section 5 (pp 25-31) includes an overview of the approach taken by other countries toward medical negligence, including New Zealand, the United Kingdom and the United States of America. Details of New Zealand's no-fault compensation scheme are provided.

The effectiveness of the reforms is discussed in section 6 (pp 32-38). It explores such questions as what was driving the rise in insurance premiums, has anything changed, as

well as highlighting some of the concerns that remain.

The recommendations of the Negligence Review Panel are included as Appendix A. The recommendations of the Medical Indemnity Policy Review Panel are located in Appendix B.

1 INTRODUCTION¹

In early 2001 there were frequent media reports of a doctors' crisis in NSW. Professional indemnity insurance premiums had risen substantially, attributed to an increase in medical litigation. The NSW Government responded in February 2001 by announcing the details of a rescue package designed to solve the problem of ever increasing medical indemnity insurance premiums. However, in late 2003 more than 100 doctors in NSW and Queensland handed in their resignations, protesting against bills for the IBNR (Incurred But Not Reported) levy issued by the Commonwealth Government. The current inquiry into Camden and Campbelltown hospitals has again brought the topic of medical negligence to the fore. This paper is primarily concerned with medical litigation and its influence on medical indemnity premiums.

This paper examines the many events that have occurred since 2001 that have had an impact on medical litigation. There have been numerous legislative changes in NSW, including an overhaul of health care and civil liability law. United Medical Protection (UMP), the principal medical defence organisation (MDO) in NSW, has entered provisional voluntary liquidation and emerged again, the first body to do so in Australian corporate history. The debate surrounding medical indemnity has become a national issue, as evidenced by the development of a comprehensive rescue package by the Commonwealth Government. The Negligence Review Panel, chaired by Justice Ipp, published its review of the law of negligence, with many of its recommendations subsequently implemented by the states, including NSW. Medical defence organisations are now required to operate as insurers under the supervision of APRA, rather than as mutual indemnity societies. This paper examines these changes, analyses the effectiveness of the reforms, and highlights the concerns that still exist.

¹ This paper updates Background Paper No 2/01, *Medical Negligence and Professional Indemnity Insurance* by Rachel Callinan.

2 SIGNIFICANT EVENTS SINCE 2001

A number of significant events have occurred in relation to medical negligence since early 2001. These events have influenced both the shape of the reforms and their relative effectiveness. The following table provides an overview of the development of the medical negligence and professional indemnity debate since 2001.

2001	
27 Feb	The NSW Government announced the details of its rescue package in response to the perceived medical indemnity crisis.
15 Mar	HIH Insurance (the reinsurer for a number of Medical Defence Organisations) entered provisional liquidation.
19 June	The <i>Health Care Liability Bill 2001</i> was introduced into the Parliament of NSW.
5 July	The <i>Health Care Liability Act 2001</i> (NSW) received assent. The Act, with the exception of Part 3, took effect from this date.
27 Aug	HIH Insurance went into liquidation following the removal of its provisional status. The exposure of United Medical Protection (UMP), the major medical defence organisation in NSW and Queensland, to HIH was calculated to be \$64.6 million at 30 June 2002. ²
11 Sept	Terrorists hijacked four US planes and crashed into the World Trade Centre, the Pentagon and a field in Pennsylvania resulting in the loss of more than 3000 lives.
21 Nov	Australia's largest medical indemnity judgment was handed down in <i>Simpson v Diamond</i> [2001] NSWSC 1048 (21 November 2001). The original award of over \$14 million was subsequently reduced on appeal in April 2003 to just under \$11 million. ³ However, the case still remains the largest judgment in Australia regarding medical negligence.
11 Dec	UMP announced an increase in premiums. The majority of doctors in NSW were affected as UMP provided cover for approximately 90% of doctors in NSW at the time.

² United Medical Protection, *Annual Report 2002*, p 22.

³ *Diamond v Simpson (by her tutor William Charles Simpson)* [2003] NSWCA 67 (7 April 2003).

19 Dec	<p>The NSW Government announced that from 1 January 2002 it would fully indemnify all visiting medical officers (VMOs) for all work performed on public patients in public hospitals in NSW. It was also announced that the Government would cover liability for all claims that may arise from public work in past years that have not been reported as yet. Health Minister Craig Knowles stated that:</p> <p style="padding-left: 40px;">This initiative means any doctor in NSW can work on public patients in our public hospitals with the security of a Government indemnity. In exchange for this all doctors will be required to sign up for comprehensive risk reduction programs to systematically eliminate poor practices and increase patient safety.⁴</p>
2002	
1 Jan	<p>Part 3 of the <i>Health Care Liability Act 2001</i> took effect. All medical practitioners in NSW must be covered by approved professional indemnity insurance unless exempt.</p> <p>The NSW Government introduced the VMO Public Hospital Liability Scheme. Thereafter incidents involving a public patient at a public hospital are to be managed by the Treasury Managed Fund if they evolve into a civil claim.</p>
29 Apr	<p>UMP/AMIL entered voluntary provisional liquidation with approximately \$460 million in unfunded liabilities. A provisional liquidator was appointed on 3 May.</p>
May	<p>The Commonwealth Department of Health and Ageing established a Medical Indemnity Taskforce.</p>
31 May	<p>The Federal Government announced that it would assist UMP/AMIL by covering payment for claims finalised and incidents occurring between 29 April and 30 June made under an existing or renewed policy. The period covered was subsequently extended to 31 December 2002.</p>
18 June	<p>The <i>Civil Liability Act 2002</i> (NSW) received assent. The Act aims to reduce the number and cost of civil claims in NSW. Section 2 of the Act ensured that its provisions apply retrospectively from 20 March 2002.</p>
2 July	<p>The federal government announced the terms of reference for the Review of the Law of Negligence. The Negligence Review Panel was to be chaired by Ipp J. The terms of reference for the review noted that:</p> <p style="padding-left: 40px;">The award of damages for personal injury has become unaffordable and</p>

⁴ Hon C Knowles MP, 'NSW Government to cover public indemnity for doctors', *Media Release*, 19/12/01.

	<p>unsustainable as the principal source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and the quantum of damages arising from personal injury and death.⁵</p>
2 Sept	<p>The Negligence Review Panel published their first report, <i>Review of the Law of Negligence</i> (the Ipp Report). The Report recommended that the standard of care for medical practitioners be determined according to the opinion held by a significant number of respected practitioners in the field (Recommendation 3), unless the court deems that opinion to be irrational. It was also recommended that a medical practitioner's duty to inform be expressed as a duty to take reasonable care (Recommendation 6).</p>
3 Sept	<p>The consultation draft of the <i>Civil Liability Amendment (Personal Responsibility) Act</i> (NSW) was released. The Act sought to implement a number of the recommendations of the Ipp Report.</p>
2 Oct	<p>The Final Ipp Report was published.</p>
23 Oct	<p>The Prime Minister released a legislative package to address the problems of medical indemnity insurance including the: <i>Medical Indemnity Bill 2002</i>, the <i>Medical Indemnity (IBNR Indemnity) Contribution Bill 2002</i>, the <i>Medical Indemnity (Enhanced UMP Indemnity) Contribution Bill 2002</i> and the <i>Medical Indemnity (Consequential Amendments) Bill 2002</i>. The package was designed to 'address rising medical insurance premiums and ensure a viable and ongoing medical indemnity insurance market'.⁶ The package included a:</p> <ul style="list-style-type: none"> ▪ Medical Indemnity Subsidy Scheme – obstetricians, neurosurgeons, and GPs performing procedures are to receive direct financial support in recognition of their relatively high premiums; ▪ High Cost Claims Scheme – a scheme to meet 50% of the cost of claims payments greater than \$2 million (up to the insured amount) made by medical indemnity insurers; ▪ IBNR Scheme – the funding of incurred but not reported (IBNR) liabilities for Medical Defence Organisations that had not set aside enough money to cover their liability in this area. The cost of the scheme is to be recouped through a levy on the members of these MDOs payable over an extended period; and ▪ Enhanced risk management approaches. <p>However, in return, MDOs are to be regulated to a greater extent than before. They are to be subject to a new regulatory framework administered by the</p>

⁵ Negligence Review Panel (Chairman: Ipp J), *Review of the Law of Negligence: Final Report*, September 2002.

⁶ Hon J Howard MP, 'A new medical indemnity insurance framework', *Press Release*, 23 October 2002.

	Australian Prudential Regulation Authority (APRA). The Australian Competition and Consumer Commission is to monitor medical indemnity insurance premiums to determine whether they are actuarially and commercially justified. The Commonwealth also requested that the NSW Government remove caps on premiums by the end of 2003 so premiums could be set according to risk and therefore be commercially sustainable. The guarantee to UMP members was extended from 31 December 2002 to 31 December 2003.
7 Nov	PricewaterhouseCoopers released their report on the financial implications of the implementation of the Ipp Report's recommendations.
18 Nov	The Director-General of the NSW Department of Health made a formal complaint to the Health Care Complaints Commission following nurses' disclosures concerning Camden and Campbelltown hospitals. The complaint focused on 'the standard of health care provided to patients; the adequacy of systems to ensure safe and quality care – clinical governance, risk management, performance and incident reporting and investigation, training and support; allegations that management had intimidated and disciplined nurses who reported problems and errors'. ⁷
6 Dec	The <i>Civil Liability Amendment (Personal Responsibility) Act 2002</i> (NSW) commenced.
2003	
1 Jan	The <i>Medical Indemnity Act 2002</i> (Cth), <i>Medical Indemnity (IBNR Indemnity) Contribution Act 2002</i> (Cth) and <i>Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002</i> (Cth) received assent, thus implementing the IBNR and High Cost Claims Scheme.
6 June	The Federal Minister for Health and Ageing, Senator Kay Patterson, announced the 'blue sky' scheme. As part of this scheme, the Commonwealth would assume liability for all amounts over \$20 million in relation to claims notified from 1 July 2003.
1 July	Medical Defence Organisations are required to operate as insurers supervised by the Australian Prudential Regulation Authority following passage of the <i>Medical Indemnity (Prudential Supervision and Product Standards) Act 2003</i> (Cth) and <i>Medical Indemnity (Prudential Supervision and Product Standards)(Consequential Amendments) Act 2003</i> (Cth).

⁷ Health Care Complaints Commission, *Investigation Report, Campbelltown and Camden Hospitals Macarthur Health Service*, December 2003, p 2.

Sept	30,000 doctors received a bill for the IBNR levy payable 1 November 2003. 90% of the notices were for less than \$5000 a year. ⁸ However, when combined with premiums that had already increased substantially, over 20% of doctors in NSW faced medical indemnity bills equivalent to more than 10% of their private practice income in 2003. ⁹ Numerous doctors threatened to resign in response to the levy.
28 Sept	A rally protesting the IBNR levy was held at Royal Randwick racecourse, attracting 4000 people.
2 Oct	The <i>Sydney Morning Herald</i> reported that 18 orthopaedic surgeons and obstetricians had quit public hospitals in the past week because of the IBNR levy. ¹⁰ The report claimed that 100 obstetricians are planning to quit by 2008 and a fifth of surgeons will retire in the near future because of medical indemnity issues.
3 Oct	The Federal Government announced an 18 month moratorium on IBNR levies of more than a thousand dollars.
7 Oct	The Hon Tony Abbott MP replaced Senator the Hon Kay Patterson as the Minister for Health and Ageing.
10 Oct	The Federal Government announced that it would withdraw all IBNR levy notices and lift the levy on staff specialists in public hospitals. The Medical Indemnity Policy Review Panel was formed to recalculate the levy and determine how to provide both affordable medical services and security for medical professionals. The Federal Government extended the High Cost Claims Scheme so that 50% of claims between \$500,000 and \$20 million (limited to the amount insured) were covered.
14 Oct	The provisional liquidator of UMP made an application to the Supreme Court of NSW for the winding up applications to be dismissed and for provisional liquidation to be terminated.
16 Oct	The Minister for Health and Ageing, the Hon Tony Abbott MP, announced the membership and terms of reference for the Medical Indemnity Policy Review Panel.

⁸ Medical Indemnity Policy Review Panel, *Affordable, Secure and Fair: Report to the Prime Minister*, 10 December 2003, p 2. A copy of the report is available from www.health.gov.au/medicalindemnity/

⁹ Ibid.

¹⁰ 'Children's surgeons quit, more will follow', *Sydney Morning Herald*, 2/10/03, p 3.

6 Nov	The Commonwealth Government introduced the <i>Medical Indemnity Amendment Bill 2003</i> (Cth) and the <i>Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2003</i> (Cth). If passed, the Acts would amend the <i>Medical Indemnity Act 2002</i> (Cth) to suspend the operation of the IBNR contribution legislation, and secure an 18 month moratorium on contributions of more than \$1000 a year. The Acts would also give effect to the Exceptional Claims Scheme. The <i>Medical Indemnity Amendment Act 2003</i> (Cth) and <i>Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003</i> (Cth) received assent on 5 December.
10 Nov	The Supreme Court of NSW decided to release UMP from provisional liquidation on 15 November 2003, the first time in Australian corporate history that a body has emerged from provisional liquidation.
10 Dec	The Medical Indemnity Policy Review Panel presented their report to the Prime Minister.
Dec	The Health Care Complaints Commission released <i>Investigation Report: Campbelltown and Camden Hospitals Macarthur Health Service</i> . The Report provided details of 19 deaths at Campbelltown and Camden Hospitals.
11 Dec	NSW Minister for Health, the Hon Morris Iemma MP announced the key actions to be undertaken in response to the Health Care Complaints Commission's report. These actions would include: <ul style="list-style-type: none"> ▪ Removal of the HCCC commissioner; ▪ Establishment of a special commission of inquiry; ▪ Dissolution of the South Western Sydney Area Health Service Board; and ▪ Disciplinary proceedings against administrators and clinicians. The Special Commission of Inquiry into Macarthur Health Services is to report to the NSW Government by April 2004.
15 Dec	Federal Cabinet considered the Medical Indemnity Policy Review Report. The Government subsequently announced its support for the majority of the Report's recommendations.

3 NSW REFORMS

To establish negligence at common law, a plaintiff must prove that:

1. the defendant owed a duty of care;
2. the defendant breached the duty of care; and
3. material damage occurred as a result.

Once negligence has been established, the plaintiff is entitled to damages as compensation for the injury suffered. Damages are calculated on the basis of loss, both economic and non-economic. They are awarded under various heads of damage including general damages, loss of past earnings, loss of future earning capacity, out of pocket expenses, future needs, gratuitous care, and interest. Damages for future economic loss are usually discounted to account for the benefit gained in the accelerated receipt of the money.

However, the law as it relates to medical negligence has significantly changed in NSW. A number of statutes have been enacted, including the *Health Care Liability Act 2001*, *Civil Liability Act 2002*, *Civil Liability Amendment (Personal Responsibility) Act 2002* and *Civil Liability Amendment Act 2003*, that aim to clarify the law of negligence, as well as limit the number of claims and damages awarded. This section provides an overview of each of these Acts, illustrating how the NSW Government has sought to reform tort law.

3.1 The Government's rescue package

On 27 February 2001, the NSW Government revealed its medical indemnity rescue package. The package, designed to alleviate the pressures associated with the medical indemnity insurance crisis, sought to:¹¹

- Alter the discount rate;
- Cap future loss of earnings to a weekly maximum;
- Cap general damages for the most serious cases at the current level;
- Introduce compulsory mediation and specialist lists for medical negligence cases to be handled by judges with relevant expertise;
- Provide statutory protection for 'good samaritans';
- Require MDOs to maintain and publish data regarding claims risk, including incidents which have been incurred but are not reported at present;
- Introduce risk management programs;
- Impose compulsory indemnity requirements for doctors; and
- Prevent MDOs 'cherry picking' the market.

3.2 Health Care Liability Act 2001

The rescue plan evolved into the *Health Care Liability Bill 2001*, which was introduced in NSW Parliament on 19 June 2001. The Bill quickly moved through both Houses and received assent on 5 July 2001. Section 3 of the *Health Care Liability Act 2001* sets out its objects as:

¹¹ Hon C Knowles MP, 'Knowles announces medical indemnity rescue package', *Media Release*, 27/2/01.

- To facilitate access to fair and sustainable compensation for persons who sustain severe injuries from the provision of health care;
- To keep the costs of medical indemnity premiums sustainable, in particular by limiting the amount of compensation payable for non-economic loss in cases of relatively minor injury, while preserving principles of full compensation for those with severe injuries involving ongoing impairment and disabilities;
- To promote the reasonable distribution across the medical indemnity industry of the costs of compensation for persons who sustain severe injuries from the provision of health care;
- To facilitate the effective contribution by medical indemnity providers to risk management and quality improvement activities in the health care sector;
- To enable the medical profession and the community to be better informed as to the costs of compensation for, and developing trends in, personal injury claims arising from the provision of health care.

The Act, in its original form, consisted of various parts dealing with the award of damages in health care claims, professional indemnity insurance, and protection from liability regarding the voluntary provision of health care in an emergency. 'Health care claims' are defined in section 4 to mean 'a claim, in any civil action, for damages against a health care provider in respect of an injury or death caused wholly or partly by the fault of a health care provider in providing health care'. 'Health care' refers to 'any care, treatment, advice, service or goods provided in respect of the physical or mental health of a person'.

However, the Act was substantially amended by the *Civil Liability Act 2002* and the *Civil Liability Amendment (Personal Responsibility) Act 2002* which, amongst other things, repealed parts 2 and 4 as similar provisions were subsequently to be located in the *Civil Liability Act*. Nevertheless, the *Health Care Liability Act*, in its original form, is discussed in detail to facilitate an understanding of the initial action taken by the Government in 2001. Whilst parts 2 and 4 are no longer in force, the discussion relating to those parts is still relevant in many respects as similar provisions are found in the more recent *Civil Liability Act*. The continued relevance of the *Health Care Liability Act* in and of itself is largely limited to its requirement that medical practitioners be appropriately insured. However, the original Act still applies to health care claims that commenced in a court before 20 March 2002.

Part 2: Awarding of damages in health care claims

The provisions in part 2 of the Act were concerned with the award of damages in health care claims. These provisions made a number of significant changes to the calculation of damages. Section 9 of the Act fixed the maximum level for past and future lost earnings in line with the motor accident scheme so that any net weekly earnings beyond \$2,603 were to be disregarded. Section 11 increased the discount rate to apply to calculations of future economic loss to 5%. The Act also fixed the maximum amount of damages that could be awarded for non-economic loss at \$350,000 as well as establishing a minimum threshold for non-economic loss.¹² Accordingly, a claimant was not to be eligible for damages for

¹² Section 13.

non-economic loss unless the severity of the loss was at least 15% of the most extreme case. The damages to be awarded were based on a sliding scale, which scaled down damages if the severity of the non-economic loss was assessed as being between 15 and 32% of the most extreme case. Once the severity was assessed as being greater than 32%, the full proportion of non-economic loss was awarded. The reason for scaling down in the lower ranges was that it was thought to produce a saving that could be directed towards the more severely injured.¹³ Section 16 of the Act empowered courts to consider the contributory negligence of a deceased person in health care claims brought under the *Compensation to Relatives Act 1897*. Section 17 of the Act prevented a court from awarding exemplary and punitive damages.

Part 2 of the Act was repealed by the *Civil Liability Act 2002* (see below) with similar, albeit broader, provisions now found in that Act.¹⁴

Part 3: Professional indemnity insurance

Part 3 of the Act, which sets out the provisions on professional indemnity insurance, commenced on 1 January 2002. Section 19 stresses that ‘a person is not entitled to practise as a medical practitioner unless the person is covered by approved professional indemnity insurance’. Accordingly, the Medical Board is not to register a person as a medical practitioner unless satisfied that the person is covered by approved professional indemnity insurance or satisfies the requirements of an exemption. The Board can cancel the registration of a medical practitioner if he or she is found to be without approved professional indemnity insurance. The benefit of compulsory insurance was noted by the Australian Health Ministers Advisory Council (AHMAC) Legal Process Reform Group, which recommended that professional indemnity cover be compulsory for all registered health professionals in Australia, as in NSW.¹⁵

Section 21 introduced mandatory requirements relating to data collection, reporting and risk management. Accordingly, insurers are to comply with data collection and reporting requirements as specified by the relevant insurance regulation order. Insurers are to have a comprehensive risk management program that ‘identifies potential problems in relation to individual medical practitioners and particular categories of medical services and provides strategies to effectively deal with those problems’.

Section 22 is designed to prevent the problems associated with ‘cherry-picking’. The Minister may impose certain requirements by insurance regulation order, such as requiring insurers to provide professional indemnity insurance in respect of all categories of specialty medical practice. An order can also be made that insurers not engage in conduct that would discourage ‘medical practitioners of a particular category of specialty medical practice from

¹³ Hon C Knowles MP, Second Reading Speech, *NSWPD*, 19/6/01, p 14782.

¹⁴ See Part 2 of the *Civil Liability Act 2002*.

¹⁵ AHMAC Legal Process Reform Group, *Responding to the Medical Indemnity Crisis: An Integrated Reform Package*, Chair: Professor Marcia Neave, 2002, p 102.

obtaining professional indemnity insurance from the insurer’.

Part 4: Provision of emergency health care – protection from liability

Sections 26 and 27 of the Act protected medical practitioners, registered nurses and certain other health practitioners from liability should they provide emergency health care in good faith and on a voluntary basis without fee. However, part 4 of the Act was repealed by the *Civil Liability Amendment (Personal Responsibility) Act 2002* which inserted similar provisions concerning ‘good samaritans’ into the *Civil Liability Act 2002*.¹⁶

In summary, the *Health Care Liability Act* introduced most of the measures contained in the rescue package announced by the NSW Government on 27 February 2001. However, the Act did not introduce any measures regarding compulsory mediation and specialist lists for medical negligence cases. It was noted in the Second Reading Speech that the Attorney-General’s Department would consult with the chief judge of the District Court on possible improvements to the way medical negligence cases are handled.¹⁷

3.3 Review of the Law of Negligence (the Ipp Report)

The Negligence Review Panel, chaired by Justice Ipp, was formed as a result of the second ministerial meeting on public liability in May 2002. The terms of reference for the review of the law of negligence were announced on 2 July 2002. The Panel’s recommendations were to guide tort law reform in the Australian states and territories. An extract from the terms of reference follows:

The award of damages for personal injury has become unfathomable and unsustainable as the principal source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death.

Accordingly, the Panel is requested to:

1. Inquire into the application, effectiveness and operation of common law principles applied in negligence to limit liability arising from personal injury or death, including:
 - (a) the formulation of duties and standards of care;
 - (b) causation;
 - (c) the foreseeability of harm;
 - (d) the remoteness of risk;
 - (e) contributory negligence; and
 - (f) allowing individuals to assume risk.

¹⁶ See Part 8 of the *Civil Liability Act 2002*.

¹⁷ Hon C Knowles MP, Second Reading Speech, *NSWPD*, 19/6/01. p 14786.

2. Develop and evaluate principled options to limit liability and quantum of awards for damages.
3. In conducting this inquiry, the Panel must...

(d) develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accords with the generally accepted practice of the relevant profession at the time of the negligent act or omission.

The terms of reference were criticised by some for their rigidity and making a number of assumptions about the cause of the current crisis that are unable to be challenged. Feldthusen noted that:

Both the problem and the type of solution appear to have been stated by fiat, with no underlying empirical evidence in support. Nor was the Ipp Panel empowered to investigate or challenge either. Strikingly absent is any desire to investigate alleged malfunction in the private insurance market... The Ipp Panel was not permitted to challenge the premise that negligence law was 'unpredictable'; nor that it was 'too easy' for plaintiffs to recover; nor that damages were 'too high'.¹⁸

The Panel agreed that the 'common opinion' in Australia was that the law of negligence is unclear and unpredictable, it is too easy for plaintiffs to establish liability, and awards of damages are too high.¹⁹ However, the Panel alluded to the restrictive nature of the terms of reference by stressing that it was not their role to determine the validity of the 'common opinion'. Nonetheless, it was noted that 'irrespective of whether these perceptions are correct they are serious matters for the country because they detract from the regard in which people hold the law, and, therefore, from the very rule of law itself'.²⁰

The Panel, in any event, did challenge the validity of some of the assumptions believed to be driving the insurance crisis:

The Panel has formed the view that there is a considerable amount of misunderstanding, especially amongst medical practitioners, about personal injury law. We believe that this is a source of a certain amount of unnecessary fear and anxiety on the part of medical practitioners (in particular) about the risk of being successfully sued, and a source of unrealistic expectations in society about the role of personal injury law in providing compensation for personal injury and death. For this reason, we believe that there are certain respects in which it would be worthwhile legislatively to restate the law to make it more widely known and

¹⁸ Feldthusen B, 'Posturing, tinkering and reforming the law of negligence – a Canadian perspective?', *University of New South Wales Law Journal*, 8(2) November 2002, pp 31-2.

¹⁹ Negligence Review Panel, n 5, p 25.

²⁰ *Ibid*, p 26.

understood, even if a decision is made not to change it.²¹

The Final Report of the Review of the Law of Negligence (the Ipp Report) was published in September 2002. The full text of the recommendations is attached as Appendix A.

3.4 Civil Liability Act 2002

The *Civil Liability Act* was passed by NSW Parliament on 7 June 2002, receiving assent on 18 June 2002. However, the Act applied retrospectively to 20 March 2002. The Act repealed Part 2 and section 28 of the *Health Care Liability Act 2001*. The *Civil Liability Amendment (Personal Responsibility) Act 2002* implemented the second stage of reforms to civil liability in NSW, based on a number of recommendations in the Ipp Report. It also removed Part 4 from the *Health Care Liability Act*.

The *Civil Liability Act* is broader in scope than the *Health Care Liability Act* as it applies to awards of personal injury damages in general rather than being restricted to health care claims.²² Much of the Act was based on measures that had been introduced with the *Health Care Liability Act*, as well as schemes in relation to motor accidents and workers' compensation. As this paper is concerned with medical negligence, a comprehensive discussion of the *Civil Liability Act* is not provided.²³ Analysis is limited to those sections relevant to medical negligence.

Part 1A Negligence

Part 1A of the Act attempts 'to redefine and restrict the whole body of principles known as the law of negligence'.²⁴ Negligence is defined in section 5 to mean a 'failure to exercise reasonable care and skill'. Recommendation 28 of the Ipp Report stressed that statutory schemes should embody the principle that 'a person is not negligent by reason only of failing to take precautions against a foreseeable risk of harm'. This recommendation is implemented in section 5B of the *Civil Liability Act*. The duty of care to be applied is set out in section 5B(1) as:

- A person is not negligent in failing to take precautions against a risk of harm unless:
- (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and
 - (b) the risk was not insignificant, and

²¹ Ibid, p 44.

²² However, some types of personal injury damages are excluded by section 3B of the Act including, amongst others, acts that are done with the intention of causing injury or death, sexual assault, claims in relation to dust diseases, damages in relation to the use of tobacco products, and workers compensation.

²³ For further discussion of tort law reform in NSW and the *Civil Liability Act* see Briefing Paper No 7/02, *Public Liability* by Roza Lozusic and Briefing Paper No 11/02, *Public Liability: An Update* by Roza Lozusic.

²⁴ Goldring J, 'The Civil Liability Act 2002 (NSW)', *The Judicial Review*, 6, 2003, p 280.

(c) in the circumstances, a reasonable person in the person's position would have taken those precautions.

When determining whether a reasonable person would have taken precautions, a court is to consider:²⁵

- (a) the probability that the harm would occur if care were not taken,
- (b) the likely seriousness of the harm,
- (c) the burden of taking precautions to avoid the risk of harm,
- (d) the social utility of the activity that creates the risk of harm.

However, these considerations have been criticised by Judge John Goldring of the District Court of NSW on the basis that they are problematic as the language used is imprecise.²⁶ He stresses that these considerations are not a 'precise mathematical tool' and are 'not overly helpful to courts that have to work with words and phrases in a legal context'.²⁷

Professional negligence is detailed in Division 6 of Part 1A. Section 5O establishes the standard of care for professionals as:

a person practising a profession... does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

However, peer professional opinion is not to be relied upon should the court consider it to be irrational. Although there are some differences, section 5O largely implements recommendation 3 of the Ipp Report which suggested the applicable standard of care should be:

A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.

Section 5O restores a modified version of the Bolam test to medical negligence law in Australia. The Bolam test was established by *Bolam v Friern Hospital Management Committee* (1957) 2 All ER 118 which held that the standard of care to be applied to medical practitioners was to be determined by a reasonable body within the medical profession. Lord Scarman in *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 817 at 881 described the Bolam principle in the following terms:

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In

²⁵ Section 5B(2).

²⁶ Goldring, n 24, p 282.

²⁷ *Ibid.*

short the law imposes a duty of care: but the standard of care is a matter of medical judgment.

However, *Rogers v Whitaker* (1992) 175 CLR 479 made it clear that, whilst the court might be guided by acceptable medical practice, the court is to determine the appropriate standard of care for the medical profession. The Court also stressed that a doctor has a duty to warn his or her patient of a material risk of the proposed treatment.

The *Civil Liability Act* does not completely restore the Bolam principle as section 5P precludes the application of the standard of care in section 5O to the duty to warn of risk. Accordingly, the standard of care to be applied when warning of risk is to be determined by the courts rather than peer professional opinion, thus preserving the rule in *Rogers v Whitaker*.²⁸ However, section 5O applies the standard of care to all professionals, not just those in the medical field.

Part 2 Personal injury damages

Provisions regarding the calculation of personal injury damages are found in Part 2 of the Act. These provisions were seen as ‘a new (and quite radical) method of assessing damages for death or personal injury’.²⁹ However, they are largely the same as those previously found in the *Health Care Liability Act*. Section 12 is similar to section 9 of the *Health Care Liability Act*. However, rather than capping the damages that may be awarded for economic loss at a specific amount, it is to be determined by reference to three times the amount of average weekly earnings. Section 12 also refers to the claimant’s gross, rather than net, weekly earnings. However, the effect of this section is likely to be minimal as only 0.5% of claimants earn an income greater than three times the average weekly wage.³⁰ The Ipp Report had suggested that damages for the loss of earning capacity be capped at twice the average full time adult ordinary time earnings (recommendation 49). Damages for future economic loss are not to be awarded unless ‘the claimant first satisfies the court that the assumptions about future earning capacity or other events on which the award is to be based accord with the claimant’s most likely future circumstances but for the injury’.³¹

Damages for future economic loss are to be discounted by 5%.³² Prior to the *Health Care Liability Act*, the discount usually applied was 3%. The Ipp Report was in favour of the 3% discount rate (recommendation 53). By increasing the discount to 5%, it is thought that

²⁸ Clark S, Harris C and McInnes R, ‘Tort reform take two’, *Law Society Journal*, 41(2) February 2003, p 56.

²⁹ Goldring, n 24, p 296.

³⁰ PriceWaterhouseCoopers, *Report to the NSW Treasury on Tort Law Reforms in Public Liability Insurance*, 2002, p 15.

³¹ Section 13. This section is identical in form to section 10 of the Health Care Liability Act.

³² Section 14.

damages for future economic and care needs will be reduced by approximately 20%.³³

Section 15 limits the extent to which damages may be awarded for gratuitous attendant care services. Such damages cannot be awarded unless the court is satisfied that:

- (a) there is (or was) a reasonable need for the services to be provided, and
- (b) the need has arisen (or arose) solely because of the injury to which the damages relate, and
- (c) the services would not be (or would not have been) provided to the claimant but for the injury.

However, unlike under the *Health Care Liability Act*, the services must be provided for a minimum of six hours per week and for more than six months for the claimant to be eligible for such an award. This accords with recommendation 51 of the Ipp Report. The AHMAC Legal Process Reform Group recommended that similar limits to that imposed by section 15 be applied in other states and territories.³⁴

Section 16 is virtually identical to the old section 13 of the *Health Care Liability Act* and limits the maximum amount of damages for non-economic loss to \$350,000. This is higher than the cap of \$250,000 suggested in the Ipp Report (recommendation 48). The impact of the section 16 cap is likely to be limited as at the time of its introduction, \$350,000 was the maximum generally awarded by courts.³⁵ Nonetheless, the PricewaterhouseCoopers Report noted that it establishes a benchmark for awards under that cap.³⁶ However, no damages for non-economic loss are to be awarded unless the severity is at least 15% of the most extreme case, in keeping with recommendation 47 of the Ipp Report. The damages are based on a sliding scale, so that damages are scaled down where the severity of the non-economic loss is assessed as being between 15 and 32% of the most extreme case. Once the severity is assessed as being greater than 32%, the full proportion of non-economic loss is awarded. The reasoning behind the scaling down in the lower ranges is to produce a saving that can be directed toward the more severely injured.³⁷ Indeed analysis by PricewaterhouseCoopers found that the saving on small claims would be largely offset by increased costs in more serious claims.³⁸ Section 16 is thought to save the greatest amount and it is hoped that it will discourage people from initiating smaller claims.³⁹ Interest is not to be awarded for non-economic loss or gratuitous attendant care services.⁴⁰

³³ PriceWaterhouseCoopers, n 30, p 16.

³⁴ AHMAC Legal Process Reform Group, n 15, p 80.

³⁵ PriceWaterhouseCoopers, n 30, p 11.

³⁶ Ibid.

³⁷ Hon C Knowles MP, Second Reading speech, *NSWPD*, 19/6/01, p 14782.

³⁸ PriceWaterhouseCoopers, n 30, p 13.

³⁹ Hon R Carr MP, Second Reading speech, *NSWPD*, 28/5/02, p 2087.

⁴⁰ Section 18.

Section 21 provides that a court cannot award exemplary, punitive and aggravated damages. The Negligence Review Panel was in favour of the abolition of exemplary and aggravated damages (recommendation 60). However, it is thought that section 21 will not produce much of a saving as such damages are rarely awarded.⁴¹ Nonetheless, it does prevent a future increase in this area.⁴²

Division 7 of Part 2 allows for the periodic payment of damages through structured settlements, 'an agreement that provides for the payment of all or part of an award of damages in the form of periodic payments funded by an annuity or other agreed means'.⁴³ The court is to give the parties involved a reasonable opportunity to negotiate a structured settlement and is to inform the parties of the terms of the award it proposes to make in excess of \$100,000 in respect of future loss.

Part 8 Good samaritans

A good samaritan is defined in section 56 as a person 'who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured'. It is wider than the equivalent provision in the *Health Care Liability Act* as it is not limited to health professionals. Section 57 states that 'a good samaritan does not incur any personal civil liability in respect of any act or omission done or made by the good samaritan in an emergency when assisting a person who is apparently injured or at risk of being injured'. However, there is an exception if it was the good samaritan's intention or negligence that caused the injury or risk of injury in the first place.⁴⁴ The protection also does not apply if his or her ability to exercise reasonable care and skill was significantly impaired by the influence of alcohol or a drug voluntarily consumed, or if he or she failed to exercise reasonable care and skill. It also excludes a person who impersonates a health care or emergency services worker or police officer, or if he or she falsely claims to have skills or expertise regarding the provision of emergency assistance.

Other changes

The *Civil Liability Act 2002* inserted section 198D into the *Legal Profession Act 1987* (NSW), the effect of which was to limit the amount of costs that could be claimed for legal services. In a personal injury claim of less than \$100,000, costs are limited to a maximum of 20% of the amount recovered or \$10,000 whichever is the greater. Section 198J prevents a solicitor or barrister from acting unless there are reasonable prospects of success, with the threat of a costs order being made against them should section 198J be contravened.

⁴¹ PriceWaterhouseCoopers, n 30, p 21.

⁴² Ibid.

⁴³ Section 22.

⁴⁴ Section 58.

The *Civil Liability Amendment (Personal Responsibility) Act 2002* amended the *Limitation Act 1969* to alter the applicable limitation period. Consequently, a three year limitation period commences from the time when the cause of action is discoverable up to a maximum of 12 years after the act which caused the injury.⁴⁵ However, section 62A of the *Limitation Act* empowers the court to extend this period in circumstances where it is just and reasonable to do so.

Comment

The *Civil Liability Act* has not escaped criticism. Judge John Goldring of the District Court of NSW is not in favour of the Act on the basis that it ‘invokes the personal responsibility of plaintiffs, and appears to overlook the basic premise that people become defendants because they have failed in *their* personal responsibility’.⁴⁶ The *Civil Liability Act* also failed to fully implement the Ipp Report’s recommendations. However, the NSW Government has justified some of these departures on the basis that the alternative approaches promote greater certainty and a fairer sense of responsibility.⁴⁷

The fairness of imposing the burden for the care of victims, especially the catastrophically injured, on the insurance system is an issue that remains outstanding. A no-fault compensation scheme is an alternative and is discussed in detail in section 5.1 – New Zealand.

3.5 Civil Liability Amendment Act 2003

There have recently been a couple of high-profile cases before the courts involving issues of medical negligence. The decisions in *Presland v Hunter Area Health Service and Anor*⁴⁸ and *Cattanach v Melchior*⁴⁹ were criticised by the Government as the courts ‘finding new areas of liability, creating new bodies of law, and awarding damages that the community simply will not tolerate’.⁵⁰

In *Presland*, the plaintiff successfully sued the Hunter Area Health Service and a doctor who he claimed had negligently discharged him from a psychiatric hospital in 1995. The plaintiff had killed his brother’s fiancée only six hours after being discharged. However, the plaintiff was acquitted of the murder on the grounds of mental illness. *Presland* subsequently initiated the civil claim. Adams J held the attack on the fiancée to be

⁴⁵ Section 50C *Limitation Act 1969* (NSW).

⁴⁶ Goldring, n 24, p 277.

⁴⁷ Debus R, ‘Tort law reform in New South Wales: State and federal interactions’, *University of New South Wales Law Journal*, 8(2) November 2002, p 13.

⁴⁸ [2003] NSWSC 754 (19 August 2003).

⁴⁹ (2003) 77 ALJR 1312.

⁵⁰ Hon R Carr MP, *NSWPD*, 13/11/03, p 4980.

foreseeable and consequently found the defendants to be negligent. The plaintiff was awarded damages for \$310,000.

The High Court determined in *Cattanach* that the costs of raising a healthy child conceived and born as the result of a negligent sterilisation procedure were recoverable. Mrs Melchior had undergone a tubal ligation in 1992 performed by Dr Cattanach. Mrs Melchior informed the doctor that she had an appendectomy in 1967 in which her appendix, right ovary and fallopian tube were removed. Dr Cattanach could not locate her right ovary and fallopian tube during the surgery and accordingly only clipped the left fallopian tube. However, the right tube did exist but had been covered and hidden by scar tissue and adhesions from the surgery in 1967. Mrs Melchior subsequently fell pregnant and gave birth to a healthy child. Whilst it was held that Dr Cattanach had not negligently performed the surgery, he was found to have been negligent as he failed to positively confirm the absence of the right fallopian tube with Mrs Melchior after the operation. Accordingly, Mrs Melchior was awarded \$105,000 in damages.

The *Civil Liability Amendment Bill 2003* was introduced into NSW Parliament on 13 November 2003 to ensure that such cases would not be successful in the future. The Act received assent on 10 December 2003 and amended the *Civil Liability Act 2002* by inserting section 54A which limits the damages that may be recovered for non-economic or certain economic losses resulting from an act that would have been a crime but for mental illness. This is to counteract the risk that ‘doctors will behave too conservatively, detaining patients unnecessarily, out of fear that they can be sued by the patient for anything he or she does if not detained’.⁵¹ The Act also inserted Part 11 which is concerned with damages for the birth of a child. Section 71 ensures that whilst damages may be awarded for a pregnancy and childbirth resulting from negligence, they may not be awarded in relation to the cost of raising a child.

⁵¹ Hon M Iemma MP, *NSWPD*, 13/11/03, p 4993.

4 COMMONWEALTH REFORMS

The debate over medical negligence and professional indemnity insurance has shifted in many aspects to the federal level. In December 2001, then NSW Health Minister, the Hon Craig Knowles MP, claimed that the NSW Government had done all it could and that it was now up to the Commonwealth Government to provide the necessary reforms for doctors working in the private sphere.⁵² The Australian Medical Association has directed its attention in the last year or so towards the Commonwealth Government and its rescue package, reflecting this shift in focus.

4.1 Medical indemnity package

The Commonwealth Government acknowledged the importance of the medical indemnity issue by instituting a number of changes known collectively as the medical indemnity package to ensure that medical practitioners continued to practice in Australia. This package was developed to contain the potential repercussions following the entry of UMP into provisional liquidation. Features of this package include:⁵³

- **The Medical Indemnity Subsidy Scheme.** Under this scheme, the cost of premiums for doctors who practice in high risk areas are subsidised by the government. This includes specialist obstetricians, neurosurgeons and procedural GPs. The Scheme is to be replaced by the Premium Support Scheme from 1 July 2004 which is designed to make insurance more affordable for all doctors (see section 5.3 – Medical Indemnity Policy Review Panel).
- **The High Cost Claims Scheme.** The Government has committed itself to meeting half the cost of settlements or judgments greater than \$500,000 up to the limit of the doctor's insurance cover.
- **The IBNR Scheme.** As at 30 June 2002, the liability of UMP in regard to IBNR claims was \$460 million.⁵⁴ The Commonwealth Government assumed responsibility for the entire amount with doctors originally to contribute a sum based on their 2000-01 UMP premiums over a period of 10 years. However, this aspect of the package has been extremely controversial and is further discussed in section 5.2 – IBNR Scheme. The IBNR levy is currently capped at \$1000 a year for the remainder of the 18 month moratorium that commenced 1 July 2003. At the end of the moratorium doctors will pay either the original bill, 2% of gross Medicare billable income, or \$5000, whatever is the smallest amount.

⁵² Hon C Knowles MP, 'NSW government to cover public indemnity for doctors', *Media Release*, 19/12/01.

⁵³ Details of the Commonwealth package are explained on the Commonwealth Department of Health and Ageing website: www.health.gov.au/medicalindemnity

⁵⁴ United Medical Protection, n 2, p 8.

- **The Exceptional Claims Scheme (previously known as the Blue Sky scheme).** The Exceptional Claims Scheme was established to deal with claims for an amount greater than a doctor's contract of insurance, arising out of the treatment of private patients. Incidents notified after 1 January 2003 will be covered, but doctors must have cover of \$20 million from 1 July 2003 (or \$15 million if between 1 January 2003 and 30 June 2003) to be eligible.
- **Retirement cover package.** Medical indemnity providers are to at least offer doctors retiring in 2003-04 cover in the event of death, permanent disablement, or permanent retirement at or after 60 years. The cover is to be for the remainder of the term of the contract and subsequently renewed annually for six years. The Commonwealth is currently examining possible options for retirement cover arrangements.
- Medical Defence Organisations are to be subject to the same requirements as general insurers. They are to offer contracts of insurance rather than discretionary cover, under the supervision of the **Australian Prudential Regulatory Authority (APRA)**.⁵⁵ This is to ensure that practitioners have access to affordable cover and that all parties concerned can be reasonably sure that claims will be met.⁵⁶
- The **Australian Competition and Consumer Commission** monitors medical indemnity insurance premiums.

The Commonwealth Government has also passed legislation in support of state initiatives. For example, changes have been made to some taxation laws to encourage the use of structured settlements permitted under the *Civil Liability Act 2002* (NSW). The *Taxation Laws Amendment (Structured Settlements and Structured Orders) Act 2002* (Cth) amended the *Income Tax Assessment Act 1997* (Cth) to provide an income tax exemption for annuities and deferred lump sums paid as compensation for seriously injured persons.

4.2 IBNR Scheme

The financial difficulties of UMP were largely due to its failure to collect and retain adequate funds to meet claims that had been incurred but were not yet reported. Whilst the Commonwealth made a commitment to provide continued protection to doctors who had been covered by UMP, it required those doctors who had been a member of UMP as at 30 June 2000 to compensate the government under the IBNR Scheme by way of a levy imposed over a ten year period commencing 1 November 2003. Accordingly, general practitioners were to pay an annual sum of about \$1500, with high-risk specialists to contribute between \$8000 and \$10,000 a year.⁵⁷ Doctors claimed that they could not afford to practice if such a levy was imposed on top of already greater premiums. The AMA and

⁵⁵ See the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (Cth).

⁵⁶ Hon P Slipper MP, *CPD(HR)*, 12/12/02, p 10270.

⁵⁷ 'No cure-all in this crisis', *The Australian*, 8/10/03, p 11.

others also claimed that the Commonwealth government had incorrectly calculated UMP's unfunded liabilities because the impact of reforms in NSW was not taken into account. The *Sydney Morning Herald* reported that 'Government officials admitted... the original estimates for the levy had been inflated because they had failed to consider the effect of the significant overhaul of negligence law in NSW'.⁵⁸ Consequently, it was argued that the Commonwealth Government did not need to collect as much from doctors. More than 130 doctors in NSW and Queensland threatened to resign, with many more to follow after 1 November 2003, in protest of the levy.⁵⁹

The Government responded by announcing on 10 October 2003 that it would withdraw the IBNR levy notices. A taskforce, later known as the Medical Indemnity Policy Review Panel, was formed to recalculate the unfunded liabilities and to develop an affordable and secure model of insurance. The Medical Indemnity Policy Review Panel reported to the Commonwealth Government on 10 December 2003. Its members included: Tony Abbott MP (Minister for Health and Ageing); Senator Helen Coonan (Assistant Treasurer and Minister for Revenue); Dr Bill Glasson (Federal President of the Australian Medical Association); Dr Andrew Pesce (Chairman of AMA's medical indemnity taskforce); Associate Professor Don Sheldon (Chairman of the Council of Procedural Specialists); Nancy Milne (Partner, Clayton Utz); Dr Susan Page (President of the Rural Doctors' Association of NSW); and John Phillips (former Deputy Governor of the Reserve Bank of Australia).

The IBNR scheme has been successful in some areas. The provisional liquidator of UMP was able to report to the NSW Supreme Court on 30 August 2003 that UMP was solvent on a cash flow basis because IBNR claims were no longer a liability of UMP as a result of the IBNR Scheme.⁶⁰ This contributed to the removal of UMP from provisional liquidation.

4.3 Medical Indemnity Policy Review Panel

The Medical Indemnity Policy Review Panel was directed to focus its work on ensuring that 'doctors can continue to treat their patients with certainty and confidence and that the medical indemnity arrangements which underpin this confidence provide secure and affordable long term protection for patients and doctors'. The Panel was required to report on ways that:

will ensure that medical indemnity arrangements in Australia: are financially sustainable, transparent and comprehensible to all parties; provide affordable, comprehensive and secure cover for all doctors; enable Australia's medical workforce to provide care and continue to practice to its full potential; safeguards the interests of the consumers and the community.⁶¹

⁵⁸ 'Wrong sums force review of health levy', *Sydney Morning Herald*, 8/10/03, p 1.

⁵⁹ 'Unstable prognosis', *The Australian*, 11/10/03, p 24.

⁶⁰ United Medical Protection, n 2, p 3.

⁶¹ Hon Tony Abbott MHR, 'The New Medical Indemnity Policy Review Panel', *Media Release*,

The Medical Indemnity Review Panel reported to the Prime Minister on 10 December 2003 and made a number of recommendations that if implemented would ensure that the system of medical indemnity in Australia would be 'affordable, sustainable and secure'. Before reaching their conclusions the Panel considered the impact of the reforms introduced by the Commonwealth Government as well as the effect of reforms to state-based tort law. The Panel acknowledged the significance of tort law reform, accepting that it 'is at the heart of a sustainable, affordable medical indemnity system'.⁶²

The Panel recommended that:⁶³

- A Premium Support Scheme funded by the Commonwealth be established to ensure that premiums are affordable.
- Insurers be required to have premium income bands per specialty that take account of the actual range of incomes.
- The High Cost Claims Scheme be extended to cover 50% of claims above a \$300,000 threshold up to a doctor's limit of insurance. It is hoped that this will remove the burden of long-term care costs from the insurance system. Previously the scheme covered 50% of all claims over \$500,000. It was also recommended that the Exceptional Claims Scheme (regarding claims for an amount greater than a doctor's contract of insurance) be retained.
- A Run-off Reinsurance Vehicle (RRV) be introduced to secure cover for permanently retired doctors over the age of 65, or those on medical leave. The cost is to be incorporated into normal annual premiums.
- The proportion of IBNRs of MDOs eligible for the RRV be passed to the RRV, with the balance to remain with the Commonwealth.
- State and Territory governments continue to implement professional standards legislation and such schemes as compulsory insurance, risk management, alternative dispute resolution, and capped liability, with the Commonwealth to provide legislative support.
- The Ministerial Meetings on Insurance develop a scheme for the long-term care of the catastrophically injured.
- Professional colleges continue to develop, implement and appraise appropriate risk management programs.
- That the States and Territories implement tort law reform consistent with the recommendations of the Ipp Report, and examine the option of Medical Assessment Panels which would analyse cases on a clinical basis before they become part of the legal process.
- Medical indemnity insurers continue to be regulated by APRA to ensure that they hold sufficient reserves and remain viable.
- A working party be established in mid-2005 to evaluate the effectiveness of the new

16/10/03.

⁶² Medical Indemnity Policy Review Panel, n 8, p 4.

⁶³ Ibid.

arrangements, consider alternatives (if necessary) and consider developments in relation to a long term care scheme, the handling of clinical disputes, and improvements in claims handling.

- These recommendations be implemented in consultation with the medical profession, insurers and other relevant parties.

The full text of the Medical Indemnity Policy Review Panel's recommendations is attached as Appendix B.

The Commonwealth Government has adopted the majority of these recommendations.⁶⁴ The Government has established a Premium Support Scheme to replace the Medical Indemnity Subsidy scheme from 1 July 2004. The Scheme implements the first two recommendations of the Medical Indemnity Policy Review Panel. Rather than providing support to individual doctors, payments will be directed to medical indemnity insurers, to ensure premiums are more affordable. Insurers will receive funding equivalent to 80% of the amount by which a doctor's medical indemnity costs exceed 7.5% of gross private medical income. Medical indemnity costs include premiums, IBNR levies and run-off cover. The scheme is expected to substantially reduce the premiums paid by doctors. For example, in NSW, the premium for an orthopaedic surgeon with an income of less than \$200,000 should fall from \$40,000 to \$20,000 a year, and the premium for an orthopaedic surgeon with an income of \$475,000 should fall from \$67,000 to \$42,000 a year.⁶⁵

The Commonwealth Government has also agreed to establish run-off reinsurance vehicles so that doctors who have permanently left private practice or are on maternity leave have run-off cover. The cost of RRV is to be absorbed into normal premiums. The High Costs Claims Scheme is to be altered so that medical indemnity insurers are reimbursed for 50% of an insurance payout over \$300,000 to the limit of the doctor's cover. This applies to claims notified on or after 1 January 2004 and is to minimise the impact of large claims on insurance premiums.

The Panel believes that tort law reform and improved professional standards are the most effective means for ensuring affordable medical indemnity premiums.⁶⁶ It also argues that:

more professional accountability, further tort law reform, support for long term care costs, premium support for insurers with high risk members, and a government-backed reinsurance vehicle to provide run-off cover – will not only ensure that premiums start to fall immediately but will provide a sustainable structure for the medium term at least.⁶⁷

⁶⁴ Hon T Abbott MP, Minister for Health and Ageing, 'Medical Indemnity Arrangements', *Media Release*, 17/12/03.

⁶⁵ *Ibid.*

⁶⁶ Medical Indemnity Policy Review Panel, n 8, p 5.

⁶⁷ *Ibid.*, p 6.

5 THE SITUATION ELSEWHERE

5.1 New Zealand

The treatment of medical negligence in New Zealand is radically different to Australia. New Zealanders do not have the right to sue for personal injury, other than for exemplary damages, as a no-fault accident compensation scheme exists. This scheme is administered by the Accident Compensation Corporation (ACC) under the *Injury Prevention, Rehabilitation and Compensation Act 2001*. The ACC is responsible for preventing injury, collecting levies, evaluating claims, paying compensation to those who are eligible, and advising the government.⁶⁸

A medical misadventure account operates as part of the compensation scheme for persons injured as the result of treatment by a registered health professional or organisation. It is jointly funded by a levy on workers' incomes and by the government. The following table provides an overview of the various types of injuries covered by the scheme, including those that result from medical misadventure, as well as noting the source of funding:

Account Name	Source of funding	What the account pays for
Employers' Account	Levies paid by employers based on industry risk.	Work-related injuries.
Earners' Account	Earners' levies, paid through PAYE plus self-employed levies based on earnings.	Non-work injuries (at home and during sport and recreation) to earners and to self-employed.
Self-Employed Work Account	Earnings-related levies based on industry risk.	Personal work-related injury to self-employed and private domestic workers.
Non-earners' account	Government.	All personal injuries to people not in the paid workforce: students, beneficiaries, older people and children.
Motor Vehicle Account	Petrol excise duty and a levy collected with the motor vehicle relicensing fee.	Personal injuries involving motor vehicles on public roads.
Medical Misadventure Account	Earners' and Non-earners' Accounts	Injuries from error by medical practitioners or from unexpected outcomes of medical or surgical procedures properly carried out.
Residual Claims Account	Levies paid by employers and self-employed.	Continuing cost of work-related injuries from before 1 July 1999 and non-work injury suffered by earners prior to 1 July 1992.

Source: New Zealand, Accident Compensation Corporation, *Annual Report 2003*, p 3.

The New Zealand scheme has often been proposed as an alternative to the current system in Australia. However, it is seen as expensive option as the cost of implementing a similar

⁶⁸ For further information on the ACC visit their website www.acc.org.nz

scheme in Australia has been estimated at \$1 billion.⁶⁹ Nonetheless, it is claimed that insurers already pay \$600 million to care for the seriously injured, and the government contributes an equivalent of the remaining monies needed to the medical indemnity scheme.⁷⁰ Therefore, Australia may be able to afford such a scheme.

No-fault accident compensation schemes are thought to alleviate some of the disadvantages of the Australian system. Luntz has claimed:

that the problem with the present system of compensation is its slow, cumbersome, expensive and discriminatory operation; that many of the costs of injury are inevitable and will be incurred anyway; that the real issue is how the unavoidable costs should be allocated; and that to make the system more affordable requires the elimination of the wasteful costs of investigation into fault.⁷¹

However, the New Zealand scheme has also been harshly criticised. The Australian Plaintiff Lawyers Association strongly opposes the introduction of such a system in Australia, as they do not believe it solves the problem of unaffordable public liability insurance.⁷² They also claim that victims are not adequately compensated by no fault schemes. There is a concern that a sense of responsibility for others' safety is diminished as liability is removed. The Australian Competition and Consumer Commission is also critical of no fault schemes. It perceives the New Zealand system as seriously flawed, with grossly inadequate compensation payments.⁷³ They claim that the scheme had \$NZ 3.9 billion in unfunded liabilities as at June 2001.⁷⁴ On the other hand, Todd argues that the scheme is a substantial success, despite problems with the level of coverage, rehabilitation incentives, methods of funding and overall expense, as 'the cost compares very well with any system where liability needs to be proved, the coverage is far greater and the benefits are affordable'.⁷⁵

No-fault compensation schemes also operate in other countries including Sweden, Finland,

⁶⁹ ABC Radio National, Background Briefing, 'What Insurance Crisis?', 30/11/03. A copy of the transcript is available from www.abc.net.au

⁷⁰ Ibid.

⁷¹ Luntz H, 'Reform of the law of negligence wrong questions – wrong answers', *University of New South Wales Law Journal*, 8(2) November 2002, p 18.

⁷² Australian Plaintiff Lawyers Association, *National Ministerial Summit into Public Liability Insurance: APLA Submission*, 20 March 2002. Available from www.apla.com.au Accessed 28 November 2003.

⁷³ Australian Competition and Consumer Commission, *Second Insurance Industry Market Pricing Review*, September 2002, p 84.

⁷⁴ Ibid.

⁷⁵ Todd S, 'Negligence liability for personal injury: a perspective from New Zealand', *University of New South Wales Law Journal*, 8(2) November 2002, p 58.

Denmark and Norway.⁷⁶ In the USA, Virginia and Florida have established no-fault compensation for babies with birth-related neurological injuries.⁷⁷ However, apart from the USA, claimants in these countries are not prevented from pursuing a claim in court.

5.2 United Kingdom

There are many similarities between medical negligence claims in the UK and Australia. The size and number of medical negligence claims in both countries has been rising. In the UK, in 1974/75, annual NHS clinical negligence expenditure in 2002 terms was £6.33 million.⁷⁸ By 2001/02, it had increased to £446 million. The cost of medical litigation in the UK is equivalent to 0.04% of Gross Domestic Product.⁷⁹

Since the 1950s, doctors have been required to obtain coverage from a Medical Defence Organisation. However, a massive change occurred in 1990 following the introduction of NHS Indemnity. The National Health Service Litigation Authority now defends clinical negligence claims whilst Medical Defence Organisations are responsible for claims arising from primary care, and hospital doctors in private practice.

There have been a number of changes in recent years that have impacted medical negligence including:⁸⁰

- increased emphasis on liability being admitted in justifiable circumstances (rather than defending claims at all costs);
- faster, more expert handling of claims;
- cases settling earlier; and
- defence costs being contained.

However, there are concerns over the sustainability of the law as it relates to medical negligence. In 2001, the Department of Health began to formally consider the possibility of reforming the response of the National Health Service (NHS) to clinical negligence. The Chief Medical Officer published the report, *Making Amends*, in 2003.⁸¹ One of its main recommendations was the establishment of a NHS Redress Scheme for patients harmed as a result of seriously substandard NHS hospital care.⁸² The proposed scheme involves alleged

⁷⁶ United Kingdom, Department of Health, *Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*, A report by the Chief Medical Officer, June 2003, p 14. A copy of the report is available from www.doh.gov.uk/makingamends/pdf/cmomakingamends.pdf

⁷⁷ Ibid.

⁷⁸ Ibid, p 9.

⁷⁹ Ibid, p 11.

⁸⁰ Ibid, p 12.

⁸¹ Ibid.

⁸² For a detailed description of the proposed NHS Redress Scheme see United Kingdom, Department of Health, n 76, pp 16-18.

incidents being investigated, an explanation provided to the patient harmed, the development and delivery of a package of care, with payments to be made for pain and suffering, out of pocket expenses, and care or treatment that cannot be provided by the NHS. The Scheme would not remove a person's right to sue. Nonetheless, there would be a presumption that the claimant had first applied to the Redress Scheme. Those who had accepted care and compensation under the scheme would also be required to waive their right to sue.

The review examined no-fault compensation schemes that operate in other countries. However, the implementation of a no-fault compensation scheme in England was rejected, as it would give rise to a number of difficulties including:⁸³

- an increase in the number of claims;
- less compensation would be provided to claimants than under the current tort system, if the scheme is to be affordable;
- the difficulties of distinguishing harm from that caused by the natural progression of disease; and
- a belief that such a scheme would neither reduce harm nor encourage learning from errors.

5.3 United States of America

The main characteristics of the medical liability system in the US include:⁸⁴

- high contingency fees for lawyers;
- large jury awards in medical malpractice cases. In 2000, the median award was \$1 million;
- the common practice of defensive medicine (the costly habit of subjecting patients to numerous tests and procedures for the primary purpose of minimising the doctor's prospects of being held liable should an adverse event occur);
- very high malpractice premiums for some doctors;
- high rates of claims in some specialties. For example, obstetricians are sued an average of three times in their careers; and
- lack of access to medical care in the more litigious states as doctors have left to practice in other states.

The US is currently experiencing similar problems to Australia in terms of health care liability, with rapid increases in insurance premiums being attributed to greater awards of damages. Like Australia, doctors have threatened to retire early as they cannot afford the increases, with specialists, such as neurologists and obstetricians, particularly affected. An enormous amount of medical litigation occurs in the US, equivalent to 0.2% of Gross Domestic Product, the highest proportion in the world.⁸⁵

⁸³ Ibid, p 15.

⁸⁴ Ibid, p 27.

⁸⁵ Ibid.

The average amount paid on medical malpractice claims increased by 3% each year between 1988 and 1997.⁸⁶ However, between 1998 and 2001 it rose by 8.2% per year. The US has also been affected by the withdrawal of some major insurers from the market. For example, in 2002 the St Paul companies ceased writing all medical malpractice insurance because of declining profitability. It was previously the second largest medical malpractice insurer in the US.

However, like Australia, there are other influences on the amount of insurance premiums, including the movement between hard and soft insurance markets. Soft markets, such as existed between 1990 and 1998 in the US, are characterised by ‘slowly rising premium rates, less stringent underwriting standards, expanded coverage, and strong competition among insurers’.⁸⁷ Hard markets, on the other hand, are characterised by ‘rapidly rising premium rates, tightened underwriting standards, narrowed coverage, and often by the departure of some insurers from the market’.⁸⁸

The United States General Accounting Office recently completed a study of medical malpractice insurance to examine the extent of the increases, determine the contributing factors, and identify any influential changes in the insurance market.⁸⁹ It examined the situation in California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania and Texas. It found that the factors that had contributed to the increase in premiums in those states included:⁹⁰

1. the rapid increase in insurers’ losses on medical malpractice claims since 1998.
2. decreases in the investment income of medical malpractice insurers between 1998 and 2001.
3. unsustainable premiums set during the 1990s due to fierce competition, that were temporarily offset by high investment returns.
4. the rapid increase in reinsurance rates from 2001.

The study concluded that:

Multiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer cost, and in the long run, premium rates are set at a level designed to cover anticipated costs. However, the year-to-year increase in premium rates can vary substantially because of perceived future losses and a

⁸⁶ United States General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, June 2003, p 15.

⁸⁷ *Ibid*, p 33.

⁸⁸ *Ibid*.

⁸⁹ *Ibid*.

⁹⁰ *Ibid*, pp 4-5.

variety of other factors, including investment returns and reinsurance rates.⁹¹

California substantially reformed its tort law system in the 1970s, and is often cited as a model for how to balance the competing interests of adequate compensation for victims whilst ensuring premiums remain affordable. The *California Medical Injury Compensation Reform Act 1975*: capped non-economic damages at \$250,000; placed limits on contingency fees charged; prevented double recoveries; and permitted periodic payments rather than lump sum awards.⁹² According to a House Committee report, medical professional indemnity premiums in California have increased by 167% since 1976, compared to an average of 505% for the rest of the US.⁹³

In order to address the ‘crisis’ in America, the *Help Efficient, Accessible, Low-cost, Timely Healthcare (Health) Act of 2003* was introduced in Congress in 2003. The bill was based on the Californian model, and sought to introduce similar reforms. It allowed the damages to be apportioned between defendants, and set guidelines for the award of punitive damages. According to section 2(b):

It is the purpose of this Act to implement reasonable, comprehensive, and effective health care liability reforms designed to –

- (1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;
- (2) reduce the incidence of ‘defensive medicine’ and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;
- (3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;
- (4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and
- (5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

The House of Representatives passed the bill on 13 March 2003. It was read a second time on 21 March 2003 and placed on the Senate calendar. The Senate considered a similar bill in July 2003. However, it failed to invoke the necessary support. It did not receive sufficient votes on a motion to proceed and was subsequently not fully considered by the Senate. The Congressional Budget Office estimated that had the Act been passed, medical liability insurance premiums would have been reduced by 25 to 30%, and would have saved the federal government \$11.3 billion over 10 years.⁹⁴

⁹¹ Ibid, p 43.

⁹² United States of America, *House Committee Report 32: Help Efficient, Accessible, Low-Cost, Timely Healthcare (Health) Act of 2003*, 108th Congress. A copy of the report is available from <http://thomas.loc.gov>

⁹³ Ibid.

⁹⁴ Congressman Jim Greenwood, ‘Medical Liability Insurance Reform’, www.house.gov/greenwood/issues.shtml Accessed 5 December 2003.

6 HAVE THE REFORMS BEEN EFFECTIVE?

Much has changed in relation to medical negligence since 2001. This section evaluates the effectiveness of the reforms introduced by the NSW Government by providing an overview of the changes, questioning whether the surge in insurance premiums was due to increasing medical litigation, and outlining some of the concerns that remain.

6.1 Overview of reforms

The NSW Government has identified what it believes to be its achievements in the area of medical negligence. These achievements include:⁹⁵

- Capping payouts;
- Tightening the statute of limitations;
- Extensive tort reform;
- Covering doctors for public work in the public system;
- Covering rural doctors for private work in the public system;
- Regulating the amount insurers can charge doctors practising obstetrics and neurosurgery;
- Outlawing cherry-picking in the industry; and
- Meeting the IBNR tail of UMP and other medical defence organisations for public patient claims.

6.2 What was driving the increase in insurance premiums?

The rise in insurance premiums is commonly attributed to the increased willingness of people to sue. Premier Carr has warned of the ‘Americanisation’ of our culture and the need to wind back this ‘culture of blame’.⁹⁶ Newspaper reports of the Camden and Campbelltown hospitals controversy mention that solicitors are currently preparing negligence claims on behalf of the families of patients who died.⁹⁷ However, there is some doubt as to whether the amount of medical litigation had reached crisis proportions. A sample of the various views that exist follows:

- The Senate Economic References Committee in their review of public liability and professional indemnity insurance found little evidence in support of propositions that: Australians are becoming more litigious; courts are defining negligence in a broader way; schemes such as ‘no win, no fee’ encourage claims; and unmeritorious claims are not effectively discouraged.⁹⁸

⁹⁵ Hon M Iemma MP, ‘Commonwealth bailout package a doctor’s nightmare’, *Media Release*, 16/9/03.

⁹⁶ Hon R Carr MP, *NSWPD*, 23/10/02, p 5765.

⁹⁷ ‘Hospital deaths: enter the lawyers as families plan to sue for compensation’, *Sydney Morning Herald*, 20/1/04, p 1.

⁹⁸ Senate, Economics References Committee, *A Review of Public Liability and Professional Indemnity Insurance*, October 2002, p xiv.

- Peter Cashman, former National President of the Plaintiff Lawyers Association, claims that the award of general damages in NSW has not increased in over a decade and that the incidence of medical negligence cases lodged with Australian courts decreased in the years prior to 2001.⁹⁹
- The AHMAC Legal Process Reform Group found ‘little evidence that there is a recent change in behaviour where many more patients are suddenly suing their doctors and hospitals. What is more certain is that the long term pattern of litigation in this area, like many others, has been upward over several decades, from a very low rate of litigation in the mid-part of the twentieth century to where it is now’.¹⁰⁰ The Group acknowledged that the average cost of claims has increased, but noted that the cost is driven mostly by large claims, as claims for over \$1 million constitute 30% of the total costs yet represent less than 1% of total claims.¹⁰¹
- On 30 November 2003, ABC Radio National broadcast a documentary that questioned whether there was an insurance crisis that was the result of people suing more often, as alleged by politicians and insurance companies.¹⁰² The program claimed that Australians were not particularly litigious and that the financial difficulties experienced by some insurance companies were the result of their own financial mismanagement. Joanne Doroshow, Executive Director of the Centre for Justice and Democracy in New York, argued that the insurance crisis was really part of a cyclical global crisis, the third one to have occurred in 30 years. When the economy is weaker and interest rates fall, insurance premiums will rise and insurers may refuse to offer certain policies. Nonetheless the program acknowledged that the amount of damages awarded to seriously injured plaintiffs had increased. The program also recognised the need for bigger damages than in the past, the result of an increase in life expectancy and the cost of care.
- Spigelman J believes the crisis resulted from the tort system.¹⁰³ He argues that the scope of damages for negligence has expanded considerably in recent decades and that courts are defining negligence more broadly than before. However, he views developments in the insurance industry as the catalyst of the crisis.¹⁰⁴

There are various factors that may contribute to changes in the number and frequency of

⁹⁹ Cashman P, ‘The Medical Indemnity ‘Crisis’’, *Plaintiff*, April 2001, p 5.

¹⁰⁰ AHMAC Legal Process Reform Group, n 15, p 19.

¹⁰¹ *Ibid*, p 19.

¹⁰² ABC Radio National, n 69.

¹⁰³ Spigelman J, ‘Negligence and insurance premiums: Recent changes in Australian law’, *Torts Law Journal*, 11(3) November 2003, p 293.

¹⁰⁴ *Ibid*.

claims. Actual data on the number of claims initiated as a result of medical negligence is not readily available. Nonetheless, figures provided by the Medical Indemnity Protection Society suggest that the size and number of claims has grown.¹⁰⁵ The number of claims reported for every 1000 doctors each year doubled between 1980 and 1990, and doubled again between 1990 and 2000. The cost of litigation almost tripled between 1980 and 2000 because of higher process costs, and greater awards or settlements.

Whilst there does appear to be a greater number of claims made against medical practitioners, the number of services provided by Medicare and the number of hospital admissions have also risen in the last 15 years, increasing by 66% and 76% respectively.¹⁰⁶ Therefore a greater exposure to risk now exists which would flow on into an increase in the number and frequency of claims.

There are a number of factors, other than an increase in the size and number of claims, which have contributed to the rise in insurance premiums. Some of these factors include:¹⁰⁷

- Medical Defence Organisations failed to maintain adequate funds for many years. Premiums were underpriced as part of an aggressive attempt to increase market share. The higher premiums are part of an attempt to address the problems caused by inadequate funds.
- Doctors originally paid similar premiums, in the range of \$1000 to \$2000 per doctor, as the risk was spread across all specialties. However, in the late 1980s, MDOs moved away from mutuality and risk pooling across all doctors, thus shrinking the size of each risk pool.
- The cost of providing insurance has grown as a result of the introduction of prudential supervision and the need to increase capital reserve adequacy.
- Some national and international events have had a short-term inflationary effect. For example, September 11 caused a rise in the price of reinsurance; HIH, who provided reinsurance for a number of MDOs, collapsed; and UMP, the largest MDO in Australia, went into voluntary provisional liquidation. Such events exacerbated the effect of other factors.

The relationship between a doctor and his or her patient has also changed, with patients being more prepared to sue should something go wrong:

No longer are most people treated by respected family practitioners, nor are they visited in their homes as they once were. The social status and education of the patient (now often called a 'client') are no longer inferior to the doctor's; and the latter's fallibility is more easily recognised, possibly as a result of consulting the Internet.¹⁰⁸

¹⁰⁵ Australian Competition and Consumer Commission, n 73, p 68.

¹⁰⁶ Ibid, p 18.

¹⁰⁷ AHMAC Legal Process Reform Group, n 15, p 21.

¹⁰⁸ Luntz, n 71, p 18.

However, this does not mean that people are necessarily quick to sue their doctor. The majority of people who have an adverse experience in hospital do not sue. Less than 4% of hospitals experience an adverse outcome, and less than 1% of these are due to negligence.¹⁰⁹ Those who litigate do not lodge a claim solely because of a desire for compensation. A survey conducted in the United Kingdom found that other common reasons for litigation include:¹¹⁰

- to stop the same thing happening to another person;
- to obtain an apology;
- the opportunity presented to make the other side understand the concerns of the claimant;
- a desire for someone to show that they care about what happened;
- to enable arrangements to be made for subsequent treatment; and
- the opportunity to meet the other side in person, hear what they have to say and talk through the issues.

Whether or not the litigation crisis is real, the perception that there is one has a definite impact on society: a rise in defensive medicine; young doctors avoiding specialties with high contribution rates; and doctors currently in those specialties retiring earlier due to the financial impact of premiums.¹¹¹

6.3 What has changed?

New South Wales is commonly acknowledged as leading the reform agenda in Australia.¹¹² However, Feldthusen has criticised many of the reforms, arguing that they are superficial:

The problem they [the Ipp Panel] identified was the perception that it is too easy to recover in negligence. The solution they recommended was to create the perception that this would be so no longer. Much of law reform operates entirely on this level.¹¹³

In many ways it is too early to fully measure the impact of the legislative changes in NSW.¹¹⁴ The Medical Indemnity Policy Review Panel found that ‘the effects of tort law

¹⁰⁹ ‘Getting the facts straight on negligence: straight talking’, *Australian Medicine*, 15(21), November 2003, p 1.

¹¹⁰ Mulcahy L, Selwood M, Netten A, *Mediating Medical Negligence Claims: An Option for the Future?*, University of London, 2002, p 12. A copy of the paper is available from www.doh.gov.uk/mediation/index.htm

¹¹¹ AHMAC Legal Process Reform Group, n 15, p 61.

¹¹² Clark et al, n 28, p 54.

¹¹³ Feldthusen, n 18, p 32.

¹¹⁴ Smyth T, ‘Tort law reform – new NSW Act likely to be model for other States and Territories’, *Australian Health Law Bulletin*, 11(4) 2002/2003, p 46.

reform are yet to flow through the system'.¹¹⁵ According to Tony Abbott, Federal Minister for Health, no cases had come to judgment by October 2003 under the new rules introduced by the NSW Government.¹¹⁶ However, it is anticipated that the changes will have a significant impact on the size and number of claims. This was recognised by the Commonwealth Government, as it recalculated the IBNR levy to account for the effect of the reforms in NSW. This implies that the reforms in NSW are achieving their purpose.

The Medical Indemnity Policy Review Panel believes that the, 'tort law reforms already implemented have the potential to reduce considerably the costs of medical indemnity. It is estimated that the NSW reforms, following the Ipp Report very closely, will bring down claims costs by 30 per cent compared with 2001 costs'.¹¹⁷ According to Mr Abbott, claims made on UMP have dropped from 60 to 15 a month since July 2002.¹¹⁸

The number of claims lodged with the District Court of NSW appears to be less than in previous years. In 2002, there were 12,686 matters registered in the District Court of NSW compared to 20,784 in 2001 and 15,070 in 2000.¹¹⁹ A marked decrease in the registration of new matters occurred in the latter half of 2002 after the new civil liability legislation commenced. The District Court is not certain whether this reduction in the number of cases is due to the effectiveness of the legislation or whether the legislation caused a rush to file matters before the legislation commenced with the effect that practitioners had filed all relevant claims.¹²⁰ Whether this is a long-term trend is likely to become clear with the passage of time.

There is some anecdotal evidence that smaller damages are being assessed as a result of the *Health Care Liability Act* and the *Civil Liability Act*.¹²¹ UMP has claimed that apart from the Commonwealth Government assuming responsibility for the IBNR liability, the legislative changes in NSW aided its bid to exit provisional liquidation.¹²²

Fredman completed a case study in 2002 to determine the impact of the *Health Care Liability Act 2001* on the award of damages.¹²³ The example used was the decision of

¹¹⁵ Medical Indemnity Policy Review Panel, n 8, p 14.

¹¹⁶ Abbott T, 'Doctors must stay at posts while Canberra searches for cures', *Sydney Morning Herald*, 7/10/03, p 13.

¹¹⁷ Medical Indemnity Policy Review Panel, n 8, p 18.

¹¹⁸ Abbott T, 'Doctors must stay at posts while Canberra searches for cures', *Sydney Morning Herald*, 7/10/03, p 13.

¹¹⁹ District Court of NSW, *Annual Review 2002*, p 23.

¹²⁰ *Ibid.*

¹²¹ Chambers K, 'Medical indemnity – is there a crisis? Is there a solution?', *Australian Health Law Bulletin*, 11(2), October 2002, p 16.

¹²² 'UMP comes out of liquidation', *Australian Financial Review*, 11/11/03, p 3.

¹²³ Fredman J, 'Health Care Liability Act 2001 (NSW): Impact on Damages Awards – a case

Whealy J in *Simpson v Diamond* in which the plaintiff was awarded \$14 million in damages. Ms Simpson suffered from athetoid cerebral palsy, the result of Dr Diamond attempting to deliver her five times with forceps before performing a caesarean section. Fredman found that had Ms Simpson's case been subject to the *Health Care Liability Act*, the award of damages would have been much less, more in the vicinity of \$9 million.

The influence of the reforms on the size of insurance premiums is questionable. Premiums, on average, doubled between 1997-98 and 2002-03.¹²⁴ Whilst acknowledging that professional indemnity premiums have risen, some argue that it is by a smaller amount than would have been the case had the changes not been introduced.¹²⁵ For example, the NSW Government claimed that without the *Health Care Liability Act*, UMP's premiums would have risen more dramatically at the end of 2001, with neurosurgeons being charged \$275,000 as opposed to \$82,500.¹²⁶ At the time, UMP, Dr Kerryn Phelps (then President of the Australian Medical Association), and Dr Michael Wooldridge (former federal Health Minister), also acknowledged the benefit of the reforms.¹²⁷ It is likely that the new national Premium Support Scheme, developed by the Commonwealth Government, will also have an impact on the amount paid by doctors.

6.4 Remaining concerns

Not all the effects of the reforms are necessarily beneficial. There is a possibility that the cost burden has been shifted from the person/s responsible for the wrong to the victim, because the amount of damages that can be awarded for medical negligence has been limited. The Ipp Report warned that this might happen:

If implemented, the recommendations made by the Panel will, to a degree, shift the cost of injuries from injurers to injured persons. As a result, some injured persons who, under the current law, would be entitled to compensation will no longer be so entitled; and other persons will be entitled to less compensation. How these issues are to be dealt with is a matter of policy for governments to determine and is not dealt with in our Report.¹²⁸

The burden may also be shifted to the social security system, and consequently to

study', *Australian Health Law Bulletin*, 10(4) 2002, p 31ff

¹²⁴ Medical Indemnity Policy Review Panel, n 8, p 10.

¹²⁵ Mockler D, 'Practice and Procedure in Relation to the Civil Liability Changes', *Personal Injury Revisited 03/05*, Continuing Professional Education Seminar Papers, College of Law, Presented on 15 February 2003, p 201.

¹²⁶ Hon Craig Knowles MP, 'NSW indemnity reforms rescue doctors from higher rises', *Media Release*, 11/12/01.

¹²⁷ Ibid.

¹²⁸ Negligence Review Panel, n 5, p 28.

Australian taxpayers.¹²⁹

If the recent legislative changes in NSW are largely cosmetic as some argue, then some rights have been eroded for little benefit. For example, as exemplary damages were rarely awarded it is unlikely that their abolition will make a substantial difference to insurance premiums. Spigelman J has been critical of this aspect of the reforms, doubting that ‘their abolition has made any practical difference to insurance premiums. The speed with which the changes have been introduced and the focus on controlling premiums did not permit the consideration of the various social purposes, other than compensation, performed by the law of torts’.¹³⁰ Courts are now unable to express their condemnation of gross negligence by imposing exemplary damages, and this limitation does not appear to be for any real benefit.

Cashman has condemned the changes in much stronger terms referring to them as tort ‘deforms’ as they:

seek to achieve a relatively simple solution to what is in reality a complex problem. The first wave of reforms, initially enacted in NSW but now being advocated in other jurisdictions, is intended to curtail, abolish or discount damages entitlements. Such solutions are not only unfair, in that they limit or take away the legal rights of innocent victims of medical negligence, they also fail to deal with real causes of the crisis.¹³¹

In contrast, the Attorney-General Hon R Debus MP has described the NSW reforms as ‘principle-driven’, noting that:

The NSW Government has taken a constructive approach to federal-State interaction on the issue, both through advancing concrete proposals for reform and supporting the Ipp Report’s recommendations in the interests of national consistency. The Government is strongly committed to developing and implementing a system of compensation for negligence that accords with the basic community values of fairness, personal responsibility and common sense.¹³²

¹²⁹ AHMAC Legal Process Reform Group, n 15, p 60.

¹³⁰ Spigelman, n 103, p 311.

¹³¹ Cashman P, ‘Tort reform and medical indemnity ‘crisis’’, *University of New South Wales Law Journal*, 8(2) November 2002, p 51.

¹³² Debus R, ‘Tort law reform in New South Wales: State and federal interactions’, *University of New South Wales Law Journal*, 25(3) 2002, p 830.

7 CONCLUSION

The legislative changes made by the NSW and Federal Governments have impacted on the provision of medical indemnity insurance. However, the extent to which they have influenced insurance premiums is a matter of some debate. Perhaps the real impact of the legislative changes is their cultural influence, as argued by Sant, who predicts that:

The cultural change brought about by the media and political ruckus about personal injury claims and the pressure on judges to make a shift in favour of defendants in every area of negligence will probably have far more impact on breach than the terms of the Act itself.¹³³

This prediction may be in the process of realisation. Harold Luntz has detected a change in the pattern of decisions made by the High Court since 2001.¹³⁴ His research found that in 80% of cases dealing with liability or damages for personal injury between 1987 and 1999 the Court found for the plaintiff. However, since the start of 2001, a pro-defendant trend has emerged, with 64% of personal injury cases being found in favour of the defendant.

The debate surrounding medical negligence and professional indemnity insurance premiums is complex as many competing interests are involved. There is a need to adequately compensate those injured as a result of another's negligence. Doctors also need to have access to affordable, sustainable insurance premiums so their services continue to be available across all specialties, in the public and private systems. The extent to which each aim is being realised as a result of the reforms introduced by the NSW and Federal governments will be further revealed with time.

¹³³ Sant K, 'The Impact of Recent Legislation on Medical Negligence Claims', *Medical Negligence NSW 2003*, Legalwise Seminars, 2003, p 26.

¹³⁴ Luntz H, 'Turning points in the law of torts in the last 30 years', *Insurance Law Journal*, 15(1) December 2003, p 22.

Appendix A: Ipp Report Recommendations

Source: Negligence Review Panel (Chairman: Ipp J), *Review of the Law of Negligence: Final Report*, September 2002, pp 1-24.

List of Recommendations

Implementation of the Panel's Recommendations

A national response

Recommendation 1

The Panel's recommendations should be incorporated (in suitably drafted form) in a single statute (that might be styled the *Civil Liability (Personal Injuries and Death) Act* ('the Proposed Act')) to be enacted in each jurisdiction.

Overarching recommendation

Recommendation 2

The Proposed Act should be expressed to apply (in the absence of express provision to the contrary) to any claim for damages for personal injury or death resulting from negligence regardless of whether the claim is brought in tort, contract, under a statute or any other cause of action.

Professional Negligence

Treatment by a medical practitioner — standard of care

Recommendation 3

In the Proposed Act, the test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be:

A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational.

Standard of care — professionals generally

Recommendation 4

The Proposed Act should embody the following principles:

In cases involving an allegation of negligence on the part of a person holding himself or herself out as possessing a particular skill, the standard of reasonable care should be determined by reference to:

- (a) What could reasonably be expected of a person professing that skill.
- (b) The relevant circumstances at the date of the alleged negligence and not a later date.

Duties to inform

Recommendation 5

In the Proposed Act the professional's duties to inform should be legislatively stated in certain respects, but only in relation to medical practitioners.

Recommendation 6

The medical practitioner's duties to inform should be expressed as duties to take reasonable care.

Recommendation 7

The legislative statement referred to in Recommendation 5 should embody the following principles:

- (a) There are two types of duties to inform, a proactive duty and a reactive duty.
- (b) The proactive duty to inform requires the medical practitioner to take reasonable care to give the patient such information as the reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment.
- (c) The information referred to in paragraph (b) should be determined by reference to the time at which the relevant decision was made by the patient and not a later time.
- (d) A medical practitioner does not breach the proactive duty to inform by reason only of a failure to give the patient information about a risk or other matter that would, in the circumstances, have been obvious to a reasonable person in the position of the patient, unless giving the information is required by statute.
- (e) Obvious risks include risks that are patent or matters of common knowledge; and a risk may be obvious even though it is of low probability.
- (f) The reactive duty to inform requires the medical practitioner to take reasonable care to give the patient such information as the medical practitioner knows or ought to know the patient wants to be given before making the decision whether or not to undergo the treatment.

Procedural recommendations

Recommendation 8

Consideration should be given to implementing trials of a system of court-appointed experts.

Recommendation 9

Consideration should be given to the introduction of a rule requiring the giving of notice of claims before proceedings are commenced.

Not-for-Profit Organisations

No exemption for NPOs

Recommendation 10

Not-for-profit organisations as such should not be exempt from, or have their liability limited for, negligently-caused personal injury or death.

Recreational services generally

Recommendation 11

The Proposed Act should embody the following principles:

The provider of a recreational service is not liable for personal injury or death suffered by a voluntary participant in a recreational activity as a result of the materialisation of an obvious risk.

- (a) An obvious risk is a risk that, in the circumstances, would have been obvious to a reasonable person in the position of the participant.
- (b) Obvious risks include risks that are patent or matters of common knowledge.
- (c) A risk may be obvious even though it is of low probability.

Recommendation 12

For the purposes of Recommendation 11:

- (a) 'Recreational service' means a service of
 - (i) providing facilities for participation in a recreational activity; or
 - (ii) training a person to participate in a recreational activity; or
 - (iii) supervising, adjudicating, guiding or otherwise assisting a person's participation in a recreational activity.
- (b) 'Recreational activity' means an activity undertaken for the purposes of recreation, enjoyment or leisure which involves a significant degree of physical risk.

Recommendation 13

The principles contained in Recommendation 11 should not apply in any case covered by a statutory scheme of compulsory liability insurance.

Warning and giving notice of obvious risks

Recommendation 14

The proposed Act should embody the following principles:

A person does not breach a proactive duty to inform by reason only of a failure to give notice or to warn of an obvious risk of personal injury or death, unless required to do so by statute.

- (a) An obvious risk is a risk that, in the circumstances, would have been obvious to a reasonable person in the position of the person injured or killed.
- (b) Obvious risks include risks that are patent or matter of common knowledge.
- (c) A risk may be obvious even though it is of low probability.

Recommendation 15

The principles contained in Recommendation 14 should not apply to 'work risks', that is, risks associated with work done by one person for another.

Emergency services

Recommendation 16

There should be no provision regarding the liability of not-for-profit organisations as such for personal injury and death caused by negligence in the provision of emergency services.

Trade Practices

Part IVA

Recommendation 17

The TPA should be amended to provide that the rules relating to limitation of actions recommended in this Report, and those relating to the quantum of damages that will be recommended in the Panel's second report, apply to any claim for negligently-caused personal injury or death brought under Part IVA of the TPA in the form of an unconscionable conduct claim.

Recommendation 18

The TPA should be amended (to the relevant and appropriate extent) to provide that other limitations on liability recommended in this Report, and that will be recommended in the Panel's second report, apply to any claim for negligently-caused personal injury or death brought under Part IVA of the TPA in the form of an unconscionable conduct claim.

Part V Div I

Recommendation 19

The TPA should be amended to prevent individuals bringing actions for damages for personal injury and death under Part V Div I.

Recommendation 20

The TPA should be amended to remove the power of the ACCC to bring representative actions for damages for personal injury and death resulting from contraventions of Part V Div 1.

Part V Div IA, Part V Div 2A and Part VA

Recommendation 21

The TPA should be amended to provide that the rules relating to limitation of actions recommended in this Report, and those relating to the quantum of damages that will be recommended in the Panel's second report, apply to any claim for negligently-caused personal injury or death brought under Part V Div 1A, Part V Div 2A or Part VA of the TPA.

Recommendation 22

The TPA should be amended (to the relevant and appropriate extent) to provide that other limitations on liability recommended in this Report, and that will be recommended in the Panel's second report, apply to any claim for negligently-caused personal injury or death brought under Part V Div 1A, Part V Div 2A or Part VA of the TPA.

Limitation of Actions

General provision

Recommendation 23

The Proposed Act should provide that all claims for damages for personal injury or death resulting from negligence are governed by the limitation provisions recommended in this Chapter.

The limitation period and the long-stop period

Recommendation 24

The Proposed Act should embody the following principles:

- (a) The limitation period commences on the date of discoverability.
- (b) The date of discoverability is the date when the plaintiff knew or ought to have known that personal injury or death:
 - (i) had occurred; and
 - (ii) was attributable to negligent conduct of the defendant; and
 - (iii) in the case of personal injury, was sufficiently significant to warrant bringing proceedings.
- (c) The limitation period is 3 years from the date of discoverability.
- (d) Subject to (e), claims become statute-barred on the expiry of the earlier of
 - (i) the limitation period; and
 - (ii) a long-stop period of 12 years after the events on which the claim is based ('the long-stop period').
- (e) The court has a discretion at any time to extend the long-stop period to the expiry of a period of 3 years from the date of discoverability.
- (f) In exercising its discretion, the court must have regard to the justice of the case, and in particular:
 - (i) whether the passage of time has prejudiced a fair trial of the claim.
 - (ii) the nature and extent of the plaintiff's loss.
 - (iii) the nature of the defendant's conduct.

Suspending the limitation period — minors and incapacitated persons

Recommendation 25

The Proposed Act should embody the following principles:

- (a) The running of the limitation period is suspended during any period of time during which the plaintiff is a person under a disability.
- (b) 'Person under a disability' means:

- (i) a minor who is not in the custody of a parent or guardian;
- (ii) an incapacitated person (such as a person who is unable, by reason of mental disorder, intellectual handicap or other mental disability to make reasonable judgments in respect of his or her affairs) in respect of whom no administrator has been appointed.
- (iii) a minor whose custodial parent or guardian is a person under a disability.
- (c) In the case of minors and incapacitated persons who are not persons under a disability, the relevant knowledge for the purpose of determining the date of discoverability is that of the parent, guardian or appointed administrator, as the case may be.
- (d) Where the parent or guardian of a minor is the potential defendant or is in a close relationship with the potential defendant, the limitation period (called ‘the close-relationship limitation period’) runs for 3 years from the date the plaintiff turns 25 years of age.
- (e) A close relationship is a relationship such that:
 - (i) the parent or guardian might be influenced by the potential defendant not to bring a claim on behalf of the minor against the potential defendant; or
 - (ii) the minor might be unwilling to disclose to the parent or guardian the conduct or events on which the claim would be based.
- (f) In cases dealt with in (d), the court has a discretion at any time to extend the close-relationship limitation period to the expiry of a period of 3 years from the date of discoverability.

Survival of actions

Recommendation 26

The Proposed Act should embody the following principles:

- (a) Subject to sub-para (b), the limitation principles contained in Recommendations 24 and 25 should apply to an action brought by the personal representative of a deceased person acting as such.
- (b) In such a case, the limitation period should begin at the earliest of the following times:
 - (i) When the deceased first knew or should have known of the date of discoverability, if that knowledge was acquired more than 3 years before death;
 - (ii) When the personal representative was appointed, if he or she had the necessary knowledge at that time;
 - (iii) When the personal representative first acquired or ought to have acquired that knowledge, if he or she acquired that knowledge after being appointed.

Contribution between tortfeasors

Recommendation 27

The Proposed Act should provide for limitation periods in regard to contribution between tortfeasors.

Foreseeability, Standard of Care, Causation and Remoteness of Damage

Standard of care

Recommendation 28

The Proposed Act should embody the following principles:

- (a) A person is not negligent by reason only of failing to take precautions against a foreseeable risk of harm (that is, a risk of harm of which the person knew or ought to have known).
- (b) It cannot be negligent to fail to take precautions against a risk of harm unless that risk can be described as 'not insignificant'.
- (c) A person is not negligent by reason of failing to take precautions against a risk that can be described as 'not insignificant' unless, under the circumstances, the reasonable person in that person's position would have taken precautions against the risk.
- (d) In determining whether the reasonable person would have taken precautions against a risk of harm, it is relevant to consider (amongst other things):
 - (i) the probability that the harm would occur if care was not taken;
 - (ii) the likely seriousness of that harm;
 - (iii) the burden of taking precautions to avoid the harm; and
 - (iv) the social utility of the risk-creating activity.

Causation

Recommendation 29

The Proposed Act should embody the following principles:

Onus of proof

- (a) The plaintiff always bears the onus of proving, on the balance of probabilities, any fact relevant to the issue of causation.

The two elements of causation

- (b) The question of whether negligence caused harm in the form of personal injury or death ('the harm') has two elements:
 - (i) 'factual causation', which concerns the factual issue of whether the negligence played a part in bringing about the harm; and
 - (ii) 'scope of liability' which concerns the normative issue of the appropriate scope of the negligent person's liability for the harm, once it has been established that the negligence was a factual cause of the harm. 'Scope of liability' covers issues, other than factual causation, referred to in terms such as 'legal cause', 'real and effective cause', 'commonsense causation', 'foreseeability' and 'remoteness of damage'.

Factual causation

- (c) The basic test of 'factual causation' (the 'but for' test) is whether the negligence was a necessary condition of the harm.
- (d) In appropriate cases, proof that the negligence materially contributed to the harm or the risk of the harm may be treated as sufficient to establish factual causation even though the but for test is not satisfied.

- (e) Although it is relevant to proof of factual causation, the issue of whether the case is an appropriate one for the purposes of (d) is normative.
- (f) For the purposes of deciding whether the case is an appropriate one (as required in (d)), amongst the factors that it is relevant to consider are:
 - (i) whether (and why) responsibility for the harm should be imposed on the negligent party, and
 - (ii) whether (and why) the harm should be left to lie where it fell.
- (g)
 - (i) For the purposes of sub-paragraph (ii) of this paragraph, the plaintiff's own testimony, about what he or she would have done if the defendant had not been negligent, is inadmissible.
 - (ii) Subject to sub-paragraph (i) of this paragraph, when, for the purposes of deciding whether allegedly negligent conduct was a factual cause of the harm, it is relevant to ask what the plaintiff would have done if the defendant had not been negligent, this question should be answered subjectively in the light of all relevant circumstances.

Scope of liability

- (h) For the purposes of determining the normative issue of the appropriate scope of liability for the harm, amongst the factors that it is relevant to consider are:
 - (i) whether (and why) responsibility for the harm should be imposed on the negligent party; and
 - (ii) whether (and why) the harm should be left to lie where it fell.

Contributory Negligence, Assumption of Risk and Duties of Protection

Contributory negligence

Recommendation 30

The Proposed Act should embody the following principles:

- (a) The test of whether a person (the plaintiff) has been contributorily negligent is whether a reasonable person in the plaintiff's position would have taken precautions against the risk of harm to himself or herself.
- (b) For the purposes of determining whether a person has been contributorily negligent, the standard of the reasonable person is the same as that applicable to the determination of negligence.
- (c) In determining whether a person has been contributorily negligent, the following factors (amongst others) are relevant:
 - (i) The probability that the harm would occur if care was not taken.
 - (ii) The likely seriousness of the harm.
 - (iii) The burden of taking precautions to avoid the harm.
 - (iv) The social utility of the risk-creating activity in which the person was engaged.
- (d) Whether a plaintiff has been contributorily negligent according to the criteria listed in (a) and (c) must be determined on the basis of what the plaintiff knew or ought to have known at the date of the alleged contributory negligence.

Apportionment

Recommendation 31

The Proposed Act should embody the following principle:

Under the Apportionment Legislation (that is, legislation providing for the apportionment of damages for contributory negligence) a court is entitled to reduce a plaintiff's damages by 100 per cent where the court considers that it is just and equitable to do so.

Assumption of risk

Recommendation 32

The Proposed Act should embody the following principles:

For the purposes of the defence of assumption of risk:

- (a) Where the risk in question was obvious, the person against whom the defence is pleaded (the plaintiff) is presumed to have been actually aware of the risk unless the plaintiff proves on the balance of probabilities that he or she was not actually aware of the risk.
- (b) An obvious risk is a risk that, in the circumstances, would have been obvious to a reasonable person in the plaintiff's position. Obvious risks include risks that are patent or matters of common knowledge. A risk may be obvious even though it is of low probability.
- (c) The test of whether a person was aware of a risk is whether he or she was aware of the type or kind of risk, not its precise nature, extent or manner of occurrence.

Mental Harm

Recognised psychiatric illness

Recommendation 33

A panel of experts (including experts in forensic psychiatry and psychology) should be appointed to develop guidelines, for use in legal contexts, for assessing whether a person has suffered a recognised psychiatric illness.

Duty of care — mental harm

Recommendation 34

The Proposed Act should embody the following principles:

- (a) There can be no liability for pure mental harm (that is, mental harm that is not a consequence of physical harm suffered by the mentally-harmed person) unless the mental harm consists of a recognised psychiatric illness.
- (b) A person (the defendant) does not owe another (the plaintiff) a duty to take care not to cause the plaintiff pure mental harm unless the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances, suffer a recognised psychiatric illness if reasonable care was not taken.
- (c) For the purposes of (b), the circumstances of the case include matters such as:
 - (i) whether or not the mental harm was suffered as the result of a sudden shock;
 - (ii) whether the plaintiff was at the scene of shocking events, or witnessed them or their aftermath;

- (iii) whether the plaintiff witnessed the events or their aftermath with his or her own unaided senses;
- (iv) whether or not there was a pre-existing relationship between the plaintiff and the defendant; and
- (v) the nature of the relationship between the plaintiff and any person killed, injured or put in peril.

Recommendation 35

The Proposed Act should embody the following principle:

The rules about when a duty to take reasonable care to avoid pure mental harm arises are the same regardless of whether the claim for pure mental harm is brought in tort, contract, under a statute (subject to express provision to the contrary) or any other cause of action.

Contributory negligence

Recommendation 36

The Proposed Act should embody the following principle:

In an action for damages for negligently-caused pure mental harm arising out of an incident in which a person was injured, killed or put in peril as a result of negligence of the defendant, any damages awarded shall be reduced by the same proportion as any damages recoverable from the defendant by the injured person (or his or her estate) would be reduced.

Consequential mental harm

Recommendation 37

The Proposed Act should embody the following principles:

- (a) Damages for economic loss resulting from negligently-caused consequential mental harm are recoverable only if:
 - (i) the mental harm consists of a recognised psychiatric illness; and
 - (ii) the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances, suffer a recognized psychiatric illness if reasonable care was not taken
- (b) In determining the question of foreseeability in (a)(ii), the test is whether it was foreseeable, in the light of all the relevant circumstances, including the physical injuries in fact suffered by the plaintiff, that if care was not taken a person of normal fortitude, in the position of the plaintiff, might suffer consequential mental harm.

Expert evidence

Recommendation 38

The expert panel referred to in Recommendation 33 should be instructed to develop options for a system of training and accreditation of forensic psychiatric experts.

Public Authorities

Policy defence

Recommendation 39

The Proposed Act should embody the following principle:

In any claim for damages for personal injury or death arising out of negligent performance or non-performance of a public function, a policy decision (that is, a decision based substantially on financial, economic, political or social factors or constraints) cannot be used to support a finding that the defendant was negligent unless it was so unreasonable that no reasonable public functionary in the defendant's position could have made it.

Recommendation 40

In the Proposed Act, the term 'public functionary' should be defined to cover both corporate bodies and natural persons.

Compatibility

Recommendation 41

The Proposed Act should embody the following principle:

A public functionary can be liable for damages for personal injury or death caused by the negligent exercise or non-exercise of a statutory public function only if the provisions and policy of the relevant statute are compatible with the existence of such liability.

Breach of statutory duty

Recommendation 42

The Proposed Act should embody the following principle:

In the absence of express provision to the contrary in the relevant statute, any action for damages for negligently-caused personal injury or death made in the form of a claim for breach of statutory duty is subject to the provisions of this Act.

Non-Delegable Duties and Vicarious Liability

Recommendation 43

The Proposed Act should embody the following principle:

Liability for breach of a non-delegable duty shall be treated as equivalent in all respects to vicarious liability for the negligence of the person to whom the doing of the relevant work was entrusted by the person held liable for breach of the non-delegable duty.

Proportionate Liability

Recommendation 44

In relation to claims for negligently-caused personal injury and death, the doctrine of solidary liability should be retained and not replaced with a system of proportionate liability.

Damages

Legal costs

Recommendation 45

The Proposed Act should embody the following principles:

- (a) No order that the defendant pay the plaintiff's legal costs may be made in any case where the award of damages is less than \$30,000.
- (b) In any case where the award of damages is between \$30,000 and \$50,000, the plaintiff may recover from the defendant no more than \$2,500 on account of legal costs.

Tariffs for general damages

Recommendation 46

The Proposed Act should embody the following principles:

- (a) In assessing general damages, a court may refer to decisions in earlier cases for the purpose of establishing the appropriate award in the case before it.
- (b) Counsel may bring to the court's attention awards of general damages in such earlier cases.
- (c) The Commonwealth Attorney-General, in consultation with the States and Territories, should appoint or nominate a body to compile, and maintain on a regular basis, a publication along the same lines as the English Judicial Studies Board's Guidelines for the Assessment of General Damages in Personal Injury Cases.

Threshold for general damages

Recommendation 47

The Proposed Act should impose a threshold for general damages based on 15 per cent of a most extreme case.

Cap on general damages

Recommendation 48

- (a) The Proposed Act should provide for a cap on general damages of \$250,000.
- (a) If such a provision is not enacted, each State and Territory should enact legislation providing for a single cap on general damages that will apply to all claims for personal injury and death.

Cap on damages for loss of earning capacity

Recommendation 49

The Proposed Act should provide for a cap on damages for loss of earning capacity of twice average full-time adult ordinary time earnings (FTOTE).

Health care costs

Recommendation 50

The Proposed Act should embody the following principle:

For the purposes of assessing damages for health care costs, the issue of reasonableness should be determined by reference to a benchmark constituted by the use of public hospital facilities, and Medicare scheduled fees (where applicable).

Gratuitous services

Recommendation 51

The Proposed Act should embody the following principles:

- (a) Damages for gratuitous services shall not be recoverable unless such services have been provided or are likely to be provided for more than six hours per week and for more than six consecutive months.
- (b) The maximum hourly rate for calculating damages for gratuitous services shall be one fortieth of average weekly FTOTE.
- (c) The maximum weekly rate for calculating damages for gratuitous services shall be average weekly FTOTE.
- (d) Damages for gratuitous services may be awarded only in respect of services required by the plaintiff as a result of the injuries caused by the negligence of the defendant.

Loss of capacity to care for others

Recommendation 52

The Proposed Act should embody the following principles:

- (a) Damages for loss of capacity to provide gratuitous services for others shall not be recoverable unless, prior to the loss of capacity, such services were being provided for more than six hours per week and had been provided for more than six consecutive months.
- (b) Such damages are recoverable only in relation to services that were being provided to a person who (if the provider had been killed rather than injured) would have been entitled to recover damages for loss of the deceased's services.
- (c) The maximum hourly rate for calculating damages for loss of capacity to provide gratuitous services for others shall be one fortieth of average weekly FTOTE.
- (d) The maximum weekly rate for calculating damages for loss of capacity to provide gratuitous services shall be average weekly FTOTE.

Future economic loss

Recommendation 53

The Proposed Act should embody the following principles:

- (a) The discount rate used in calculating damages awards for future economic loss in cases of personal injury and death is 3 per cent.
- (b) An appropriate regulatory body should have the power to change the discount rate, by regulation, on six months notice.

Interest

Recommendation 54

The Proposed Act should provide that pre-judgment interest may not be awarded on damages for non-economic loss.

Death claims — damages for loss of support

Recommendation 55

The Proposed Act should embody the following principles:

- (a) In calculating damages for loss of financial support any amount by which the deceased's earnings exceeded twice average FTOTE shall be ignored.
- (b) A dependant may not recover damages for the loss of gratuitous services the deceased would have provided unless such services would have been provided for more than six hours per week and for more than six consecutive months.
- (c) The maximum hourly rate for calculating damages for loss of gratuitous services the deceased would have provided is one fortieth of average weekly FTOTE.
- (d) The maximum weekly rate for calculating damages for loss of gratuitous services the deceased would have provided is average weekly FTOTE.
- (e) A dependant shall be entitled to damages for loss only of those gratuitous services that the deceased would have provided to the dependant but for his or her death.

Death claims — contributory negligence

Recommendation 56

The Proposed Act should provide that in a claim by dependants for damages in respect of the death of another as a result of negligence on the part of the defendant, any damages payable to the dependants shall be reduced on account of contributory negligence on the part of the deceased by the same proportion as damages payable in an action by the estate of the deceased person would be reduced.

Structured settlements

Recommendation 57

Rules of court in every jurisdiction should contain a provision to the following effect:

Before judgment is entered in any action for damages for negligently-caused personal injury or death where:

- (a) In a case of personal injury, the award includes damages in respect of future economic loss (including loss of superannuation benefits, loss of gratuitous services and future health-care expenses) that in aggregate exceed \$2 million; or
- (b) In a case of death, the award includes damages for loss of future support and other future economic loss that in aggregate exceed \$2 million, the parties must attend mediation proceedings with a view to securing a structured settlement.

Superannuation contributions

Recommendation 58

The Proposed Act should embody the following principles:

- (a) Damages for loss of employer superannuation contributions should be calculated as a percentage of the damages awarded for loss of earning capacity (subject to the cap on such damages).
- (b) The percentage should be the minimum level of compulsory employers' contributions required under the relevant Commonwealth legislation (the Superannuation Guarantee (Administration) Act 1992 (Cwth)).

Collateral benefits

Recommendation 59

The Proposed Act should embody the following principles:

- (a) In assessing damages in an action under this Act, whether for personal injury or death, all collateral benefits received or to be received by the plaintiff as a result of the injury or death (except charitable benefits and statutory social-security and health-care benefits) should be deducted from those damages on the basis of the like-against-like principle.
- (b) Collateral benefits should be set off against the relevant head of damages before any relevant damages cap is applied.

Exemplary and aggravated damages

Recommendation 60

The Proposed Act should contain a provision abolishing exemplary and aggravated damages.

Indexation

Recommendation 61

The Proposed Act should provide that the fixed monetary amounts referred to Recommendations 45, 48 and 57 should be indexed to the CPI.

Appendix B: Recommendations of the Medical Indemnity Policy Review Panel

Source: Medical Indemnity Policy Review Panel, *Affordable, Secure and Fair: Report to the Prime Minister*, 10 December 2003.

Making premiums affordable

Recommendation 1

The Government provide funding to insurers for a new medical indemnity Premium Support Scheme. The scheme would:

- (a) assist doctors who pay more in total medical indemnity costs than a determined affordability threshold or thresholds;
- (b) replace current subsidy arrangements for doctors;
- (c) ensure that no doctor currently receiving a subsidy receives less support under the new arrangements;
- (d) provide the support to doctors automatically without any application process, with the Government support shown separately on premium notices; and
- (e) come into full operation on 1 July 2004, with transitional arrangements to offer an equivalent level of assistance to insurers for the six months beginning 1 January 2004.

Recommendation 2

As part of the new scheme, insurers be required to:

- (a) have premium income bands for each specialty that have regard to the range of doctors' actual incomes;
- (b) offer cover at a pro rata cost relative to full-year premiums (after allowance for any genuinely fixed costs) to doctors who are seeking cover for periods of time shorter than one year;
- (c) offer cover to any doctor who holds a valid medical registration; and
- (d) provide de-identified claims data to relevant professional colleges for incorporation into educational programs.

Recommendation 3

The High Cost Claims Scheme be extended, to include 50 per cent of all claims above a \$300,000 threshold up to a doctor's limit of insurance, and the Exceptional Claims Scheme retained.

Security through Guaranteed Run-off Cover and Other Measures

Recommendation 4

The Government introduce a guaranteed Run-off Reinsurance Vehicle (RRV) to provide security of cover to doctors who have permanently retired from private medical practice or gone on medical leave.

Recommendation 5

The RRV provide cover for:

- (a) claims against doctors aged 65 or more who have permanently retired from private medical practice, and doctors (irrespective of age) who die, are permanently disabled or go on maternity leave. This cover would have immediate effect; and

(b) claims made three or more years after a doctor (irrespective of age) has left private medical practice.

Recommendation 6

The cost of run-off under the RRV be incorporated into normal annual premiums to ensure that run-off was available free of charge at the time a doctor needed it.

Recommendation 7

In relation to run-off in other circumstances:

- (a) doctors should have access to free cover for up to three years if they meet specified membership qualifying periods; and
- (b) the medical profession and insurers consult on how this may be achieved; and
- (c) the Government should require insurers to offer run-off cover to doctors at cost in all other circumstances.

Addressing Problems with the IBNR Levy

Recommendation 8

The proportion of IBNRs of both UMP and other MDOs that is eligible for the RRV be passed to the RRV, with the balance of the UMP IBNR remaining on the Government's books.

Protecting Patients

Recommendation 9

The Government encourage all State and Territory governments to continue efforts to implement professional standards legislation and schemes for medical professionals which include compulsory insurance, risk management and alternative dispute resolution in return for capped liability, and the Australian Government implement its own legislation to support the schemes.

Recommendation 10

The Government urge the Ministerial Meetings on Insurance to develop a scheme for the long-term care of the catastrophically injured.

Recommendation 11

Professional colleges should continue to develop, implement and appraise appropriate risk management programs to assist in the reduction of claims.

Striking a Balance

Recommendation 12

The Government and the medical representatives on the Panel call on the States and Territories:

- (a) to continue the downward pressure on premium costs by continuing to implement tort law reform conforming to all the recommendations of the Ipp Report in a consistent manner; and
- (b) to examine the option of Medical Assessment Panels to analyse cases on a clinical basis before they become part of the legal process and enable such panels to refer matters to Medical Boards where appropriate.

Keeping the System Stable

Recommendation 13

Medical indemnity insurers continue to be prudentially regulated by the Australian Prudential Regulation Authority to ensure that they hold sufficient reserves and remain viable, providing security for patients and doctors.

Reviewing the Results

Recommendation 14

The Government set up a working party in mid-2005 to:

- (a) evaluate the effectiveness of the new arrangements put in place in 2004; and
- (b) if the current market arrangements have failed to deliver sustainable and affordable cover give detailed consideration to the feasibility, costs and benefits of alternative arrangements, including the option of a single doctor-owned monopoly insurer; and
- (c) consider developments in relation to a long term care scheme, the handling of clinical disputes, and improvements in claims handling.

Implementation

Recommendation 15

The recommendations of this Review, if accepted by Government, should be implemented in consultation with the medical profession, insurers, and other relevant parties.