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**Medical Negligence and
Professional Indemnity
Insurance**

by

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Background Paper No 2/01

ISSN 1325-5142
ISBN 0 7313 16916

May 2001

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GLOSSARY OF TERMS

Adverse outcome	An injury sustained by a patient in the course of receiving medical treatment, which was not a reasonably foreseeable side effect of the treatment.
Call-up	An additional membership payment required by an MDO of its members to ensure that the MDO is fully funded.
Claims incurred cover	The type of indemnity arrangement traditionally used by MDOs. To qualify for assistance doctors must be members of the MDO only at the time an incident occurs. It does not matter that the doctor is not still a member when the claim or incident is reported.
Claims made cover	The type of cover traditionally used by insurers and insurance brokers to cover health professionals and is increasingly being used by MDOs. To qualify for assistance doctors must be members of the MDO <i>both</i> at the time an incident occurs, and when they notify the organisation of it. Notification can occur either as soon as the incident happens, or when it becomes the subject of a patient's claim.
Discretionary cover	The nature of the indemnity cover provided by MDOs. There is no contractual agreement between a member doctor and the MDO. Therefore, there is no guarantee that an indemnity will be paid (although generally it will be). The discretionary cover offered by MDOs distinguishes them from commercial insurers who offer contractually based cover.
Fully funded	A financial state whereby an MDO has sufficient funds to cover all the liabilities of its members.
Incurred but not reported claims (IBNR's)	Indemnity claims which are made later and where potential for the claim is not known at the time the care is given. The aggregate of all the IBNR's is called 'the tail'.
Professional indemnity insurance	Insurance cover which indemnifies the insured against the consequences of a breach of professional duty, particularly professional negligence.
Reinsurance	An arrangement where by a risk carrier (who may operate as an insurer or a provider of discretionary indemnity) buys insurance for part of their risk, usually with a firm specialising in reinsurance.
Run-off cover	A supplementary indemnity arrangement to provide cover into the future for doctors who have been indemnified under claims-made cover and who wish to cease their membership.
Self-insurance	An arrangement where by a body that has a large pool of financial resources under its control, such as a Government, a hospital or medical chain, considers that it has sufficient assets to fund any costs of professional liability from its own resources, without the risk-spreading benefits of insurance, and without becoming insolvent.
Structured settlements	A settlement agreement for a negligence claim whereby compensation is to be paid periodically rather than in a single lump sum.
Visiting Medical Officer	Specialists who see public patients in public hospitals. They may also treat private patients in public hospitals in NSW. VMO's are accorded visiting rights by the hospital, but are not employed by hospital.

ABBREVIATIONS

ADR	Alternative Dispute Resolution
AHMAC	Australian Health Ministers Advisory Council
ALRC	Australian Law Reform Commission
AMA	Australian Medical Association
IBNRs	Incurred But Not Reported Claims
MAA	New South Wales Motor Accident Authority
MDO	Medical Defence Organisation
MIPS	Medical Indemnity Protection Society
NADRAC	National Alternative Dispute Resolution Advisory Council
PIAC	Public Interest Advocacy Centre
PIR	Commonwealth of Australia, Review of Professional Indemnity Arrangements for Health Care Professionals
RACGP	Royal Australian College of General Practitioners
SSG	Structured Settlement Group
United	United Medical Protection (also commonly referred to as UMP).
VPLRC Inquiry	Victorian Parliament Law Reform Committee Inquiry into the Legal Liability of Health Service Providers
VMO	Visiting Medical Officer

EXECUTIVE SUMMARY

The purpose of this paper is to comment on the professional indemnity insurance 'crisis' among doctors in New South Wales and several proposals for reform in this area.

Introduction (page 1)

In the past few months the media has reported a 'crisis' among doctors in New South Wales, caused by the escalating cost of professional indemnity insurance premiums. In late February 2001, the Minister for Health, the Honourable Craig Knowles MP, announced a 'rescue package' of measures designed to create an enduring solution to the problem of escalating medical indemnity insurance premiums. This paper reviews several of the measures contained in the Government's package. It also examines other reform options proposed in the context of this debate.

The issue of professional indemnity insurance premiums and suggestions of reforms to combat the rise in premiums is not new, nor is it particular to New South Wales. From 1991-1995 the Federal Government conducted an extensive review called: *The Review of Professional Indemnity Arrangements for Health Care Professionals*. The Victorian Parliament Law Reform Committee inquired into the legal liability of health care providers in 1996 and 1997. The paper draws on these works.

Adverse outcomes, medical negligence and professional indemnity insurance (page 2 -8)

Injuries sustained during medical treatment are commonly referred to as 'adverse outcomes'. A medical practitioner is liable for adverse outcomes caused by his or her negligence. Professional indemnity insurance is a form of insurance that indemnifies the insured against the consequences of a breach of professional duty, particularly, negligence. Most commonly, doctors take out private professional indemnity cover through membership of an Medical Defence Organisation (MDO). MDOs are discretionary mutual organisations. They operate on a 'not for profit' basis and offer discretionary, rather than contractually defined, cover. Because they provide discretionary cover, MDOs are not subject to the same regulation as commercial insurance providers.

The professional indemnity insurance 'crisis' in New South Wales (pages 8 - 12)

In November 2000, the largest MDO in New South Wales, United Medical Protection (United), made a call-up equal to a full year's premium and announced a general increase in its premiums of 8%. Most of the other Australian MDOs have made call-ups in recent years and there has also been a steady increase in premiums nationwide. The main reasons for the call-ups and increases cited are: an 'explosion' of medical negligence litigation; and the lack of regulation of MDOs. However, there is considerable disagreement about the underlying causes, particularly the nature of the so called litigation 'explosion'.

After United's call-up, it was reported that many doctors, particularly specialists in rural areas, were finding that the viability of their practices were threatened by the rising cost of indemnity insurance. However, without accurate data it is difficult to make a conclusive assessment of the effect of the call-up and general increase in premiums on New South Wales doctors. Some people refute the idea of a crisis altogether. While the precise nature of the cause and effect of the increase in premiums on New South Wales doctors needs clarification, the current situation has

resulted in pressure on the New South Wales Government to make changes to the current scheme for compensating medical treatment. This paper addresses several of these reform options.

Reform proposals (pages 13 - 50)

Mandatory professional indemnity insurance (pages 13 - 19): The New South Wales Government proposes to introduce compulsory professional indemnity insurance for medical practitioners in New South Wales. The most obvious means of implementing this proposal is to amend the *Medical Practice Act 1992* (NSW) to make indemnity insurance a pre-requisite for registration as a medical practitioner in New South Wales.

Mandatory reporting of professional negligence claims (pages 19 - 22): In November 2000, the Parliament of New South Wales Joint Committee on the Health Care Complaints Commission recommended the introduction of mandatory reporting of medical negligence litigation in New South Wales. This recommendation is particularly relevant to the current medical indemnity debate, as the lack of data about medical negligence claims has consistently been raised in discussion of reform in this area.

Changes to court procedures for handling medical negligence cases (pages 22 - 30): The New South Wales Government has proposed two changes to the way medical negligence cases are dealt with by the courts: the introduction of a specialist list for medical negligence in the District Court of New South Wales; and compulsory mediation for medical negligence cases.

Reform of compensation awards for medical negligence (pages 31 - 41): The New South Wales Government's reform package contained a proposal to cap damages for future loss of earnings and general damages. It has also been announced that the Government has recently written to the Federal Government to request that they make changes to Federal tax laws to facilitate the use of structured settlements for compensation for personal injury. There is also speculation that the Government plans to change other aspects of compensation awards: increasing the discount rate of damages for future economic loss; and abolishing exemplary damages.

Alternatives to the common law tort system for compensating adverse outcomes (pages 42 - 45): Analysis of the state of medical negligence litigation and professional indemnity insurance raises the issue of whether there is a better alternative scheme to compensate adverse outcomes than the common law tort system. No-fault compensation schemes have been adopted in the area of workers compensation in all States and Territories in Australia and in for injuries caused by motor vehicle accidents in three Australian States. Many individuals and organisations advocate a no-fault scheme for adverse outcomes for medical treatment, such as exists in New Zealand. The AMA has developed a proposal for a State Medical Services Commission to deal with adverse outcomes of medical treatment.

Good samaritan legislation (pages 45 - 50): The New South Wales Government has announced its intention to implement good samaritan legislation. Good samaritan legislation provides protection from legal liability to medical practitioners who provide assistance in an emergency. There are several related legal issues that contribute to an understanding of good samaritan legislation including: the position of rescuers at common law; medical practitioners and the duty to rescue; a medical practitioners professional responsibility to provide assistance in an emergency.

1. INTRODUCTION

In the last few months the media has reported a ‘crisis’ among doctors in New South Wales caused by the escalating cost of professional indemnity insurance premiums. The situation was triggered by the largest indemnity provider in New South Wales, United Medical Protection (United), announcing a call on its members for extra funding as well as a general increase in premiums. It was subsequently reported that many doctors, particularly specialists, were finding that these increases threatened the financial viability of their practices.

In late February 2001, the Minister for Health, the Honourable Craig Knowles MP, announced a ‘rescue package’ of measures ‘designed to create an enduring solution to the problem of escalating medical indemnity insurance premiums’.¹ A working party is currently formulating a Bill to implement the rescue package. The Bill is expected to be introduced into Parliament in the current session. This paper reviews several of the measures contained in the Government’s package. It also examines other reform options that have been proposed in the course of the debate about the level of professional indemnity premiums for doctors. While some of these options have also been proposed as a means of reducing premiums, others concern perceived problems with the tort based system of dealing with adverse outcomes of medical treatment.

Each of the measures and options are outlined and where appropriate other Australian jurisdictions are examined for comparison. Arguments for and against the proposals are also noted. A brief commentary on the views of the various stakeholders in this issue have been included, where those views have been made publicly available.

Proposals for reform in this area are not new, nor are they particular to New South Wales. The Federal Government conducted an extensive review of professional indemnity arrangements for health care professionals between 1991 and 1995: *The Review of Professional Indemnity Arrangements for Health Care Professionals* (the PIR).² As well as reviewing the system of indemnity arrangements in Australia, the PIR looked at many of the reform options examined in this paper, including: structured settlements; mandatory indemnity insurance; good samaritan legislation; and alternative models for compensating adverse outcomes. The Victorian Parliament Law Reform Committee inquired into the legal liability of health care providers in 1996 and 1997 (the VPLRC Inquiry).³ The reference was given to the Committee due to concern about the increasing cost of professional indemnity insurance. The VPLRC Inquiry examined the issues arising out of court-based compensation for people who have suffered injuries as a result of services provided by a health service provider, covering several of the reform options examined in this paper and by the PIR. This paper draws on the work of the PIR and the VPLRC.

¹ C Knowles MP, Minister for Health, ‘Knowles announces medical indemnity rescue package’, *Media Release*, 27/02/01.

² Commonwealth of Australia, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care, A Final Report*, November 1995.

³ Victoria, Parliament, Law Reform Committee, *Final Report Legal Liability of Health Service Providers*, Victorian Parliament, May 1997.

2. ADVERSE OUTCOMES, MEDICAL NEGLIGENCE AND PROFESSIONAL INDEMNITY INSURANCE

2.1. ADVERSE OUTCOMES

When a patient receives medical treatment, particularly invasive or complex forms of treatment, there is some possibility that she or he may sustain an injury as a result of that treatment. Injuries sustained during medical treatment are commonly referred to as ‘adverse outcomes’. Adverse outcomes do not include reasonably foreseeable side effects of medical treatment.

Some adverse outcomes are caused by unforeseen complications and others are the result of honest and not reckless mistakes. A medical practitioner in these circumstances is not personally liable to compensate the patient. However, some adverse outcomes are caused by a doctor’s negligent, or otherwise unlawful, act. In this case, the practitioner may be personally liable to compensate the patient for these unlawful adverse outcomes. The legal avenues for compensating unlawful adverse outcomes are examined in the following section.

Other avenues of redress for adverse outcomes are found in the complaint handling functions of medical registration bodies in each State and Territory.⁴ Medical Boards have the power to review the conduct of registered medical practitioners. Reviewable conduct may encompass conduct that led to injury to a patient. They have wide disciplinary powers in the event of professional misconduct, including removing practitioners from the register in the most serious of cases. Complaints may also be made about any aspect of treatment received from a health care provider to the statutory health authorities that exist in all States and Territories except South Australia.⁵ While these avenues of redress may lead to a satisfactory result for many people, compensation cannot be sought through these avenues.

2.2. MEDICAL NEGLIGENCE

In order to seek compensation for an adverse outcome from the medical practitioner responsible, a patient may bring an action under several different areas of law, depending on the circumstances. The areas of law are: the tort law of negligence or battery, contract law, consumer protection law or product liability laws. The tort law of negligence is by far the most common method of seeking compensation for adverse outcomes. As it is the most common avenue of redress, and also the subject of most of the reform suggestions examined in this paper, only the tort of negligence will be outlined in this section.⁶

⁴ See the web site at www.nswmb.org.au for information about the New South Wales Medical Board.

⁵ At the time of writing this paper the *Health and Community Services Complaints Bill 2000* (the Bill) was in the South Australian House of Assembly. The Bill establishes a mechanism for making complaints against health or community service providers in South Australia. See the web site at www.hccc.nsw.gov.au for information about the New South Wales Health Care Complaints Commission.

⁶ For information about the other avenues see: Commonwealth of Australia, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care, A Discussion Paper*, February 1992.

Generally, under the tort of negligence, a medical practitioner owes a duty to take reasonable care in all aspects of their dealings with patients. A breach of the duty of care that causes an injury to the patient, renders the practitioner liable for the injury caused. In order to establish that a medical practitioner was negligent, it is necessary to show all of the elements of negligence. In other words, that the doctor owed the patient a duty of care, that the doctor breached that duty, and that the breach resulted in damage and loss, or materially contributed to the damage or loss. The standard of care for medical negligence is that of the ordinary skilled doctor (or specialist) exercising and professing to have the relevant skill.⁷ Whether the conduct of a medical professional meets the standard of care in particular circumstances is to be determined by the court.⁸

In New South Wales, medical negligence cases are generally heard by either the District Court or the Supreme Court. The District Court has the jurisdiction to hear cases where damages claimed are below \$750,000.⁹ While claims of over \$750,000 can be heard in the District Court with the consent of the parties, they are usually heard in the Supreme Court. The courts have the power to compensate a successful plaintiff in the form of an award of damages. The general principle of compensation for negligence at common law is to place the plaintiff, as far as possible, in the position that she or he would have been in if not for the negligence.

Compensation for negligence is assessed on a 'once and for all' basis and awarded in a single lump sum. The lump sum is made up of a number of different components according to the heads of damages. The main heads of damages are described briefly as follows:

<i>Future loss of earnings</i>	Compensation for the earnings the plaintiff would have been able to make in the future if not for the injuries.
<i>Past loss of earning (Past economic loss)</i>	Compensation for the earnings already lost as a result of being unable to work because of injuries.
<i>General damages (Non-economic loss)</i>	Compensation for pain and suffering, loss of enjoyment of life, loss of amenities of life, diminution of life expectancy.
<i>Exemplary (or punitive) damages</i>	Damages awarded (in addition to general damages) as a form of punishment.
<i>Special damages (Out of pocket expenses)</i>	Compensation for cost of medical treatment and related expenses (eg. care, accommodation, modifications) (past and future).
<i>Griffith v Kerkemeyer damages</i>	Compensation for the worth of gratuitous services provided to a plaintiff by friends, family etc (past and future).

⁷ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587 per Mc Nair J.

⁸ *Rodgers v Whitaker* (1992) 175 CLR 479.

⁹ *District Court Act 1973* (NSW), section 44.

2.3. PROFESSIONAL INDEMNITY INSURANCE AND MEDICAL DEFENCE ORGANISATIONS

The indemnity insurance arrangements for health care professionals and health care institutions have been described in a discussion paper prepared by the PIR.¹⁰ The following paragraphs are based on the material in that paper.

A person who suffers an adverse outcome caused by negligence may take proceedings against a medical practitioner (or other health professional) who has been negligent and/or a health care institution if the treatment was given within a health care institution. A health care institution can be sued either because it has been negligent, or because it is vicariously liable for the negligent acts of its employees. Who an injured person should sue will depend on several factors including whether the negligence was caused by a practitioner, or by an institution, the employment status of the medical practitioner, and which of the potential defendants is best able to pay the compensation sought.

Indemnity and insurance arrangements to cover these various forms of liability can be divided into three categories:

- (a) insurance arrangements (either commercial or through self-insurance) which cover a health care institution;
- (b) mutual indemnity arrangements which cover individual health care professionals; and
- (c) commercial insurance arrangements which cover individual health care professionals.

The second category, mutual indemnity arrangements, is the main focus of this paper. The first category is also important to an understanding of the medical indemnity premiums debate. As there are only a small number of medical practitioners who take out commercial insurance arrangements, the third category will not be explored in this paper.

Insurance arrangements which cover health care institutions

Health care institutions falls into two broad categories: public (State and Commonwealth) and private. As outlined above, a health care institution may be liable for its own negligence and it may be vicariously liable for the negligent actions of its employees. The principles of vicarious liability mean, broadly, that an employer can be held liable for the actions of its employees. It is this form of liability that is important to an understanding of the medical indemnity insurance debate, rather a health care institutions liability for its own negligence. Broadly, a doctor who is employed by a hospital is covered by the hospital's insurance, and therefore does not need to take out private indemnity insurance.

¹⁰ Commonwealth of Australia, (Tito F, Chairman, Discussion Paper), n 6, Chapter 3. For a comprehensive review of professional indemnity arrangements in Australia, see also Commonwealth of Australia, Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care, An Interim Report*, February 1994 and, Commonwealth of Australia (Tito F, Chairman, Final Report) n 2. See also, New South Wales Department of Health *Professional Indemnity Insurance for Medical Practitioners, A Discussion Paper*, August 1988, Appendix I, for a discussion of the professional indemnity arrangements of other professionals, including lawyers and accountants.

Most public hospitals are run by State and Territory Governments and each Government has some arrangement for vicarious liability of hospitals and other health care institutions. Some States and Territories have a self-insurance arrangements where the Government indemnifies its hospitals and employees for claims made. Payments are made directly by the Government from consolidated revenue through special appropriations. Other Governments, such as New South Wales, while still acting as a self-insurer, have comparatively sophisticated insurance arrangements.

In New South Wales the Treasury Managed Fund covers all Government instrumentalities including most public hospitals. Insured entities pay annual premiums calculated to reflect the actuarially determined risk incurred. The premiums are credited to an account in a central fund in the institution's name. Surplus interest earned on the amount is paid to the institution. All premiums are paid into a single fund which is managed by GIO Australia. As to coverage, the PIR noted that while the State Managed Fund's arrangements are 'in many ways comprehensive, concern has been expressed about their capacity to provide complete protection in all circumstances. Also, Visiting Medical Officers (VMOs) are not covered by the fund.'¹¹ In other Australian States and Territories, VMOs are indemnified by government insurance for their work in public hospitals.

Private health care institutions must take responsibility for their own indemnity insurance arrangements. There are a variety of indemnity arrangements among private institutions. The PIR noted that:

in private hospitals reliance is likely to be placed upon medical practitioners who treat patients within the hospitals having private professional indemnity insurance. It has been suggested to the review that many private hospitals require proof of cover before employing a doctor or nurse.¹²

Mutual indemnity arrangements - Medical Defence Organisations

While some commercial insurance companies do offer medical professional indemnity insurance, the majority of doctors in Australia take out indemnity cover with MDOs. MDOs are discretionary mutual organisations, meaning that they are owned by their members, operate on a 'not for profit' basis and offer discretionary, rather than contractually defined, cover. Discretionary cover means that the MDO can decide whether or not to indemnify a member for a particular claim. It should be noted that it is reportedly rare that an MDO will refuse to indemnify one of its members.¹³

Due to the discretionary nature of the cover provided by MDOs, they are not considered to offer insurance contracts, and consequently do not come under the regulation of the *Insurance Act 1973* (Cth). This in turn means that they are not monitored by the industry

¹¹ *ibid*, p 28.

¹² *ibid* p 29.

¹³ Commonwealth of Australia (Tito F, Cairman, Final Report) n 2, p 225.

regulator, the Australian Prudential Regulation Authority (APRA),¹⁴ as ordinary insurance companies are. As discussed in section 3.2 of this paper, this lack of regulation has been cited as one of the reasons for the rise in indemnity insurance premiums and the need for MDOs to make call-ups.

As well as indemnity protection, MDOs provide other services to their members such as legal advice and advice about medical practice. As representative organisations they also play a role as lobbyists for their members interests. Doctors can shop around within the State or Territory in which they practice, or elsewhere in Australia, for their indemnity cover. However, it is common that a doctor will take out indemnity cover with a MDO who operates in the State or Territory that they live in.

United, New South Wales's largest indemnity provider, insures over 90% of New South Wales doctors.¹⁵ It has a membership of more than 42,000 members Australia wide, over 36,000 of whom are in active practice. United estimates that its membership includes around 70% of the practising medical professionals across Australia.¹⁶ The two other MDO's that currently operate in New South Wales are the Medical Protection Indemnity Society (MIPS),¹⁷ and MDA National.¹⁸ Commercial insurers offering professional indemnity insurance to doctors in New South Wales include St Paul's¹⁹ and Macquarie Underwriting.

Type of cover provided by MDOs: MDOs traditionally offered 'claims incurred cover'. Under claims incurred cover a doctor is indemnified against a claim that relates to an incident that occurred *while* they were financial members of the MDO, *regardless* of whether they are still members when the claim or incident is reported. Therefore, claims made long after the incident and long after the doctor ceased to be a member, are still covered by the MDO. Incidents that have occurred, but have not had a claim made in relation to them are called 'incurred but not reported claims' (IBNR). Claims incurred cover is the type of cover offered for third party motor vehicle personal injury insurance.

In the past decade, MDOs have also begun to offer 'claims made cover'. Under this type of cover doctors must be members of the MDO *both* at the time an incident occurs, and when they notify the MDO of it – which could be either as soon as the incident happens, or when it becomes the subject of a patient's claim. If a doctor ceases to be a member of the MDO, she or he will have to take out *run-off* cover to ensure that they are covered for incidents that are

¹⁴ See the web site at www.apra.gov.au for information about APRA.

¹⁵ This information is contained on United's web site: www.ump.com.au Note however, that it is has recently been reported that at least 800 doctors have left United since the call up: 'United threat to *Australian Doctor*, 23/02/01, p 5.

¹⁶ See the web site at www.ump.com.au for further information about United Medical Protection.

¹⁷ See the web site at www.mips.com.au for information about the Medical Protection Indemnity Society.

¹⁸ See the web site at www.mdanational.com.au for information about MDA National.

¹⁹ St Paul's is a U.S based company. It is reported to be the world's largest provider of medical indemnity insurance: 'Indemnity Giant joins the fray', *Australian Doctor*, 15/12/00, p 3.

reported after they cease to be a member. This cover usually costs extra but is often provided free by some providers in certain circumstances eg, on retirement after 15 years membership of the fund. This type of cover is also the type of cover offered by commercial insurers.

Calculation of premiums: Professional indemnity insurance premiums are calculated by in-house actuaries who take into account many factors, including the legal cost of defending medical negligence claims, levels of compensation awarded by the courts for medical negligence, and IBNRs. A doctor's area of practice, and the relative risks of each area, are also taken into account when calculating premiums. For example, GPs are levied lower premiums than specialists, and the riskier the specialty the higher premiums.

A brief history of MDOs in Australia: The following extract contains a brief history of MDOs in Australia. It is taken from the ACT Government's *Medical Indemnity Cover Proposal* (see section 3.3 of this paper for a discussion of the proposal). The extract also helps to explain the build up to the current professional indemnity insurance 'crisis':

Up until the 1960's the frequency of litigation against doctors was very small – perhaps only one or two cases a year throughout all of Australia. With other changes in society, the frequency of litigation has risen considerably. The size of damages claims also increased. For a long time, MDO premiums didn't rise significantly. Because they weren't insurance companies, they weren't covered by the prudential requirements of the Insurance and Superannuation Commissioner. These were put in place to ensure that insurance company premiums were sufficient to meet the liabilities they had incurred, so that if they stopped trading, the claims of their customers up to that date would be able to be paid.

The MDO industry was not (and is still not) subject to this financial discipline. While they offered cover on a 'claims incurred' basis, they collected their contributions almost on a 'pay-as-you-go' basis. This meant that they collected enough each year to pay out claims they had to pay that year with an amount for their administration and costs. Crunch point came at the end of the 1980's, when two organisations had to make calls on their members to meet claims costs.

MDO premiums began to rise, and the cross-subsidisation across all doctors started to reduce, with individual speciality rating coming in the early 1990's. However, competition for members between the MDOs meant that the underfunding question was not fully addressed. The Commonwealth's Professional Indemnity Review took a close look at the MDO industry and in 1994, its actuaries estimated that the industry had unfunded liabilities of about \$250M.

From the mid 1990's, the industry went through a period of considerable change, with two large U.K. based MDOs moving out of Australia, the aggregation of a number of smaller MDOs and the movement into the market of a number of commercial insurers. While the industry was now aware of many of its problems, action on unfunded IBNRs took some time to happen, due to the competitive nature of the industry and concerns about loss of market share.

MDOs have acted in various ways to address this problem: by increasing their premiums, by changing the nature of the cover they provide to 'claims-made' and keeping premiums at the 'claims-incurred' level and by making calls on their members. Insurers and the other MDOs have opted to provide 'claims-made' cover, which means premiums are collected to cover claims which become known in that year, either because the incident was reported by the doctors or because a claim was lodged. Many MDOs set out publicly a planned approach to addressing their shortfalls and have or are in the process of trading out of their situation. To inform their members better, most MDOs except UMP now disclose their estimated IBNR liabilities on their accounts as well as the provisions made for them.²⁰

²⁰ Australian Capital Territory, *The ACT Government's Medical Indemnity Cover Proposal – An Outline, Next Steps*, January 2001, p 2-3.

3. THE PROFESSIONAL INDEMNITY INSURANCE ‘CRISIS’ IN NEW SOUTH WALES

3.1. INCREASES IN PREMIUMS AND THE CALL-UP

In November 2000, United made a call-up equal to a full year’s premium, to be paid either up front or over 5 years. A ‘call-up’ refers to a requirement by an MDO that its members pay an additional membership or premium payment. United stated that it was forced to make the call up in order to ensure that it was fully-funded. Being fully funded is a financial state whereby an MDO has sufficient funds to cover all the liabilities of its members. The call-up surprised many United members as it came only months after United stated that it had no plans for a call-up.²¹ The amount of the call up for a United member depends on the type of medicine they practice. The amount is considerably more for specialists than for GPs, as the risk of liability for specialists is greater. The following are the amounts that United’s New South Wales members are required to pay:²²

General practice, non-procedural :	\$ 2, 837
General practice, procedural:	\$ 6, 946
General physician, private practice:	\$ 5, 968
General surgeon, private practice:	\$ 27, 588
Obstetrics & gynaecology, private practice:	\$ 51, 041

Other Australian MDOs have made call-ups in recent years. For example, the two Victorian MDOs, the Medical Indemnity Protection Society (MIPS) and the Medical Defence Association of Victoria (MDAV), issued calls late in 1999. A few months later, the Medical Defence Association of SA (MDASA) also issued a call-up.²³

At the time of the call-up, United also announced a general increase in its premiums of 8%. There has also been a steady increase in premiums nationwide – estimates by the AMA range between 15 to 25 % per year.²⁴ A table of Australian MDO’s and their premiums for 2001 is contained in APPENDIX I.

There is no consensus about the underlying cause of the increases in premiums generally, and the need, in the last few years, for MDOs to make call-ups. Several reasons have been suggested, and there is difference of opinion among stakeholders. Two of the main reasons suggested are, first, an ‘explosion’ of medical negligence litigation, and second, the lack of regulation of MDOs.

²¹ Cresswell A, ‘Answering the Call’, *Australian Doctor*, 15/12/00, p 29.

²² Cresswell A, ‘United asks members for extra year’s fees’, *Australian Doctor*, 1/12/00, p 3.

²³ *ibid.*

²⁴ ‘Insurance is ruining us, warn doctors’, *The Australian*, 4/12/00, p 6.

Litigation explosion: Increases in litigation in this area, and the award of a few extremely large amounts of compensation by courts in recent times, have been cited as a significant reason for the increase in medical indemnity insurance premiums.²⁵ United's Chairman states that: 'data from major medical indemnity organisation confirm that the incidence of malpractice civil suits issued against doctors have doubled in the past 5 years, while significant components of awards for damages in the two largest Australian states, New South Wales and Victoria, have doubled in a matter of three years.'²⁶

However, the claim of a litigation 'explosion' has been challenged by others. For example, in 1997 the VPLRC Inquiry concluded that 'a number of high profile cases, particularly in NSW, has led to a widespread belief that there is a crisis in medical negligence litigation when, in fact, there is not. The Committee's view is that there is no real crisis in the level of insurance premiums that is impacting on service delivery.'²⁷ The PIR similarly concluded that Australia is not facing a litigation crisis in health care, and that it is important to dispel some of the myths which surround this area of the law. In this respect, the PIR found that:

There appears to be fewer than 2000 tort claims commenced each year where health care negligence is alleged, and many of these never result in any payment of damages. Only a handful of cases where liability is disputed go to court each year and the majority of these appear to be won by the health professional. Most cases involve small payments, with a few resulting in payments over \$500,000.²⁸

The diversity of views about the extent of the increase in medical negligence litigation reflects is indicative of the lack of publicly available data about the frequency of medical negligence claims and associated aspects of claims, such as levels of awards of damages. This issue is discussed in section 4.2 of this paper.

Lack of regulation and financial transparency of MDOs: As noted in section 2.3 of this paper, MDOs are not required to comply with the *Insurance Act 1973* (Cth), and are not subject to monitoring by the Australian Prudential Authority. Some stakeholders argue that it is this lack of regulation of the financial affairs of MDOs that is the prevailing reason for the increase in premiums and the need for call-ups in recent years. For example, the Australian Plaintiff Lawyers Association (APLA) suggests that the accountability of MDOs is the largest contributor to the current level of indemnity premiums. APLA highlights several aspects of this lack of accountability including: that claims liabilities are not stated in the balance sheets of their accounts; that MDOs tend to use cash rather than accrual accounting practices; and the lack of accountability of management of corporate affairs.²⁹

²⁵ Skene L *Law and Medical Practice: Rights Duties, Claims and Defences* (1998), Butterworths, p 1.

²⁶ Tjong, R, Chairman of the Board, United Medical Protection, *Position Paper - Medical Indemnity Reform*. See the web site at www.ump.com.au/800/Tort/position.htm to view this paper.

²⁷ Victoria, Parliament, n 3, p xviii.

²⁸ Commonwealth of Australia (Tito F, Cairman, Final Report) n 2, p xvi. See also Skene, n 25, pp 16-20.

²⁹ Cashman P, 'A Plaintiff Lawyers Perspective on the Medical Indemnity Crisis', paper presented at the Australian Orthopaedic Association Conference on the Rise and Rise of Medical Indemnity

Accounting for IBNR's: One particular aspect of the financial arrangements of MDOs that is said to have contributed to the call-ups and increases in premiums is accounting for IBNRs. The issue is explained by Janine Mace as follows:

As IBNRs are potential negligence actions not yet subject to a claims but expected to become one, there is considerable disagreement over whether they should be included in an MDO's account.....All the major MDOs except United and the Medical Defence Association of South Australia (MDSA) have started bringing their IBNR liabilities to account in their financial statements in recent years. This is significant because typical estimates are that IBNRs represent 70-80% of known liabilities, making it a very expensive exercise to include provisions for them. According to industry insiders, this move is behind the current bout of member calls, as MDOs struggle to fill the massive balance-sheet hole created by the inclusion of their IBNRs.³⁰

3.2. EFFECT OF THE INCREASE IN PREMIUMS – A CRISIS?

United's call-up and the general increase in premiums sparked a very strong response from doctors and medical organisations in New South Wales. It was widely reported that many doctors, particularly private specialists in rural areas, were finding that the viability of their practices were threatened by the rising cost of indemnity insurance. For example, doctors working in small rural areas, who provided obstetric services to only a handful of patients, were reported to be finding the indemnity cost of their obstetrics services prohibitive, as they did not make enough money from their few patients to cover their indemnity burden.³¹

In one instance, specialists working as VMOs in the Shoalhaven and Wollongong public hospitals threatened to resign because they could not recoup the cost of premiums from their public patients.³² As outlined in section 2.3, in New South Wales, VMOs are generally not covered by the Treasury Managed Fund and therefore must take out their own private indemnity insurance for their work in public hospitals. The situation was resolved when the Government agreed it would carry their insurance liability for their work in public hospitals.³³

Uncertainty about the scope of protection that the State Government's Treasury Managed Fund (discussed above in section 2.3) provides to individual doctors working in public hospital has also arisen in the current debate. For example, Dr Keith Hollebhone, an Obstetrician and executive member of the AMA has stated: 'Over the past year I have become increasingly concerned about the nature of this cover...I have seen no policy

Costs, Sydney 10-11 March 2001, p 6.

³⁰ 'Making sense of the MDO market', *Australian Doctor*, 23/02/2001, p 44.

³¹ 'More rural towns left with no obstetric service', *Australian Doctor*, 23/02/01, p 17.

³² 'Doctors and Indemnity', *The Sydney Morning Herald*, 20/01/01, p 40.

³³ 'IAHS deal settles indemnity dispute', *Illawarra Mercury*, 14/02/01, p 3 and 'Rescue plan on the bill', *Illawarra Mercury*, 1/03.01, p 7.

document, I have no idea of the extent of the cover that I am entitled to through this fund or if I am covered for incidents that happened before I retire.’³⁴

There are also indications that the cost of indemnity premiums are effecting the choices of future doctors. For example, a survey of trainees and graduates from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists revealed that the cost of premiums were effecting their decisions about whether to go into specialist areas of practice.³⁵ The survey showed that 24% of respondents had decided not to go on to practice obstetrics, and 23 % indicated that they would choose a public hospital obstetric practice where generally the cost of indemnity is covered by Health Departments.³⁶ The respondents cited the cost of premiums as one of the major reasons for their choices, along with lifestyle considerations and the risk of litigation.

It is difficult to make a conclusive assessment of the effect of the call-up and general increase in premiums on New South Wales doctors. In the two months after United’s announcement there were a great many media reports of a ‘crisis’. However, after the initial furore, the threats of resignations and claims of unreasonable indemnity burdens have subsided. As this coincides with the Government’s announcement of its rescue package, it is difficult to ascertain whether the ‘crisis’ was the result of initial reactions and media attention or whether it remains a real threat to the viability of medical practice in New South Wales. Also, some people refute the idea of a crisis altogether. For example, Merrilyn Walton, Associate Professor of Ethical Practice, Faculty of Medicine, University of Melbourne, argues that there is only anecdotal evidence that rising insurance premiums are causing specialists to leave their field.³⁷

Pressure for reform

While the precise nature of the cause and effect of the increase in premiums on New South Wales doctors needs clarification, the current situation has lead to individuals and organisations requesting the New South Wales Government to make changes to the current scheme for compensating personal injuries arising out of medical treatment. The New South Government has responded with a package of reforms designed to reduce the level of premiums. The focus of the package is on tort law reform, with other measures relating to good samaritan legislation, mandatory reporting of medical negligence and compulsory indemnity insurance. The Government’s measures, as well as other reform options that have been raised, will be examined in the following sections.

³⁴ ‘The high cost of trying to serve’, *The Daily Telegraph*, 19/01/01, p 26.

³⁵ 128 trainees and ‘recently elevated fellows’ were surveyed with a 90% response rate: Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Potential for shortage of specialist obstetricians in Australia, *Media Release*, 23/02/01.

³⁶ *ibid.*

³⁷ ‘Indemnity problem may be a case of poor diagnosis’, *The Sydney Morning Herald*, 23/01/01, p 12. See also ‘Figures debunk doctor exodus’, *The Australian*, 6/12/00, p 3.

There have also been developments in relation to medical negligence and professional indemnity insurance premiums in other jurisdictions. For example, The Australian Health Ministers Advisory Council (AHMAC) is currently considering the issue of the rising costs of professional indemnity insurance for doctors. The AHMAC is a forum for State and Federal Health Ministers. A paper prepared by ACT Health on medical indemnity reform was presented to the AHMAC in late February. The AHMAC was due to meet to consider the paper in late March.³⁸ At the date of writing (April 2001) there was no publicly available information about the progress of this issue.

Other developments include a decision by the ACT Government to develop a scheme to assist VMO's in ACT hospitals to obtain adequate indemnity cover at a reduced premium. The proposal is described as follows:

The Medical Indemnity Cover Proposal is based on using the combined purchasing power of ACT specialist doctors and the Government to get a better overall deal for ACT specialists. Specialists will pay the Government in a manner yet to be agreed, their indemnity premium at the level they paid for 2000/20001 and the premium will be used to arrange a two part program:

- The ACT Public Practice Scheme, which will cover all ACT public work;
- The Specialists Private Practice Arrangements, which will cover all private practice in the ACT and any practice outside the ACT.

The ACT Public Practice Scheme will be administered through the ACT Treasury. The Specialists Private Practice Arrangements will be put out to tender, with the tenderer being selected by a Tender Panel including doctor representatives and the Government's independent Risk Management Consultant (Mr Rex Spinley of Marsh Risk Consulting).

The tender will seek to have the cost of private cover fixed for 3 years, unless a doctor has a poor claims experience, when premiums could be adjusted in that period. Part of the premium will be used to fund the Private Specialists Private Practice arrangements with a cover provider being sought by tender. The remaining premium will contribute to the costs of the ACT Public Practice Scheme.³⁹

³⁸ 'Tort Reform', *Australian Medicine*, 5/03/01, p 3.

³⁹ Australian Capital Territory, n 20, p 4.

4. REFORM PROPOSALS

4.1. MANDATORY PROFESSIONAL INDEMNITY INSURANCE

The New South Wales Government's reform package to combat the rise in professional indemnity insurance premiums includes a proposal to introduce compulsory professional indemnity insurance for doctors.⁴⁰ Currently, doctors in New South Wales are not obliged to hold professional indemnity insurance and there is anecdotal evidence to suggest that some doctors are 'going bare', ie practising without medical indemnity insurance. For example, former New South Wales Health Care Complaints Commissioner, Merrilyn Walton has recently stated: 'during my time as NSW Health Care Complaints Commissioner, a number of doctors facing disciplinary proceedings were found to be without cover'.⁴¹ The actual number of doctors 'going bare' is uncertain as there is no data available. However, further anecdotal evidence suggests that only a very small minority of doctors are uninsured.⁴²

There are two main public policy arguments for making professional indemnity insurance mandatory, although these have little to do with reducing premiums. The first is that it will ensure that a plaintiff will always be able to identify a viable party to seek compensation from for a medical negligence claim. A plaintiff who sues a practitioner without indemnity insurance will only be able to recover money from the personal assets of the practitioner, which may not be sufficient compensation. The second argument is that liability for negligence should be borne by the party responsible (the doctor and ultimately the insurer) and not the public purse. In this respect it is argued that the social security system should not have to be resorted to by a plaintiff who cannot recover sufficient money from a doctor to take care of their needs. Arguments against this proposal generally relate to the manner in which it may be introduced. These will be examined below.

The New South Wales Department of Health, in its 1998 review of the *Medical Practice Act*, considered the issue of compulsory professional indemnity insurance. In its report, the Department indicated that it had received several submissions supporting the public benefits of such a proposal, in that consumers would be able to obtain compensation for injury caused by a practitioner. The report states that the Department of Health is 'currently considering in conjunction with the Attorney-General's Department a range of issues concerning health

⁴⁰ C Knowles MP, n 1.

⁴¹ *The Sydney Morning Herald*, n 37, p 12. See also, Commonwealth of Australia (Tito F, Chairman, Final Report) n 2, p 231, para 9.45.

⁴² South Australia, Department of Human Services, 'Legislation Review - *Medical Practitioners Act 1983*, Report of the Review Panel', March 1999, Competition Policy Review Team, p 28-9.

⁴³ *Final Report of the Review of the Medical Practice Act 1992 – December 1998*, New South Wales Health, p 86.

Implementing a requirement for compulsory professional indemnity insurance

One means of implementing this proposal is to amend the *Medical Practice Act 1992* (NSW) to make indemnity insurance a pre-requisite for registration as a medical practitioner in New South Wales. Another method of implementation would be to introduce State legislation making it an offence to provide health care services without holding indemnity insurance.⁴⁴

Linking compulsory insurance to registration is the method adopted in Victoria and South Australia (see below) and seems to be widely accepted as the most suitable method. For example, the PIR and the VPLRC Inquiry which both considered the issue of compulsory professional indemnity insurance recommended that it should be introduced as a condition of registration to practice.⁴⁵

Those who disagree with this method of implementation argue that it potentially gives power to indemnity providers to decide who can practice as a doctor in New South Wales.⁴⁶ They foresee that a doctor who provides a high risk service, or who has faced several negligence claims (termed a 'frequent flyer'), may not be able to find a provider who will insure them, and subsequently may be prevented from registering and practicing. This may threaten the role of the Medical Board to regulate the behaviour of practitioners and decide who can practice.

One way to resolve this problem is to confer upon the Board a *discretionary* power to require indemnity insurance as a pre-requisite of registration (as in Victoria), or to otherwise allow the Board to make an exception to the general requirement that practitioner be insured. With a discretionary power, the Board could examine cases on their merits, and thus taking the decision making power out of the hands of the indemnity provider. If the discretion were to be exercised only in exceptional circumstances, it would not unduly compromise the compulsory nature of the requirement.

Another way to resolve this problem was described by the PIR:

One option for linking the two mechanisms to ensure the primacy of the registration boards in determining who should practise health care would be to require all insurers to provide cover at a fair price if a health professional was registered, but to allow the insurer to set the price, having due regard to the practitioner's risk history. If the premium were considered unfair by the practitioner (compared to his or her peers), then they could appeal to the registration board to investigate the premium charged.⁴⁷

This approach changes the role of the Medical Board to one that involves an element of regulating MDOs and commercial medical indemnity insurers.

⁴⁴ Commonwealth of Australia (Tito F, Chairman, Final Report) n 2, p 234.

⁴⁵ *ibid*, recommendation 128, p 232.

⁴⁶ Victoria, Parliament, n 3, p 42, para 2.120.

⁴⁷ Commonwealth of Australia (Tito F, Chairman, Final Report) n 2, p 234.

What type of indemnity insurance should be required?

Several aspects of indemnity cover that should be addressed in relation to this proposal are outlined briefly in the following paragraphs.

Discretionary cover and/or contractually defined cover: As the cover provided by MDOs is discretionary, there is no guarantee that a doctor will be indemnified when a claim is made. While it is reportedly rare for an MDO to refuse to indemnify a member, the possibility that an MDO may refuse would undermine the compulsory nature of this requirement. Consideration needs to be given to whether discretionary cover, such as that offered by commercial insurers, is satisfactory or whether contractually defined cover should be required. A requirement that doctors have contractually defined insurance would lead to substantial change to the professional indemnity market. As noted by the PIR, if MDOs offered contractually defined insurance (and they would have to in order to stay in the market if this scheme were introduced), it would 'redefine the MDOs as insurers, requiring licensing under the Insurance Act 1973, and bringing them under the supervision of the Insurance and Superannuation Commission.'⁴⁸

Claims made or claims incurred cover: These two types of cover are explained in section 2.3 of this paper. A requirement for compulsory indemnity insurance should specify which type of cover is required, or whether either is acceptable. The PIR recommended that professional indemnity insurance for all health professionals should be required to be on a claims made basis because claims incurred cover provided most certainty of cover.⁴⁹

Other issues that should be considered include: Whether State Government insurance covering doctors employed in public hospitals is sufficient; whether retrospective cover for those that are not presently covered will be required; and what evidence is required to satisfy the Board that a practitioner has cover.

What level of indemnity is required?

Another issue is whether the level of indemnity that is required should be unlimited, or capped? This question was addressed by the PIR which made reference to the two main opposing arguments. It stated, on one hand, '...the imposition of caps on cover serves to shift costs onto the Government sector and onto injured people and their families, since often the effort of seeking recovery from an individual health professional or institution beyond the cap may be considered too difficult or expensive. Not only do caps leave health professionals financially vulnerable, they also shift the costs away from the negligence system.'⁵⁰ On the other hand, insurers argued that caps are a necessary means of ensuring adequate funding of their liabilities. The PIR concluded that it did not accept that the arguments for capping outweighed the arguments against capping.⁵¹

⁴⁸ *ibid*, p 233.

⁴⁹ *ibid*, p 238.

⁵⁰ *ibid*, p 237.

⁵¹ *ibid*, n 2, recommendation 136, p 237. The issue was also addressed by the VPLRC Inquiry which recommended that the level of cover would have to be specified by the appropriate registration

Who should be required to have compulsory professional indemnity insurance?

A further issue to be clarified if compulsory professional insurance was made a requirement for registration, is whether practitioners who want to remain registered, but who are not currently practicing, should be required to be indemnified.⁵² This includes doctors who take time off to teach or study. Most doctors who do take time off, but who are not retiring, maintain their registration.

On a more general note, while the Government's proposal only relates to doctors, there appears to be some consensus in past inquiries in this area that any move to make indemnity insurance compulsory should also apply to other health service providers. For example, the VPLRC Inquiry and the PIR examined whether the requirement should be applied to all health care professionals, and concluded that it should.⁵³

Other Australian Jurisdictions

Victoria and South Australia are the only Australian jurisdictions to have introduced steps to make professional indemnity insurance compulsory, although as described below, neither States has implemented the scheme fully.

South Australia: Section 69(1) of the *Medical Practitioners Act 1983* (SA) (the *Act*) states:

- (1) A medical practitioner *shall not* practice medicine unless-
- (a) an agreement subsists between him and a person approved of by the Board; and
 - (b) the Board is satisfied that, by virtue of that agreement, the medical practitioner will be compensated to the extent required by the Board in the event that he suffers loss by reason of civil liability incurred by him in his practice of medicine. Penalty: Five thousand dollars.⁵⁴

However, while the rest of the *Act* came into effect in 1983, section 69 was suspended⁵⁵ and has not yet been proclaimed. The Medical Board of South Australia has advised that they do not currently require medical practitioners to hold professional indemnity insurance. The *Act* was review in March 1999 by the Competition Policy Review Team, as part of the National

board, in consultation with relevant professional associations: Victoria, Parliament, n 3, recommendation 5, p 46.

⁵² Victoria, Parliament, n 3, p 42, para 2.121 (submission made by The National Association of Specialist Obstetricians and Gynaecologists (Victorian Branch) and the Royal Australian College of Obstetricians and Gynaecologists (Victorian State Branch)).

⁵³ Commonwealth of Australia (Tito F, Chairman, Final Report) n 2, recommendation 135, p 237 and Victoria, Parliament, n 3, recommendation 5, p 46.

⁵⁴ Section 69(2) gives the Board the power to exempt a medical practitioner from the requirements of section 69(1).

⁵⁵ *The South Australian Government Gazette*, 11/08/83, p 326.

Competition Policy.⁵⁶ The Review Panel recommended that section 69 be proclaimed.⁵⁷ The Report stated that: ‘there is public benefit in ensuring registered persons are adequately insured to cover any liabilities incurred by them against a member of the public.’ The report also states:

Anti-competitive costs would only arise from this Section if the cost of the insurance deterred potential registered persons from practising and thereby significantly reduced the number of medical practitioners or clinical medical technicians entering the medical profession.....There was no evidence provided in the submissions to indicate that making this requirement [compulsory indemnity insurance] would deter a person from entering the market.⁵⁸

Victoria: Amendments to the *Medical Practice Act 1994* (Vic) in 2000 gave the Medical Practitioners Board of Victoria (the Board) the power to develop voluntary codes of practice for the guidance of practitioners, and guidelines for the minimum terms and conditions required for professional indemnity insurance for practitioners. A new section 5(3)(d) was also inserted into the Act which states that, in relation to an application for registration as a medical practitioner, the Board:

may require the applicant to provide evidence that the applicant will, at the time of commencing to practice medicine, be covered by professional indemnity insurance that meets the minimum terms and conditions set out in the guidelines of the Board [emphasis added].⁵⁹

These amendments followed the recommendation of the VPLRC Inquiry to legislate to require health service providers to obtain compulsory professional indemnity insurance.⁶⁰ The Committee recommended that:

Statutorily recognised health service providers should be required to obtain compulsory professional indemnity insurance cover with respect to privately funded patients, in order to become and remain registered. The minimum cover should be specified by the appropriate registration board, in consultation with

⁵⁶ The review is conducted in compliance with an obligation upon the South Australian Government under clause 5 of the Competition Policy Principles Agreement. The Competition Principles Agreement is one of three agreements signed by the Commonwealth, State and Territory Governments in April 1995. These agreements give effect to the National Competition Policy: see South Australia, n 38.

⁵⁷ *ibid*, p 29.

⁵⁸ *ibid*, p 28-9.

⁵⁹ See also, *Medical Practice Act 1994* (Vic) section 7(3A) regarding general registration, and section 8(2A) regarding special registration.

⁶⁰ Victoria, Parliament, n 3, recommendation 5, p 46. *Response to the Final Report of the Law Reform Committee of Parliament of Victoria Legal Liability of Health Service Providers*, Victoria 1997, p 2.

relevant professional associations. Run-off cover should be provided for those who are currently insured on a different basis to the mandatory requirement.⁶¹

Professional indemnity insurance is defined in the Act to include ‘insurance against civil liability in connection with the practice of medicine and an agreement or arrangement for discretionary indemnity in respect of that liability.’⁶² The Board has advised that it is yet to formulate guidelines in relation to professional indemnity insurance. Therefore, it remains to be seen how the Board will exercise the discretion conferred upon it by section 5(3)(d).

Queensland: The Queensland Department of Health reviewed the Queensland medical and health practitioner registration acts in 1996. In its draft policy paper the Department addressed the issue of mandatory professional indemnity insurance. It recommended that professional indemnity insurance not be made a requirement of registration of health practitioners at that time, but that Queensland should participate in national discussions on the matter.⁶³

Stakeholder views

United’s position is that insurance cover should be mandatory for all health care providers.⁶⁴ Other stakeholders who support of the proposal are APLA⁶⁵ and the PIAC.⁶⁶

The New South Wales Branch of the AMA has recently stated that it is ‘vigorously opposed to any move toward compulsory medical indemnity insurance for all doctors.’⁶⁷ The AMA President has also expressed concern that making indemnity compulsory would ‘grant indemnity insurers greater power than the NSW Medical Board to disqualify doctors’.⁶⁸

Arguments for and against compulsory professional indemnity insurance for doctors

Arguments for compulsory professional indemnity insurance for doctors can be summarised as follows:

⁶¹ Victoria, Parliament, n 3, recommendation 5, p 46.

⁶² *Medical Practice Act 1994 (Vic)*, section 3.

⁶³ Note in formulating this recommendation the paper made reference to the PIR recommendation concerning mandatory indemnity insurance and particularly the recommendation that this matter be considered on a national basis by the AHMAC: Queensland Health, *Review of Medical and Health practitioner Registration Acts – Draft Policy Paper*, September 1996, p 68.

⁶⁴ Tjong R, n 26.

⁶⁵ Cashman P, n 29, p 1.

⁶⁶ Cornwall, A, ‘Whose rescue package?’, paper presented at the Patient Perspective’s on Medical Error Forum, 7 March 2001.

⁶⁷ AMA (NSW), ‘Tort Law Reform – A First Step in the Right Direction’, *Media Release*, 27/02/01.

⁶⁸ ‘Indemnity Costs down \$1400’, *Australian Doctor*, 9/03/01.

- It will inject more funds into MDO's which will contribute to reducing premiums;
- It will ensure that a plaintiff will be able to identify a viable party to seek compensation from; and
- Liability for the negligence will be borne by the person responsible for the injury ie the doctor (though the doctor's MDO), and not by the public.

Arguments against compulsory professional indemnity insurance for doctors can be summarised as follows:

- Unless a discretion is conferred upon the Medical Board to decide the consequences of a doctor's failure to acquire professional indemnity insurance, it potentially gives power to indemnity providers to decide who can practice as a doctor; and
- The effect that this measure is likely to have on lowering premiums is minimal as there are not many doctors currently uninsured. In any case, whether the amount actually reduces premiums overall depends on how the MDOs use the funds.

4.2. MANDATORY REPORTING OF MEDICAL NEGLIGENCE CLAIMS

The Parliament of New South Wales Joint Committee on the Health Care Complaints Commission (the Committee) has recently recommended that 'in the public interest, mandatory reporting of medical negligence litigation be introduced into New South Wales.'⁶⁹ This recommendation is particularly relevant to the current medical indemnity debate, as the lack of data about medical negligence claims has consistently been raised in discussion of reform in this area. It is apparent that information about the number of medical negligence claims, the level of awards of compensation, the nature of settlements agreements and other aspects of medical negligence would contribute greatly to an informed understanding of the issues in this area. In particular, it would assist in understanding the nature of the so-called medical negligence explosion, the need for reform in this area and the likely effects of the reform options discussed in this paper.

In November 2000, the Committee issued a report titled 'Report on Mandatory Reporting of Medical Negligence.' The Report examines the need for mandatory reporting of medical negligence in New South Wales. It highlighted the problem by noting that the Health Care Complaints Commission is unable to fulfil a statutory requirement to investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care practitioners because of the lack of information.⁷⁰

The Committee argues that the mandatory disclosure of certain information about medical negligence claims is a means of gathering information about 'consumer unhappiness with the health system and where and why adverse events occur and to feed it back into the system in a meaningful way'.⁷¹ According to the Committee this then allows for providers, practitioners

⁶⁹ *ibid*, p12.

⁷⁰ NSW, Parliament, Joint Committee on the Health Care Complaints Commission, *Report on Mandatory Reporting of Medical Negligence* (J Hunter MP Chairman), 2000, p 10.

⁷¹ *ibid*, p 8.

and regulatory authorities to understand where the real problems are located and attempt to address them.⁷² The Report also identified arguments against the mandatory reporting. These arguments focus on the privacy rights of doctors and the difficulties in obtaining accurate data about why particular matters were settled rather than adjudicated. Additionally, it acknowledged that information obtained could be misleading and therefore prejudicial to doctors if not handled correctly.⁷³

The recommendation of the Committee involves implementing a statutory requirement that doctors must report information about medical negligence claims to an appropriate body, such as the New South Wales Medical Board, or the Health Care Complaints Commission. The Committee recommended the introduction of a ‘two-pronged approach’ which it described in the following terms:

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

Information which contains much greater detail concerning the facts of each claim received and any settlement or adjudication and identifies the parties concerned should be reported by indemnifiers and insurers to the New South Wales Medical Board. The Medical Board should undertake an initial assessment where it looks like there may be a public health and safety or professional issue which is of interest to the Board and/or the Commission. This would initially be undertaken as a two year pilot project. The Report recommends that extension of mandatory reporting requirements to other health professional be considered at a later stage after the results of the pilot project with doctors are known.⁷⁴

The PIR

The lack of information about medical negligence claims was also highlighted as a significant problem by the PIR. The PIR explored a nation wide solution, recommending:

the establishment of a national minimum data set for health care negligence cases that includes sufficient details to allow the data to be used to examine trends in particular specialties and diagnostic areas, and to detect areas likely to benefit from active prevention strategies. The contributors to the data based should be all MDOs, any insurers providing health care professional indemnity cover either to individuals practitioners or facilities, and all State governments and private sector

⁷² *ibid.*

⁷³ *ibid.*, p 10.

⁷⁴ *ibid.*, p 8.

self-insurers.⁷⁵

New South Wales Government proposal to require MDOs to publish claims data

The New South Wales Government has proposed requiring MDOs to publish data about indemnity claims made by its members.⁷⁶ MDOs are a major source of information about negligence claims and levels of compensation awarded by the courts and agreed upon in settlements. The reluctance of MDOs to disclose data about negligence claims is well documented. Therefore, it is argued that a legal requirement to disclose information would contribute significantly to public debate.

Mandatory reporting requirements in South Australia and Victoria

In South Australia, it has been mandatory, since 1983, for registered medical practitioners to supply the Medical Board of South Australia with details of the amount of any damages or other compensation awarded against them for negligence committed in the course of medical practice.⁷⁷ The practitioner must inform the Board within 30 days, after being ordered by a court to pay damages or other compensation, or agreeing to pay a sum of money in settlement of a claim.⁷⁸

A similar provision was enacted in Victoria in July 2000. It is now mandatory for registered medical practitioners and applicants for registration, or renewal of registration in Victoria, to supply the Medical Practitioners Board of Victoria with details of the amount of any damages for negligence awarded against them.⁷⁹

Stakeholder views

While stakeholders have not commented specifically on the recommendation of the Joint Standing Committee on the Health Care Complaints Commission, there have been numerous references to the desirability of more information about medical negligence claims. Although, as indicated above, MDOs have been reluctant to disclose information in the past and may not welcome a proposal to require them to participate in mandatory reporting.

Arguments for and against mandatory reporting of medical negligence claims

Arguments in support of mandatory reporting of medical negligence claims can be summarised as follows:

- Information about medical negligence claims would assist in understanding the precise

⁷⁵ Commonwealth of Australia (Tito F, Cairman, Final Report) n 2, Chapter 2, recommendation 9.

⁷⁶ C Knowles MP, n 1.

⁷⁷ *Medical Practitioners Act 1983* (SA), section 72.

⁷⁸ *ibid.*

⁷⁹ *Medical Practice Act 1994* (Vic), section 21(A).

nature of the so-called litigation explosion and the effect that it has on indemnity insurance premiums;

- Mandatory reporting can provide a risk assessment tool by highlighting problems within particular areas of the health system;
- Information about medical negligence claims would also be useful in understanding the need for reform and whether particular reforms proposed would be useful.

Arguments against reporting of medical negligence claims can be summarised as follows:

- A requirement to provide information about negligence claims violates the privacy of medical practitioners;
- information obtained could be misleading and therefore prejudicial to doctors if not handled correctly; and
- It is difficult to obtain accurate data about why particular negligence claims are settled rather than finalised by a court.

4.3. CHANGES TO COURT PROCEDURES

The New South Wales Government proposes to introduce two procedural reforms to the way in which medical negligence cases are dealt with. The first is to introduce a specialist list for medical negligence cases in the District Court of New South Wales. The second is to introduce compulsory mediation for medical negligence cases.⁸⁰

4.3.1. Medical negligence list

Specialist lists are a case management tool used in many Australian courts. In the past few years, there has been a concerted move toward the use of case management in the Australian court system, to ensure the efficient conduct of cases and reduce the time it takes to finalise a case. The case management approach represents a move away from a system where courts reacted to the actions of the litigants, to one in which they manage the conduct of litigation themselves.⁸¹

Courts organise their case loads into several different divisions and lists according to the subject matter of the cases. Usually a court will be divided into broad divisions, for example, the common law and equity divisions of the New South Wales Supreme Court, or the civil and criminal divisions of the New South Wales District Court. These broad categories may be subdivided into smaller categories, which may also be called divisions, or more commonly, lists. Some of these lists are distinguished further as specialist lists in that they are more closely controlled and monitored than cases on other lists. Specialist lists are generally managed by a designated judge. Specific court rules and practice notes are issued to govern the progress of cases on specialist lists.

⁸⁰ C Knowles MP, n 1.

⁸¹ District Court of New South Wales, Annual Review 1999, p 19.

An example of a specialist list of particular relevance to this paper is the Professional Negligence List within the Common Law Division of the New South Wales Supreme Court.

*Divisions and Lists of the New South Wales Supreme Court*⁸²

COMMON LAW DIVISION	EQUITY DIVISION	
Differential Case Management	Protective List*	General List
Civil Matters List	Probate List*	Short Notice List
Administrative Law List*	Admiralty List*	Master's List
Defamation List*	Construction List*	Adoptions List*
Professional Negligence List*	Commercial List*	Corporations List*
Possession List*	Family List	Expedition List
Common Law Duty List		
Criminal List		
Bails List		
	* specialist lists	

The Professional Negligence List (the List) was introduced in 1999.⁸³ The List deals with matters arising from claims against medical practitioners, allied health professionals (such as dentists, chemists and physiotherapists), hospitals, solicitors and barristers.⁸⁴ The objective of the List is to 'reduce delay and costs and increase the number of settlements and improve communication between the parties.'⁸⁵ The List is administered by a judge appointed as the Professional Negligence List Judge. There are no judges specifically assigned to preside over proceedings on the List; cases are allocated to the next available judge when the time arises. The Honourable Justice A.R. Abadee RFD, who administered the List when it was introduced, described it in the following terms:

The essential innovation involved in the List is the role undertaken by the Court (through the Professional Negligence List Judge) in controlling and managing the case from the time of institution of proceedings to the time of trial. This is a new approach to case management in the Common Law Division and reflects a need that the class of case to be dealt with in the list receive specialised management and early intervention by the Court.⁸⁶

Cases in the List are managed in accordance with specific Supreme Court Rules and Practice Notes.⁸⁷ Practice Note 104 sets out the procedure to be followed for several matters including

⁸² This information is drawn from the Supreme Court of New South Wales, *Annual Review 1999*, p 9-11, 26-29.

⁸³ The list is governed by Pt 14C of the Supreme Court Rules and Practice Note No. 104.

⁸⁴ The Supreme Court of New South Wales, *Annual Review 1999*, p 10.

⁸⁵ The Honourable Justice A. R. Abadee RFD, 'Professional Negligence Litigation; A New Order in Civil Litigation - the Role of Experts in a New Legal World and in a New Millenium', Paper presented at the Australian College of Legal Medicine, Canberra, 16 October 1999.

⁸⁶ *ibid.*

⁸⁷ *Supreme Court Rules 1970*, Part 14C and Practice Note 104.

conference hearings, actions prior to conference hearings, representation, mediation and the use of expert witnesses. Parties to cases in the List are particularly encouraged to use mediation, and it has been noted by the Court that mediation has already produced positive outcomes in terms of settlement, or narrowing or resolving of issues.⁸⁸

As the List has only been operating for 2 years is difficult to ascertain how effective it has been in reducing the time it takes to finalise a case. The latest available annual review of the Supreme Court (the 1999 review) states only that it is too early to draw solid conclusions.⁸⁹ However, there is some indication that the List may be having a positive impact. For example, four months after the List was introduced the Honourable Justice H.D. Sperling of the Supreme Court stated that 'in many instances, professional negligence cases in the List are already being entered in the Holding List, ready for trial, much more quickly than has been the situation to date.'⁹⁰

The only other Australian jurisdiction with a specialist list dealing with medical negligence is Victoria. The 'Major Torts List' was established in the Supreme Court of Victoria in 1995. Any proceeding which is primarily of a tortious nature, including substantial personal injuries, professional negligence, defamation and industrial torts litigation may be entered in the List.⁹¹ In the County Court of Victoria, there is also a 'Damages List' which incorporates, a general division, a defamation division and a medical division.⁹² Each of these divisions are managed by designated judges.

Introducing a specialist list into the New South Wales District Court

The New South Wales District Court has jurisdiction to hear medical negligence claims with a monetary value up to \$750,000 (or greater with the consent of the parties). At present, medical negligence cases in the District Court are handled in the General List of the Civil Division. Establishing a specific list to deal with medical negligence cases in the District Court would involve the Court exercising its power under the *District Court Act 1973*⁹³ to make civil procedure rules.

⁸⁸ The Supreme Court of New South Wales, *Annual Review 1999*, p 10.

⁸⁹ *ibid.* Note that the Supreme Court's annual review for 2000 was not available at the time of publication of this paper.

⁹⁰ The Honourable Justice H. D. Sperling, 'The Supreme Court Professional Negligence List', paper presented at the August State Legal Conference 1999, Sydney 24-27 August 1999. See the papers by Justices' Sperling and Aberdee at: www.lawlink.nsw.gov.au/sc/sc.nsf/pages/sperling_1 and www.lawlink.nsw.gov.au/sc/sc.nsf/pages/speeches_index#abadee for further information about the Professional Negligence List.

⁹¹ Supreme Court of Victoria Practice Note No. 4, Major Torts List [1995] 2 VR 555.

⁹² County Court of Victoria Damages (Medical) Division Practice Note No 1, 21 January 1998.

⁹³ *District Court Act 1973* (NSW), section 161.

Divisions and Lists of the New South Wales District Court

CIVIL DIVISION		CRIMINAL DIVISION
General List	Construction List	
Motor Accidents List	Commercial List	

Medical negligence cases are handled in accordance with the same case management procedures as other cases in the civil division. At the beginning of 1996, all cases in the civil division came under new case management practices set out in Practice Note 33. The objective of these case management procedures is to ‘..provide a more orderly, cost effective and expeditious system for the final disposal of disputes’.⁹⁴ Through these procedures cases come within the Court’s control from the moment of commencement. The plaintiff no longer has the option of controlling the pace of the action.⁹⁵ Parties to a case are required to comply with a timetable and failure to comply, without good cause, can lead to their action being dismissed or judgement entered.⁹⁶ The Practice Note also contains directions in relation to particular aspects of conducting cases, such as entry onto the lists and filing statements of claim.

The Government proposal to introduce a specialist list for medical negligence makes reference to cases being heard by judges with specific expertise.⁹⁷ Currently, the Practice Note specifies that each of the four lists in the civil division has a judge allocated to control its management. However, hearings are allocated to a judge from a pool of judges common to all of the lists. While some specialisations occur, no judge exclusively hears matters from a particular list.⁹⁸

Stakeholder views

There has not been much comment on this aspect of the Government’s reform package. The only position known at the time of publication is that of APLA which has expressed its support for ‘case management by courts and the establishment of a specialist medical negligence list in the District Court.’⁹⁹

Arguments for and against establishing a medical negligence list in the District Court

The main argument in support of the proposal is that a medical negligence list would streamline the process of medical negligence litigation, thereby reducing the overall cost of

⁹⁴ District Court of New South Wales Practice Note No 33 ¶ 2.

⁹⁵ District Court of New South Wales, Annual Review 1999, p 14.

⁹⁶ *ibid*, p 19.

⁹⁷ C Knowles MP, n 1.

⁹⁸ District Court of New South Wales Practice Note No 33 ¶12.

⁹⁹ Cashman P, n 29, p 1.

¹⁰⁰ NADRAC *Alternative dispute resolution definitions* NADRAC Canberra 1997.

¹⁰¹ Other courts with the power to refer parties to mediation with or without their consent include: the Supreme Court of South Australia (*Supreme Court Act 1935* (SA), section 65(1)), the Supreme Court of Victoria (*Supreme Court (General Civil Procedure) Rules 1996*, Chapter 1, Rule 50.07), the County Court of Victoria (*County Court Act 1958* (Vic), section 47A), the Western Australian Supreme Court (*Supreme Court Rules 1971* (WA), Order 29 and 29A), the Federal Court (*Federal Court of Australia Act 1976* (Cth), section 53A(1) and (1A)) and the Federal Magistrates Court (*Federal Magistrates Act 1999* (Cth), section 34).

¹⁰² This paper assumes that it refers to a new power for the District Court to refer parties to mediation without their consent (as exists in the Supreme Court), rather than a new compulsory mediation stage in medical negligence proceedings in the Supreme Court and District Court.

Mediation in the New South Wales Supreme Court

In June 2000, the Supreme Court of New South Wales was given the power to refer any civil proceedings (or part of any proceedings) for mediation if it considers the circumstances appropriate, either with *or without* the consent of the parties.¹⁰³ The mediation is to be undertaken by a mediator agreed to by the parties or, if the parties cannot agree, by a mediator appointed by the Court.¹⁰⁴ It is the duty of each party to the proceedings who are referred to mediation to participate in the mediation *in good faith*.¹⁰⁵

Previously, the Court could only refer parties to mediation with their consent. The amendment was initially raised by the Chief Justice of the Supreme Court and was subsequently supported by the recommendations of the early dispute resolution task force of the Law Society and the New South Wales Opposition.¹⁰⁶

The Chief Justice of the New South Wales Supreme Court, the Honourable J.J. Spigelman AC, recently reviewed certain aspects of the role of mediation in the Supreme Court. In relation to the power of the court to order mediation without the consent of the parties, he expressed his view that it ‘..was a useful addition to the armoury of the Court to achieve its¹⁰⁷ He also noted that the Court is in the process of gathering information (such as the experiences of mediators) which will assist the court in determining the circumstances in which an order for compulsory mediation would be beneficial.¹⁰⁸ He indicated that the power should be exercised with care and would not be exercised frequently.¹⁰⁹ As to the Courts usage of the power in professional negligence cases, he said:

a substantial practice in reference for mediation has developed in the Professional Negligence List...The judges who administer the Professional Negligence List actively encourage mediation...All the reports I get from the Professional Negligence List affirm that the role of the mediators has been of critical

¹⁰³ *Supreme Court Act 1970* (NSW), section 110K(1). This power to order mediation without the consent of the parties was brought about by the *Supreme Court Amendment (Referral of Proceedings) Act 2000* (NSW). Note that this section also provides for the referral of parties to neutral evaluation without consent. Neutral evaluation which is a process of evaluation of a dispute in which the evaluator seeks to identify and reduce the issues of fact and law that are in dispute. The evaluator's role includes assessing the relative strengths and weaknesses of each party's case and offering an opinion as to the likely outcome of the proceedings, including any likely findings of liability or the award of damages: *Supreme Court Act 1970* (NSW), section 110I(2).

¹⁰⁴ *Supreme Court Act 1970* (NSW), section 110K(2).

¹⁰⁵ *Supreme Court Act 1970* (NSW), section 110L. See the web site at: <http://www.lawlink.nsw.gov.au/sc/scsc.nsf/pages/mednevalguide> to view the Supreme Court Guidelines on mediation.

¹⁰⁶ *NSWPD*, 06/06/2000, p 6686.

¹⁰⁷ The Honourable JJ Spigelman AC, ‘Mediation and the Court’, *Law Society Journal*, March 2001, p 65.

¹⁰⁸ *ibid*, p 66.

¹⁰⁹ *ibid*.

significance in the success of the list, both in achieving settlements and in narrowing the range of issues.¹¹⁰

One potential problem alluded to by the Honourable J. J. Spigelman AC was that delays may occur because of the unavailability of a mediator chosen by the parties. In relation to the requirement that the parties must act in 'good faith', the Honourable J.J Spigelman AC has predicted that there will be cases in the future in which an interpretation of this requirement will be at issue.¹¹¹ What is required by 'good faith' was not defined in the legislation.

Mediation in the New South Wales District Court

The District Court of New South Wales currently has the power to refer parties to mediation if the circumstances are appropriate and the parties to the proceedings *consent* to the referral.¹¹² The parties must also agree as to who is to be the mediator.¹¹³ The District Court does not have the power to refer parties to mediation if they do not consent. To confer power upon the District Court to refer parties to mediation without their consent would require an amendment to the *District Court Act 1970* (NSW). If such an amendment were to require parties to participate in good faith, as specified in the relevant Supreme Court legislation, a definition of what is required by 'good faith' should perhaps be incorporated to assist the parties and the court in understanding the obligation.

Compulsory v voluntary mediation

In 1998, the Australian Law Reform Commission (ALRC) conducted a review of the adversarial system of litigation. As part of its review, it looked at ADR processes and the issue of mandatory versus voluntary ADR.¹¹⁴ The ALRC highlighted the main argument against compulsory mediation: that the underlying nature of mediation as an ADR procedure is that it is a voluntary process. On this basis it is believed that the likelihood of successful mediation is diminished if it is ordered without the consent of the parties. As unsuccessful mediation adds to the time and cost of litigation, ordering mediation against the wishes of the parties is therefore seen as unconstructive.

However, some parties who do not agree to mediate, or who are reluctant to mediate, may nevertheless participate in the process and reach a resolution. Therefore, the argument is that there are some benefits in ordering mediation even without the consent of the parties. In a subsequent discussion paper, the ALRC reported that, on the basis of submissions it had

¹¹⁰ *ibid*, p 64.

¹¹¹ See also Spence D, 'Court given power to order ADR in civil actions', *Law Society Journal*, October 2000, p 72.

¹¹² *District Court Act 1973* (NSW), section 164A(1)(a) & (b).

¹¹³ *District Court Act 1973* (NSW), section 164A(1)(c).

¹¹⁴ Australian Law Reform Commission, *Review of the Adversarial System of Litigation: ADR – its Role in Federal Dispute Resolution*, Issues Paper 25, June 1998, p 105-107. Note that while the review looked at ADR processes generally, the discussion is applicable to mediation.

received in response to its issues paper, opinions were divided as to whether parties should be required to attend ADR processes.¹¹⁵

National Alternative Dispute Resolution Advisory Council

In March 1999, the National Dispute Resolution Advisory Council (NADRAC) examined the issue of compulsory mediation in the context of the Federal Magistrates Service, and concluded that it supported the introduction of a power for the court to order compulsory mediation.¹¹⁶ It predicated its view on the assumption that the referral would be made by a suitably qualified dispute resolution (DR) assessor, and that a discretion remains in the mediator (or other facilitative DR provider) to refuse to continue with a mediation which is inappropriate. In addition, NADRAC maintained that criteria need to be carefully developed for making any such mandatory referrals to mediation.¹¹⁷

NADRAC acknowledged the argument that because of the consensual nature of mediation, unless the parties are willing to participate, the process is highly likely to fail. However, it stated that it was of the view that in some circumstances, the unwillingness of the parties to go to mediation may not necessarily be an accurate indicator of their capacity to be helped by that process. It also suggested that ‘..if parties (and their legal representatives) are not strongly motivated or encouraged to participate in non-judicial DR, few will do so, and many disputes which could reach a quicker or more suitable settlement without litigation might not be resolved.’¹¹⁸

NADRAC also commented on the issue of sanctions for non-compliance with a court referral to a dispute resolution process. In its view, sanctions such as costs penalties, contempt, or an adverse finding could be made for non-attendance at a non-judicial DR process and failure to provide information to a non-judicial DR provider. It also stated that parties should not be ordered to settle or agree.¹¹⁹

Stakeholder views

As yet there has not been a great deal of comment on this aspect of the Governments reform package. However, the views of the PIAC and United are known. PIAC supports the introduction of compulsory mediation, and points out the effect that this reform may have on the way that MDO’s conduct litigation:

¹¹⁵ Australian Law Reform Commission, *Review of the Federal Civil Justice System*, Discussion Paper 62, August 1999, p 250.

¹¹⁶ ‘The Use Of Alternative Dispute Resolution in a Federal Magistracy’, *National Alternative Dispute Resolution Advisory Council*, March 1999. Issue 12. See the web site at: www.law.gov.au/aghome/advisory/nadrac/magistracy.html#iss12 to view this document.

¹¹⁷ *ibid.*

¹¹⁸ *ibid.*

¹¹⁹ *ibid.*

The introduction of compulsory mediation is presumably aimed at addressing concerns about insurers systematically avoiding negotiation and settlement with patient claimants. Medical negligence litigation was described recently by University of Sydney law teacher, Roger Magnusson, as a 'blood sport'. He says plaintiffs don't have the financial and emotional resources to keep going – and some die in the meantime. The drop out rate for these type of claims is estimated at 30%.

Lawyers who represent injured parties say UMP's culture is to avoid negotiating with patients, even when claims are reasonable. The Australian plaintiff lawyers Association say that medical insurers defend cases even after a reasonable settlement offer in the expectation that people will fall by the way side with litigation fatigue.

The mediation process should be closely monitored and reviewed to ensure that there is a change in patterns of settlement and any costs savings. A pre-requisite would therefore be some base data about the present so that any changes can be measured.¹²⁰

United has expressed a general position that '...alternative dispute resolution measures need to be implemented to bring about the early resolution of claims in a non-adversarial setting, preferably before the litigation process is commenced.'¹²¹

Arguments for and against the introduction of compulsory mediation

The *arguments in support* of compulsory mediation can be summarised as follows:

- Compulsory mediation will lead to more early settlements of medical negligence disputes. This will decrease the time and cost of litigation and thereby have an impact on reducing indemnity premiums;
- Mediation can be valuable, despite any initial opposition of the parties;
- Parties, who would otherwise not agree to mediation because it could be perceived as a sign of weakness of their case, may be content to take part in mediation at the direction of a court;¹²²
- Where the power to order compulsory mediation is discretionary, the court can chose not to exercise it when parties are clearly not suited to mediation; and
- Even if mediation is not successful in settling the dispute entirely, it may give the parties the opportunity to settle issues in the case.

¹²⁰ Cornwall A, n 66, p 9.

¹²¹ Tjiong R, n 26.

¹²² The Honourable JJ Spigelman AC, n 107, p 65.

The *arguments against* compulsory mediation can be summarised as follows:

- Mediation is essentially a voluntary ADR process. It is unlikely that a consensus will be reached if the parties were unwilling to agree to mediation in the first place;
- Even though legislation can require parties to participate in ‘good faith’ it may be difficult to ensure that this happens when parties are reluctant to mediate;
- Compulsory mediation forces the parties to become settlement focussed instead of looking at the merits of the case;
- Unsuccessful mediation increases the length, and therefore the costs, of litigation. particularly in relation to complex cases which can require extensive preparation, the involvement of lawyers and the additional costs of the mediators fee;¹²³ and
- Power balances between parties that may be influential in mediation cannot be avoided. Therefore, vulnerable parties, who may have avoided mediation, may be pressured into forfeiting their entitlements in a compulsory mediation session.¹²⁴

4.4. REFORM OF COMPENSATION AWARDS FOR MEDICAL NEGLIGENCE

An outline of the nature of compensation awards for negligence is contained in section 2.2. The New South Wales Government’s reform package contained two changes to the way in which compensation is awarded for personal injuries arising from medical treatment.¹²⁵ There is also speculation that the Government plans to change additional aspects of compensation awards. The reforms examined in this section are as follows;

- (a) Capping damages for future loss of earnings and general damages;
- (b) Increasing the discount rate of damages for future economic loss;
- (c) Abolishing exemplary damages; and
- (d) Facilitating structured judgements and settlements.

This is not the first time that reform of compensation for negligence has been proposed in New South Wales. Similar proposals were put forward by the Greiner Government in 1990, in the form of the Personal Injury Damages Bill 1990. The Bill concerned limitations on the recovery of damages for personal injury generally, not just injury caused by medical negligence. Among other matters, it limited the amount of damages for non-economic loss, enabled the use of structured settlements and prohibited the awarding of exemplary damages. The Bill was introduced into Parliament in 1991, but did not proceed. It has been suggested

¹²³ Spence D, n 111, p 72.

¹²⁴ Australian Law Reform Commission (Issues Paper 25) n 114, p 105.

¹²⁵ C Knowles MP, n 1.

by United that this Bill is a convenient base upon which to develop a model for Australia-wide tort reform for medical negligence.¹²⁶

4.4.1. Capping damages for future loss of earnings and general damages

The Government's rescue package included 'capping future loss of earnings to a weekly maximum and general damages for most serious cases at the current level'. It was stated that these proposals will generally be in line with the New South Wales motor accidents scheme.¹²⁷ Damages for future loss of earnings are designed to compensate the plaintiff for the earnings she or he would have been able to make in the future, if not for the injuries. General damages compensate the plaintiff for pain and suffering, loss of enjoyment of life, loss of amenities of life and diminution of life expectancy. There is currently no limit on the amount of future loss of earnings damages and general damages a court can award for medical negligence in NSW. It is unclear what is meant by capping general damages for most serious cases *at the current level*.

Under motor accidents compensation legislation in New South Wales, the limit of *future economic loss* damages is \$2,500 net per week. The maximum amount that a court may award for *non-economic loss* is \$284,000.¹²⁸ These amounts are indexed and currently they are set at \$2,603 and \$284,000 respectively.¹²⁹ Note also that under the legislation a party can only access damages for non-economic loss if the degree of their permanent impairment caused by the injury is greater than 10%.¹³⁰ There is some speculation that the Government also intends to introduce this limitation in its reform Bill.¹³¹ See the web site at: www.maa.nsw.gov.au for further information about the NSW Motor Accidents Scheme.

Stakeholder views

Among the views that have been expressed publicly, there has been a mixed reaction to this proposal. Most notably, there is a difference of opinion between the representative organisations of doctors and lawyers. The New South Wales Law Society disagrees with the introduction of caps because of the negative impact it will have on the individuals who have '...already been hurt by the system'.¹³² Conversely, the AMA has welcomed the proposal.¹³³

¹²⁶ Tjong R, n 26.

¹²⁷ C Knowles MP, n 1.

¹²⁸ *Motor Accidents Compensation Act 1999* (NSW), section 125 and 134 respectively. This legislation applies to motor accidents that occurred before midnight 5 October 1999. Different rules apply to accidents that occurred before this date. For a review see, Goudkamp, T and Morrison, A *Personal Injury Law Manual NSW*, LBC Information Services 1999, Vol 1, p 2021 – 2049 and Vol 2, p 7112

¹²⁹ Section 146.

¹³⁰ Section 131.

¹³¹ *Medical Indemnity Rescue Package – Tort Law Reform Elements*, Australian Plaintiff Lawyers Association Briefing Paper, 6 March 2001, p 3.

¹³² 'Negligence claims capped law reforms will hurt *The Daily Telegraph*, 28/02/01, p 2.

The PIAC adopts a more cautious approach. Amanda Cornwall of the PIAC suggests that:

The proposal to cap damages should not proceed without much more sophisticated understanding of the litigation process, and what is driving up premiums....Any limit on damages aimed at containing the cost of premiums requires an understanding of the pattern of claims. The shape of the proposed reforms must therefore be conditional on developing a data set that provides such information.¹³⁴

She also points out that there is no way that the public can know that restricting limits on compensation pay outs will have the desired result of restricting premiums.

Arguments for and against capping damages

The *arguments in support* of capping damages can be summarised as follows:

- High awards of damages have directly contributed to the rise in indemnity premiums. Placing a cap on awards will assist in limiting this effect.
- Setting a maximum amount creates certainty which enables insurers to more accurately account for the cost of claims.

The *arguments against* capping damages can be summarised as follows:

- A cap may mean that a particular plaintiff may not be awarded enough money to take care of their needs;
- Any short fall in compensation may have to be picked up by the Government and the tax payer when a plaintiff turns to community services after their money runs out;
- While there have been some (well publicised) cases in which very high amounts of damages have been awarded, the majority of negligence claims are for relatively small amounts. A cap will not have the desired effect of lowering premiums.

4.4.2 Abolishing exemplary damages

There is speculation that the New South Wales Government intends to abolish exemplary damages for medical negligence cases.¹³⁵ However, this was not specifically included in the media release of the Government's reform package. Abolishing exemplary damages would bring medical negligence in line with workers compensation and compensation for motor accidents in New South Wales, where legislation prohibits a court from awarding exemplary or punitive damages.¹³⁶

¹³³ Rees P, 'Support for NSW Medical Indemnity Reforms', *Australian Medicine*, 19/03/01, p 7.

¹³⁴ Cornwall A, n 66, p 8.

¹³⁵ See Cashman P, n 29, p 1 and Cornwall A, n 66, p 7.

¹³⁶ *Motor Accidents Act 1988* (NSW), section 81A and *Workers Compensation Act 1987* (NSW), section 151R.

As outlined above, exemplary damages can be awarded by a court, in addition to general damages, as a form of punishment. Exemplary damages can be awarded where ‘..the conduct of a particular defendant was wanton, disclosed fraud, malice, violence, cruelty, insolence or that the defendant acted in contumelious disregard for the plaintiff’s rights.’¹³⁷ It appears that awards of exemplary damages for medical negligence are quite rare, with only a few reported cases in Australia in which exemplary damages have been awarded for medical negligence.¹³⁸

Stakeholder views

At the time of publication the only organisation to have commented on this proposal is APLA. APLA questions the utility of abolishing exemplary damages when there are so few instances when they have been awarded.¹³⁹

Arguments for and against abolishing exemplary damages

Arguments for abolishing exemplary damages can be summarised as follows:

- It will reduce the level of damages than can be awarded for medical negligence, which will in turn contribute to lowering or stabilising indemnity premiums; and
- The New South Wales Medical Board is better placed to deal with the type of behaviour that exemplary damages are designed to punish.

Arguments against abolishing exemplary damages can be summarised as follows:

- Defendants who have behaved not only negligently, but with also with fraud, malice, violence, cruelty, insolence etc will not punishable by the courts as they are now; and
- The efficacy of this proposal as a means of reducing indemnity premiums, may be limited since awards of exemplary damages for medical negligence are rare.

4.4.3. Increasing the discount rate for future economic loss

Awards of compensation for future economic loss are reduced, or discounted, to take into account the fact that a plaintiff will benefit from an accelerated receipt of income. The benefit lies in a plaintiff’s ability to invest the lump sum award, which would not have been possible with his or her pre-negligence weekly income. The discount rate is said to be a way of ensuring that the plaintiff is not overcompensated. The adjustment is made by applying the appropriate discount rate to the award for future economic loss, making reference to present value tables (see APPENDIX II). The present value tables state the present lump sum values of weekly payments of \$1 for periods from 1 to 50 years discounted at 3%, 5%, 6%, and 7%. The rate at which damages for future economic loss is discounted is set at 3% at common

¹³⁷ *Australian Professional Liability – Medical*, CCH Australia Limited, p 62,131.

¹³⁸ *Coloca v BP Australia; Thomson v James Hardie & Co Pty Ltd* (1992) Aust Torts Reports ¶81-153; *Backwell v AAA* (1996) Aust Torts Reports ¶81-387.

¹³⁹ APLA no 131, p 4.

law.¹⁴⁰ However, several Australian jurisdictions have legislated to increase this rate in relation to certain areas of personal injury including, motor accidents and workers compensation.

It is claimed that the New South Wales Government proposes to bring the discount rate applicable for future economic loss in medical negligence cases into line with the rate applying to motor accident and workers compensation.¹⁴¹ Note however, that this was not specifically included in the media release of the government's reform package

At present, the common law discount rate of 3% applies to medical negligence cases in New South Wales. The rate for motor vehicle accident cases is set by statute in New South Wales at 5%.¹⁴² The rate for workers compensation is also set at 5%.¹⁴³ The discount rate of 5% applies in workers compensation and motor accidents compensation to damages awarded for:

- deprivation or impairment of earning capacity;
- the value of future services of a domestic nature or services relating to nursing and attendance;
- loss of expectation of financial support; and
- a liability to incur expenditure in the future.¹⁴⁴

The following is a simple example to illustrate the effect of increasing the discount rate: Assume a plaintiff who is unable to work at all as a result of medical negligence. Assume that the plaintiff would have been earning \$500.00 per week after tax if not for the accident. Assume also that the plaintiff would have had another 20 years of working life, if not for the accident.

Referring to the present value table (APPENDIX II), it shows that an income of \$500.00 per week for the next 20 years discounted at 3% is equivalent to a lump sum payment of \$394,000. This amount is determined by finding the present value of a weekly payment of \$1 for a period of 20 years on the 3% table (\$788) and multiplying it by 500. An income of \$500.00 per week for the next 20 years discounted at 5% is equivalent to a lump sum payment of \$333,000. Therefore the plaintiff will be awarded \$61,000 less if the discount rate is increased from 3% to 5%.

¹⁴⁰ *Todorovic v Waller* (1981) 150 CLR 402.

¹⁴¹ Cornwall A, n 66, p 8. Australian Plaintiff Lawyers Association n 131, p 3-4, and Cashman P, n 29, p 1.

¹⁴² *Motor Vehicle (Third Party Insurance) Act 1942* (NSW), section 35B(1) for accidents occurring prior to 1/9/87, *Motor Accidents Act 1988* (NSW), section 71(1) for accidents occurring between 1/9/87 and 4/10/99, *Motor Accidents Compensation Act 1999* (NSW), section 127(2) for accidents occurring after 4 October 1999.

¹⁴³ *Workers Compensation Act 1987* (NSW), section 151J(2).

¹⁴⁴ *Motor Vehicle (Third Party Insurance) Act 1942* (NSW), section 35B(1), *Motor Accidents Act 1988* (NSW), section 71(1) and *Motor Accidents Compensation Act 1999* (NSW), section 127(1) *Workers Compensation Act 1987* (NSW), section 151J(1).

Stakeholder views

There has not been a great deal of public reaction to this aspect of the proposal to date. One position that is known is that of APLA which opposes the proposal, arguing that:

Although the changes don't appear significant, it will effect all claims for ongoing wage loss, ongoing medical treatment expense and ongoing care requirements.....the change would perhaps have its most significant impact in the context of severely injured children who will require ongoing nursing or domestic care for their entire life unless that person can invest their money so as to obtain a return of 5% after tax (importantly after inflation) then inevitably the damages award will be inadequate to cover the cost of their care.¹⁴⁵

Arguments for and against increasing the discount rate

Arguments for increasing the discount rate can be summarised as follows:

- It will reduce the level of damages than can be awarded for future economic loss, which will in turn contribute to lowering or stabilising professional indemnity insurance premiums.

Arguments against increasing the discount rate can be summarised as follows:

- It may mean that some plaintiffs are under compensated for their injuries.

4.4.4. Facilitating structured judgments and settlements

As part of its 'rescue package' the New South Wales Government announced that it has recently written to the Prime Minister and Federal Minister for Health urging them to vigorously pursue changes to Federal taxation legislation to facilitate structured settlements for medical negligence.¹⁴⁶ The use of structured settlements and structured judgements for compensation for all types of personal injury is a long standing issue in Australia. For example, an examination of structured compensation payments was undertaken by the PIR, and more comprehensively by the VPLRC Inquiry. The issue was also examined by the New South Wales Parliamentary Standing Committee on Law and Justice, in the context of personal injuries arising out of motor vehicle accidents. A lobby group called the Structured Settlement Group (SSG), which has a broad based membership (see below), has been working for several years to convince the Federal Government of the benefits of structured compensation payments for personal injuries.

What are structured judgements and settlements?

Compensation for personal injury caused by negligence is assessed on a 'once and for all' basis, and is awarded in a single *lump sum*. Once compensation is paid, the defendants

¹⁴⁵ Australian Plaintiff Lawyers Association n 131, p 3-4, and Cashman P, n 29, p 1.

¹⁴⁶ NSWPD (Proof LA), 27/02/01, p 15.

liability is discharged. The lump sum is made up of a number of different components according to the heads of damages (see section 2.2 of this paper for a discussion of the heads of damages). This pattern is also generally followed in settlement agreements. *Structured* arrangements for the payment of compensation, at settlement or by court judgement, are an alternative to the single lump sum payment of compensation. They are described by the PIR as follows:

...financial arrangements which provide a combination of periodic payments and occasional lump sums, where the timing and size of the payments are tailored to meet the needs of the recipient. They can also make provision for the claimant's dependants in the event of the claimant's death. While the term structured settlements usually refers to private contractual arrangements entered into as part of a settlement, many of the arguments can be made in relation to court judgements that achieve the same end.¹⁴⁷

Administering a structured compensation payment generally involves the purchase of an annuity from a life insurance company. This arrangement is described by the SSG in the following general terms:

[After any lump sum component is paid] the rest is used by the defendant insurer to purchase an annuity from a life insurance company for the injured person. The annuity funds the periodic payments, which are normally payable for the life of the injured person and are indexed to inflation. There is usually a minimum guarantee period, so that if the claimant dies before that period expires the payments will continue to be paid to their nominated beneficiary or estate. After the defendant insurer has purchased the annuity, it obtains a full release from liability and can close its file. The annuity is owned by the injured person who has an ongoing relationship with the life insurance company.¹⁴⁸

Some States have legislated to provide for structured settlements in relation to personal injuries caused by negligence at work, or on the road. For example, In New South Wales, structured settlements are currently available in relation to motor accidents for future economic loss and impairment of earnings (see below), and in relation to workers compensation for future economic loss.¹⁴⁹ In Victoria, structured settlements were introduced in relation to common law damages for accident compensation for workers in May 2000.¹⁵⁰ Structured settlements are commonly used in relation to personal injuries in the United States, the United Kingdom and Canada.¹⁵¹

¹⁴⁷ Commonwealth of Australia (Tito F, Cairman, Final Report), n 2, p 183.

¹⁴⁸ Structured Settlement Group, *Structured Settlements – A tax reform proposal to benefit accident victims and all tax paying Australians*, June 1999. For a discussion of annuities see Victoria, Parliament, n 3, p. 124, 139, 140.

¹⁴⁹ *Workers Compensation Act 1987* (NSW), section 71.

¹⁵⁰ *Accident Compensation Act 1985* (Vic), section 135D.

¹⁵¹ For a review of the use of structured settlements in the United States and the United Kingdom see: Victoria, Parliament, n 3, Chapter 4. The NSW Parliament Standing Committee on Law and Justice

Why the use of structured judgements and settlements is advocated

It is argued that structured judgements and settlements are a better means of ensuring that a plaintiff is adequately compensated for their injuries than lump sum payments. Without careful financial planning lump sum payments can be used up too quickly, leaving a plaintiff uncompensated and forced to rely on Government resources. It is also argued that periodic payment of compensation will have flow-on benefits to defendants, the Government and the level of insurance premiums.

Why structured judgements and settlements are not used now

Settlements: There are no obstacles to parties to a settlement negotiation agreeing on a structured settlement. However, there are tax implications of structured settlements are perceived to diminish their advantage and mean that they are hardly ever negotiated. The situation is stated by the SSG as follows:

[g]enerally speaking, common law lump sum compensation for personal injury is received by a claimant tax-free, whereas periodic payments of compensation are subject to income tax. The taxable nature of periodic payments as opposed to lump sums is a strong disincentive to their use in settling common law personal injury claims.¹⁵²

Therefore, it is argued that in order to facilitate the use of structured settlements changes need to be made to federal tax laws. However, there is some uncertainty about the exact nature of this taxation barrier. This was noted by the PIR and the VPLRC Inquiry, neither of which reached a conclusive view on how structured payments of compensation were effected by Federal tax laws.¹⁵³ In any case, as both inquiries noted, the uncertainty surrounding the tax issue did create a reluctance by plaintiffs to accept structured settlements.

Judgements: At present, Australian courts are generally unable to make awards of structured compensation payments for personal injuries arising from negligence. Legislative changes would be required to allow courts to make such awards. A discussion paper prepared by the PIR noted that:

One direct way to influence the use of structured settlements through the courts would be for all states and Territories to enact uniform legislation enabling, or perhaps compelling, courts to consider structured settlements as an alternative to

conducted a study tour of the United States, Canada and the United Kingdom in 1997 to investigate the use of structured settlements, for the purposes of its Inquiry Into the Motor Accidents Scheme. See: NSW, Parliament, Legislative Council, Standing Committee on Law and Justice, (B Vaughan MLC) *Report on the Inquiry Into the Motor Accidents Scheme (Compulsory Third Party Insurance) – Second Interim Report*, NSW Parliament, 1997, p 9 for details.

¹⁵² Structured Settlement Group, n 148.

¹⁵³ Commonwealth of Australia (Tito F, Cairman, Final Report), n 2, p 185. Victoria, Parliament, n 3, p. 132-138.

lump sum compensation in certain cases. Were uniform legislation not possible, unilateral changes by individual jurisdictions would still be a useful reform.¹⁵⁴

The benefit of legislative changes to allow courts to make structured judgements would also depend on the resolution of the taxation issues discussed above.

New South Wales Parliamentary Standing Committee on Law and Justice Inquiry Into the Motor Accidents Scheme (Compulsory Third Party Insurance)

In December 1995, the Legislative Council Standing Committee on Law and Justice (the Committee) was given a reference to inquire into and report on the Motor Accidents Scheme and compulsory third party insurance. The Committee addressed the issue of structured settlements in the Interim Report¹⁵⁵ and the Second Interim Report.¹⁵⁶ Although the Inquiry concerned the personal injuries arising out of motor accidents, its examination of structured settlements is relevant to personal injuries caused by negligent medical treatment.

As noted above, legislation in New South Wales provides that an award of damages for a motor accident can be paid in the form of a structured settlement ordered by the court if both the plaintiff and the defendant agree. However, the Interim Report states that this section is rarely utilised¹⁵⁷ and highlights the uncertainty surrounding the issue of tax as one of the main reasons for this. It was noted that without tax reform, structured settlements will never be seen as a viable option for successful plaintiffs.

The Inquiry received submissions that it would be in the Commonwealth's long term financial advantage to provide for the non-taxable status of structured settlements for personal injury claims. In this respect it was submitted that the reduction in tax received by the Australian Tax Office would be '...offset by the reduction in social security benefits payable to claimants who had exhausted their lump sum compensation awards.'¹⁵⁸

During the course of the Inquiry, the Motor Accidents Authority (MAA) developed a model for the operation of structured settlements. It also commissioned an actuarial review of the financial implications of the proposal. The review identified a net benefit to the Commonwealth of over \$200 million per year from the use of the structured settlement model developed by the MAA. Consequently, the MAA developed a submission to the NSW Government for an amendment to the Tax Act to clarify the non-taxable status of personal

¹⁵⁴ Commonwealth of Australia, Review of Professional Indemnity Arrangements for Health Care Professionals, *Structured Settlements as Payment of Compensation for Personal Injury, A Discussion Paper*, June 1995, p 19.

¹⁵⁵ NSW, Parliament (B Vaughan MP, Chairman, Interim Report), n 142, Chapter Ten.

¹⁵⁶ *ibid*, Chapter 2.

¹⁵⁷ *Motor Accidents Act 1988* (NSW) NSW, section 81. NSW, Parliament, Legislative Council, Standing Committee on Law and Justice, (B Vaughan MLC) *Report on the Inquiry Into the Motor Accidents Scheme (Compulsory Third Party Insurance) – Interim Report*, NSW Parliament, 1996, Chapter Ten, p 147.

¹⁵⁸ *ibid*, Chapter 10, p 150.

injury compensation payments paid as periodic payments.¹⁵⁹

In concluding its examination of the issue of structured settlements, the Committee recommended the use of structured settlements in appropriate personal injuries compensation cases. It also recommended that the NSW Government adopt the submission for tax reform to facilitate structured settlements prepared by the MAA.¹⁶⁰

Subsequent developments in the campaign for structured settlements in New South Wales are outlined in two Reports issued by the New South Wales Parliamentary Standing Committee on Law and Justice: its Review of the Exercise of the Functions of the Motor Accidents Authority and the Motor Accidents Council, issued in June 2000¹⁶¹ and February 2001¹⁶² respectively. The Reports note that in early 1998, the Premier of New South Wales forwarded the MAA submission to the Prime Minister indicating his support. After subsequent negotiations and an additional submission, it was widely expected that the Federal Government would announce plans to implement changes to the tax scheme to facilitate structured settlements in the May 2000 Budget. However, this was not to be. The Federal Government did not proceed with the reform in the May 2000 Budget as expected.

VPLRC Inquiry

The Inquiry's 1997 Final Report contains extensive research into the issue of structured settlements and judgements, including comparisons of the use of structured settlements and judgements in the United States and the United Kingdom. The Report also contains a review of the payment of compensation by the various statutory compensation schemes in New South Wales.¹⁶³

The Inquiry recommended that the option of awarding structured judgments for awards of between \$50,000 - \$500,000 should be made available to the courts. It recommended that compulsory structured judgements and settlements should be ordered in relation to awards over \$500,000, except in exceptional cases.¹⁶⁴ The Inquiry also recommended that the Victorian Government should ask the Federal Government to amend federal taxation law to provide that payment of compensation, including by way of structured judgements and settlement, for personal injuries are non-taxable in the hands of the payee.¹⁶⁵

¹⁵⁹ NSW, Parliament, (B Vaughan MP, Chairman, Second Interim Report), n 151, p 6-9.

¹⁶⁰ *ibid*, Recommendation 1, p 11.

¹⁶¹ NSW, Parliament, Legislative Council, Standing Committee on Law and Justice, *Review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council - First Report*, NSW Parliament, Report 13, June 2000.

¹⁶² NSW, Parliament, Legislative Council, Standing Committee on Law and Justice, *Review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council - Second Report*, NSW Parliament, Report 16, February 2001.

¹⁶³ Victoria, Parliament, n 3, p. 68 - 75.

¹⁶⁴ Victoria, Parliament, n 3, Recommendation 14, 15, 17 and 20, p 160 – 170.

¹⁶⁵ *ibid*, Recommendation 6, p 141 – 142,

Structured Settlement Group

The widespread support for the changes to federal tax laws to facilitate structured settlements is illustrated by the make-up of the SSG. The SSG is a lobby group made up of representatives organisations across a range of interest areas, including the New South Wales MAA. The SSG is the driving force behind the lobbying effort to convince the Federal Government to make changes to federal tax laws to facilitate structured settlements. Membership of the SSG includes:¹⁶⁶

- Insurance Council of Australia
- United Medical Protection
- Injuries Australia
- Law Council of Australia
- Australian Plaintiff Lawyers Association
- Motor Accident Authority
- Australian Medical Association
- NRMA Insurance
- Institute of Actuaries of Australia.

Developments in 2001

There is still much momentum for changes to be made to Federal tax laws to facilitate structured settlements. For example, as noted earlier in this section, the New South Wales Government has recently urged the Federal Government to pursue tax reform to facilitate structured settlements. On 19 March 2001, the AMA reported that in a meeting between the Prime Minister and the President of the AMA, the Prime Minister indicated that the Government was open to considering the proposals for structured settlements. The Prime Minister is reported as stating that he had sought information about the cost of the proposal from the Department of Treasury.¹⁶⁷ At the date of publication of this paper the Government has made no firm commitment to make tax changes to facilitate structured settlements. The SSG as a whole is also maintaining its lobbying activities.

Stakeholder views

The make up of the SSG, listed above, indicates the widespread support for structured settlements and judgements.

Arguments for and against structured settlements¹⁶⁸

The *arguments in support* of structured settlements can be summarised as follows:

¹⁶⁶ See: www.injuriesaustralia.com.au for further information about the SSG.

¹⁶⁷ Rees P, 'Structured settlements closer', *Australian Medicine*, 19/03/01.

¹⁶⁸ These arguments for and against are based on the advantages and disadvantages of structured settlements outlined by the MAA: NSW, Parliament (B Vaughan MP, Chairman, Interim Report), n 157, Ch 10, p 152-154. For a comprehensive review of the advantages and disadvantages of structured compensation payments see Victoria, Parliament, n 3, Chapters 5 and 6.

- The plaintiff benefits from increased after tax award of compensation and a cash flow that can be guaranteed for life;
- The structured settlement can be linked to inflation ensuring its adequacy over the years;
- The compensation pay out is not susceptible to fluctuating investment returns of an invested lump sum;
- Structured settlements are flexible, therefore an agreement or judgements could be involve a lump sum element as well as periodic payments;
- The defendant's insurer will have to pay less money overall in compensation if it is paid in instalments rather than in a lump sum (estimates range between 10% to 15% lower cost than lump sum);
- There will be a flow on effect of the insurer having to pay less money – ie lower premiums; and
- The Federal Government will benefit through reduced welfare payments, despite lower tax receipts.

The *arguments against* structured settlements can be summarised as follows:

- Once and for all lump sum payments ensure finality of litigation;
- There is a lack of flexibility and choice in determining how a compensation payment is best spent;
- A lump sum payment offers greater potential to change lifestyles or career after an injury which is critical to recovery for many plaintiffs;
- Lump sum payments are non-taxable; and
- There may be associated costs of administering structured settlements.

4.5. ALTERNATIVES TO THE COMMON LAW TORT SYSTEM FOR COMPENSATING ADVERSE OUTCOMES

The most complex reform option advocated is the introduction of a new scheme for dealing with adverse outcomes of medical treatment, to replace the tort system in whole or in part. A no-fault compensation scheme is examined in this section, as is the proposal by the AMA to introduce a State Medical Services Commission.

4.5.1. No-fault compensation scheme

A no-fault compensation scheme provides compensation for personal injuries to claimants without the need for the claimant to prove that the injury was caused by another person's fault. No-fault compensation schemes are created by statute and are administered by statutory offices or bodies. They can operate in conjunction with the common law right to compensation for personal injury caused by negligence, or can replace this avenue of redress entirely. No-fault schemes for compensating personal injuries sustained at work have been established in each Australian State and Territory. Victoria, Tasmania and the Northern Territory also have no-fault motor accident compensation schemes. No Australian jurisdiction has a no-fault scheme for compensating adverse outcomes of medical treatment.

An example of a no-fault compensation scheme for adverse outcomes of medical treatment

New Zealand has a no-fault compensation system for personal injuries arising out of ‘medical misadventure’. The Accident Compensation Commission (ACC), established in 1974,¹⁶⁹ is New Zealand’s comprehensive provider of accident insurance for people who suffer a personal injury as a result of an accident, including ‘medical misadventure’. Proceedings for damages arising directly or indirectly out of personal injury covered by the ACC scheme are barred.¹⁷⁰ As the ACC explains:

Medical misadventure is defined as a physical injury resulting from treatment by a registered health professional. The injury must be caused by a medical mishap or error. A medical mishap is when you had the right treatment and it was properly given – but you had a complication which was both rare and severe. This complication must clearly be because of the treatment not your medical condition. A medical error is when you are injured because the person treating you did not provide treatment of a reasonable standard. It includes situations when the health professional is negligent about your diagnosis, treatment or consent. It is not a medical error just because you didn’t get the desired result, or it turns out that another decision about your treatment may have been better.¹⁷¹

If the ACC accepts a claim for medical error, the medical professional involved will be informed. The medical professional has the right to apply for a review of the decision. Depending on the nature of the claim the ACC can help a person financially and in other ways. It can provide assistance (monetary or otherwise) in relation to, the cost of treatment, compensation for lost wages, an independence allowance if the injury has a serious long term effect, special equipment and the cost of someone to take care of the person, their children etc.

All New Zealander’s pay premiums for ACC cover. These are paid by employers and self-employed people to cover work-related injuries, and earners to cover non-work injuries. Motor vehicle accident cover is funded by a component of motor vehicle registration fees and a percentage of petrol sales. The Government funds the costs of injuries to people who are not in the paid workforce.¹⁷²

The PIR and the VPLRC Inquiry

Briefly, both the PIR and the VPLRC Inquiry examined the option of introducing a no-fault compensation system for compensating adverse outcomes to replace the tort system. Both

¹⁶⁹ *Accident Compensation Act 1972* (NZ).

¹⁷⁰ *Accident Insurance Act 1998* (NZ), section 394.

¹⁷¹ *Medical misadventure—your guide to making a claim for medical mishap or error*, ACC, July 2000.

¹⁷² See the web site at www.acc.org.nz for further information about the ACC scheme. For a critical review of the New Zealand Scheme see: O’Brien, Dr Mark, “The NZ Experience” *The Australian Doctor* 6 April, 2001, p 55.

concluded that a no-fault system was not the most appropriate means of adequately compensating personal injuries arising from medical treatment. The VPLRC Inquiry concluded that ‘there is no public benefit to making a change to the common law’ and that ‘there was no better formulation to balance the interests of doctors and patients.’¹⁷³

Stakeholder positions

As a no-fault compensation scheme for adverse outcomes is not part of the Government’s rescue package for medical indemnity premiums, there has not been much comment on this reform option in the current debate. However, as a no-fault scheme is a long standing law reform option for all types of personal injuries, the positions of some of the stakeholders in this debate are known.

For example, the New South Wales Opposition has stated that it ‘..does not propose, at this time, the implementation of a no-fault compensation scheme such as exists in New Zealand. Any reforms to the current tort system should be based in the important premise that negligently injured patients have a right to compensation for their injuries, through an inexpensive, accessible forum.’¹⁷⁴ In contrast, a few organisations have expressed general support for a some form of new system for dealing with adverse outcomes without going into detail about the type of scheme envisaged. *United* has expressed its support for the introduction of limited no-fault compensation for the severely injured.¹⁷⁵ The *Australian Society of Orthopaedic Surgeons*, supports the establishment of a tribunal system for dealing with medical indemnity cases.¹⁷⁶

Arguments for and against establishing a no-fault scheme for compensating adverse outcomes of medical treatment.

The *arguments for* establishing a no-fault compensation scheme for compensating adverse outcomes of medical treatment can be summarised as follows:

- The adversarial nature of the tort system is difficult for both plaintiffs and defendants;
- The tort system only compensates those who can prove negligence;
- There are difficulties in obtaining evidence (obtaining medical records is not a straight forward process) and costly expert evidence is often required;¹⁷⁷
- Legal proceedings are often lengthy, thus delaying relief to the plaintiffs;
- High levels of compensation awarded by the courts has led to an unreasonable increase in the cost of indemnity insurance premiums;

¹⁷³ *ibid.*

¹⁷⁴ Hartcher C, MP, *Medical Negligence: Reform or Restructure?*, Discussion Paper prepared by the NSW Liberal/National Coalition, p 16.

¹⁷⁵ United Medical Protection, *Key Initiatives*. See the web site at www.ump.com.au/800/Tort/key.htm to view this paper.

¹⁷⁶ SOS Medical Indemnity Meeting, Airport Hilton, Sydney NSW, 12/12/00, minutes. See the web site at www.asos.one.net.au to view the minutes of meeting.

¹⁷⁷ Skene, n 25, p 20.

- Pressure to settle cases may mean that some plaintiffs are under-compensated; and
- The fear of litigation encourages defensive medical practice.

The *arguments against* establishing a no-fault compensation scheme for compensating adverse outcomes of medical treatment can be summarised as follows:

- Common law litigation means that the party at fault is the party who pays the compensation - the cost of a no fault compensation scheme is born in large part by the public;
- The risk of litigation promotes higher standards of medical practice;
- The cost in setting up and maintaining such a scheme is high; and
- Adequate compensation payments may not be made for serious injuries where a person requires extensive treatment and care for many years.

4.5.2. AMA proposal for a State Medical Services Commission

The AMA has developed a proposal for the establishment of a State Medical Services Commission, to manage and to arrange compensation for those suffering adverse outcomes as a result of medical negligence. The focus of the Commission is on the injured party, to restore them as much as possible to the position they were in before the adverse outcome occurred. The proposal has been developed by the Victorian AMA and is suggested as a model that could be adopted by other States. The following elements of the proposed scheme were outlined in a document prepared by the Victorian AMA.¹⁷⁸

Access to the court system: The proposal envisages that some recourse to the adversarial system should be maintained, for example if the injured party thought the processes of the Commission were inadequate.

Liability is determined: The proposal is not for a no-fault scheme, but rather one in which liability for the adverse outcome is determined. The fault may be that of the system or the doctor.

Procedures: The Commission would have a mediation function to facilitate compensation agreements; all processes would be confidential; and there would be in-house expert witnesses.

Compensation: The Commission would manage claims and then the insurer would pay in accordance with current methods of assessing damages. Structured settlements will be an option.

The Board of the Commission: The proposal states that the Board will consist of representatives of the medical, legal, insurance and consumer sectors.

Other Aspects: The proposal includes a referral service to appropriate agencies for ongoing treatment and care and data would be collected to inform the profession where its weaknesses

¹⁷⁸ AMA Victoria, *Proposal for the State Medical Services Commission*, 13 December 2000.

lie. Data about settlements and costs would be publicly available. Disciplinary action against doctors is not envisaged; any questions of competency will be referred to the Medical Practitioners Board.

4.6. GOOD SAMARITAN LEGISLATION

In this context, a good samaritan is a medical practitioner who ‘volunteers to help someone in need of urgent medical attention in circumstances where a doctor-patient relationship does not exist’.¹⁷⁹ For example, a doctor who comes to the aid of a person at the scene of a car crash before an ambulance arrives. Emergency situations such as these are often volatile – the possibility of serious injury or death is already present and the intensity of the situation may increase the risk of mistake. The chances of a doctor’s actions aggravating an injury are greater than if the doctor was attending person as a patient in normal circumstances. In the aftermath a doctor’s intervention may be questioned and the question of negligence may arise.

Despite the professional and common law obligations upon medical practitioners to provide assistance in an emergency (these are outlined below), there is anecdotal evidence to suggest that medical practitioners are reluctant to provide good samaritan assistance. This reluctance stems from a fear of being sued for not being able to save life of the injured person, or for aggravating their injuries.¹⁸⁰ In New South Wales, there is no protection for a doctor against claims of negligence arising out of good samaritan acts. Even if a doctor assisted in good faith, she or he may still be sued (although the circumstances of the emergency will be taken into account). The situation at common law is described by Cowley-Smith as follows:

..once health care professionals actively become involved in assisting the injured at accident scenes, they place themselves under a duty to observe reasonable care not to cause harm or exacerbate existing injuries. Notwithstanding, considerable leeway for error is permitted in emergency situations. The standard of care that must be met by a health care professional will be defined according to the reasonably prudent professional in like circumstances.’

It seems that the fear of being sued remains significant despite the fact that there are very few reported cases where a medical practitioner has been sued in the context of medical treatment provided in an emergency.¹⁸¹ Legislation providing statutory protection from liability for good samaritans would remove this fear of litigation and encourage practitioners to help others in emergency situations.

The New South Wales Government has proposed the introduction of good samaritan legislation as part of its rescue package to reduce professional indemnity premiums for

¹⁷⁹ Victoria, Parliament, n 3, p 21.

¹⁸⁰ Victoria, Parliament, n 3, p 23-4.

¹⁸¹ *ibid*, p 22 and Commonwealth of Australian (Tito F, Chairman, Interim Report) n 10, p 286.

doctors.¹⁸² Good samaritan legislation provides immunity against liability in relation to injuries arising assistance provided in good faith, except for gross negligence. The only Australian jurisdiction which has good samaritan legislation is Queensland (see below). Good samaritan legislation also exists in most American States and Canadian Provinces.¹⁸³

Good samaritan legislation is understood in the context of several related issues: the position of rescuers at common law; medical practitioners and the development of a duty to rescue; a doctors professional responsibility to provide assistance in an emergency; professional indemnity cover for good samaritan acts; and protection from liability for emergency workers. These will be examined below.

Rescuers and the common law: At common law, there is no general duty to rescue a person in danger. This is the case even where it is foreseeable that failing to assist will lead to injury or death. However, the rescuer may owe a duty of care once a rescue attempt is under way; to ensure that the conduct of the rescuer does not increase the risk to those in peril or bring others into danger.¹⁸⁴ As to the standard of care that the rescuer must exercise: 'while the rescuer must act reasonably, this requirement is not strictly interpreted; reasonableness is determined in the context of the emergency. The actions of a rescuer are not viewed as completely voluntary and even if a rescuer is aware of the risk and consciously decides to continue, the risk has not been taken voluntarily in a legal sense.'¹⁸⁵

Medical practitioners and the development of a common law duty to rescue: Until recently, the general rule at common law was that a medical practitioner has 'no legal obligation to give assistance at the scene of an emergency or accident, even where treatment, if administered, would be life-saving. Unless a medical practitioner enters into a doctor-patient relationship, they are not obliged to render assistance to the world at large'.¹⁸⁶ Relevant exceptions to this rule provide that in some emergency situations a medical practitioner may be legally obliged to provide assistance to a person who is not their patient. For example, when a doctor occupies 'a specific and protective role' such as working in an emergency department of a hospital, or when the doctor's own behaviour caused the injury.¹⁸⁷

However, in 1996, in the case of *Lowns v Woods*,¹⁸⁸ the New South Wales Court of Appeal found that a doctor was liable in negligence for refusing to provide assistance to a boy who was having an epileptic seizure, after being asked to do so by the boy's sister. The court found that the doctor owed a duty of care to the boy even though he was not a patient. This

¹⁸² C Knowles MP, n 1.

¹⁸³ For a discussion of good samaritan legislation in the US and Canada see, Haberfield L, 'Lowns v Woods and the Duty to Rescue', (1998) *The Tort Law Review*, Vol 6, at 64.

¹⁸⁴ *Hargrave v Goldman* (1963) 110 C.L.R. 40. Victoria, Parliament, n 3, p 22-23.

¹⁸⁵ Victoria, Parliament, n 3, p 22-23.

¹⁸⁶ *ibid*, p 23.

¹⁸⁷ *ibid*, p 23-4.

¹⁸⁸ *Lowns v Woods* (1996) Aust Torts Reports 81-376 (NSW CA).

case represented an abrupt departure from the general common law rule outlined above. While there have been no other cases that have examined the courts interpretation in *Lowns v Woods*, it establishes a persuasive precedent that a doctor, unlike people without medical training, may have a duty to assist a person in an emergency, particularly when asked to do so and proximity is not an issue.¹⁸⁹

Unsatisfactory professional conduct – statutory obligation to provide urgent medical attention: In New South Wales, the *Medical Practice Act 1992* places a professional obligation on medical practitioners to render urgent medical attention. The *Act* defines ‘unsatisfactory professional conduct’ to include:

refusing or failing, without reasonable cause, to attend within a reasonable time after being requested to do so, on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner.¹⁹⁰

While there are no legal consequences of a breach of this provision, a breach can result in disciplinary action being taken by the Medical Board.

Professional indemnity insurance and good samaritan acts: Most professional indemnity insurance provided by MDOs also covers good samaritan acts.¹⁹¹ For example, all active members of MIPS are automatically covered for good samaritan acts, irrespective of their category of membership. This includes retired practitioner members and members who have suspended their practice.

Emergency workers and volunteers: Protection from liability is provided by the common law and various statutes in all Australian States and Territories for professional and volunteer emergency service personnel in the context of designated emergencies, such as bush fires,

¹⁸⁹ For a commentary on the case see Crowley-Smith L, ‘The Duty to Rescue Unveiled: A Need to Indemnify Good Samaritan Health Care Professionals in Australia, (1997) Vol 4, *Journal of Law and Medicine*, at 352 and Haberfield, L ‘Lowns v Woods and the Duty to Rescue’, (1998) *The Tort Law Review*, Vol 6, at 56.

¹⁹⁰ Section 36(1)(l). A similar provision exists in the ACT: *Medical Practitioners Act 1930* (ACT), section 35(1)(h). Legislation in other Australian States, and the Northern Territory, have more general definitions of professional misconduct that may be interpreted to include the good samaritan situation: *Medical Practitioners Act 1983* (SA), section 5; *Medical Practitioners Registration Act 1996* (Tas), section 45(2); *Medical Practice Act 1994* (Vic), section 3; *Medical Act 1894* (WA), section 13, *Medical Act* (ACT), section 38(1)(h). For a discussion of this interpretation (in relation to *Medical Practice Act 1994* (Vic), section 3) see Victoria, Parliament, Law Reform Committee, *Final Report Legal Liability of Health Service Providers*, Victorian Parliament, May 1997, p 25.

¹⁹¹ The Australian Nurses Federation which provides professional indemnity insurance for their members also covers good samaritan acts. The ANF Professional Indemnity insurance provides cover for professional indemnity (malpractice) and for public liability (negligence for injury to a third party, persons or property) of up to \$5 million and includes 24 hour insurance cover for good samaritan act. See the web site at www.anfvc.asn.au for further information.

and in emergency rescue operations.¹⁹² Therefore, if a medical practitioner provided assistance in the capacity of an emergency service professional or volunteer, the practitioner may be protected from liability for claims of negligence arising out the treatment administered.

Queensland's good samaritan legislation

A good samaritan law relating to doctors and nurses was introduced in Queensland in 1973. In 1995, it was incorporated into new legislation as part of a consolidation of several pieces of Queensland legislation. There have been no reported cases of a medical practitioner availing him or herself of the protection accorded by this provision. The relevant provision states:

Liability at law shall not attach to a medical practitioner, nurse or other person prescribed under a regulation in respect of an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency –

- (a) at or near the scene of the incident or other occurrence constituting the emergency;
- (b) while the injured person is being transported from the scene of the incident or other occurrence constituting the emergency to a hospital or other place at which adequate medical care is available; if
- (c) the act is done or omitted in good faith and without gross negligence; and
- (d) the services are performed without fee or reward or expectation of fee or reward.¹⁹³

¹⁹² For a review of Australian legislation and the common law which provides protection for professional and volunteer emergency service personnel see: Imtiaz, O, *Review of Volunteer Legislation*, Emergency Management Australia (1998).

¹⁹³ *Law Reform Act 1995* (Qld), section 16.

Northern Territory – offence of failing to provide medical treatment or assistance in certain circumstances

The failure of a medical practitioner to provide medical treatment or first aid to a person who is in urgent need of it may even constitute a criminal offence in the Northern Territory, depending on the circumstances. Section 155 of the Northern Territory Criminal Code, states:

Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of a crime and is liable to imprisonment for 7 years.¹⁹⁴

While this provision applies to all people, not just medical practitioners, a doctor is more likely to be found to be *able* to provide rescue, resuscitation, medical attention, first aid or succour than a untrained person.

VPLRC Inquiry

The question whether good samaritan laws should be introduced in Victoria was examined in 1997 by the VPLRC Inquiry. The Committee observed that while there have been no reported cases of a health practitioner being held liable for injuries arising in connection with their assistance in an urgent situation, ‘the fear of malpractice suits causes medical practitioners to avoid offering medical attention to people at the scene of an accident or in an emergency.’¹⁹⁵

The Committee recommended that:

The Victorian Government should enact legislation to provide a limited defence for medical practitioners and nurses who provide medical assistance at the scene of an accident or other emergency. The Queensland provisions contained in the *Voluntary Aid in Emergency Act 1974* should be used as a model in formulating the Victorian laws.¹⁹⁶

As yet, the recommendation has not been followed and there does not appear to be any plans by the Victorian Government to implement such statutory protection.¹⁹⁷

¹⁹⁴ The nature of this offence was examined by the Northern Territory Supreme Court in *Salmon v Chute and Dredge* (1994) 94 NTR 1.

¹⁹⁵ Victoria, Parliament, n 3, p 22.

¹⁹⁶ *ibid*, recommendation 2, p 28. It is noted that a doctor may be exempt from personal liability in respect of any injury or loss suffered by another as a result of the doctor’s actions as a volunteer emergency worker in an emergency activity covered by the *Emergency Management Act 1986* (Vic), section 37.

¹⁹⁷ The former Kennett Liberal Victorian Government deferred its response to this recommendation until a review commissioned by Emergency Management Australia that touched on this issue was completed: *Response To the Final Report of the Law Reform Committee of Parliament of Victoria: Legal Liability of Health Service Providers*, Victoria 1997, p 1. The review has been completed, see *Imtiaz O*, n 92. Note that this review does not address the liability of medical practitioners in the good samaritan context.

The PIR

The PIR examined the issue of good samaritan legislation and concluded that ‘the evidence would seem to indicate that public policy favours the encouragement of good samaritan acts, and while the possibility of a negligence action is very unlikely, it could act as a deterrent to someone providing such assistance in an emergency. This argument is even stronger in cases where there is a statutory requirement to assist.’¹⁹⁸ It recommended therefore that ‘..legislation be introduced to preclude a negligence action against a rescuer or voluntary provider of first aid services rendered in an emergency.’¹⁹⁹

Stakeholder views

There has not been much comment about this proposal. However, the New South Wales Shadow Attorney-General, Chris Hartcher MP, has recently expressed his view that good samaritan legislation ‘...is important in terms of social policy, and will help ensure that health care providers are able to offer assistance in emergency situations without fear of litigation.’²⁰⁰ And APLA has stated its opinion that good samaritan legislation is unnecessary and will have very little impact on the cost of indemnity insurance premiums. It also expresses concern about how good samaritan legislation ‘..will be implemented and how widely the net of ‘good samaritan’ protection might be cast.’²⁰¹

Arguments for and against good samaritan legislation

Arguments for good samaritan legislation can be summarised as follows:

- Doctors should be protected from liability for negligence arising for a good samaritan act;
- Legislative protection would encourage doctors to provide good samaritan assistance by removing the fear of litigation;
- Good samaritan legislation would not protect doctors who were grossly negligent;
- Doctors would also be made aware that as a class of citizens with particularly useful skills they are encouraged, above others to render assistance.
- Like non-medical people, some doctors may be reluctant to ‘get involved’ in good samaritan situations and the potential for litigation may be used as an excuse. Good samaritan legislation would remove this excuse.

Arguments against good samaritan legislation can be summarised as follows:

- Since there have been very few cases in which a doctor has been sued in the context of a good samaritan act, legislative protection from liability will have no impact on indemnity premiums.

¹⁹⁸ Commonwealth of Australia (Tito, Chairman, Final Report) n 2, p 240.

¹⁹⁹ *ibid*, recommendation 139, p 240.

²⁰⁰ Hartcher C, MP, n 174, p 18.

²⁰¹ Australian Plaintiff Lawyers Association 131, p 4-5.

5. CONCLUSION

The diversity of the reform options discussed in this paper illustrates that there are many elements that combine to make the issue of medical indemnity premiums complex. The paper has also highlighted the wide range of people effected by rises in indemnity premiums and the proposals for reform, including doctors, health care institutions, health care consumers, MDOs, commercial insurers, lawyers and the courts.

The paucity of data about medical negligence claims, and the lack of transparency in the financial affairs of MDOs, makes it difficult to understand the precise nature of the relationship between the current level of indemnity premiums, medical negligence, and the Government's reforms. The introduction of the bill to implement the New South Wales Government's 'rescue package' will no doubt raise further issues for consideration.

This paper has drawn upon the extensive work of the Commonwealth Government's Review of the Professional Indemnity Arrangements for Health Care Professionals and the Victorian Parliament Law Reform Committee's Inquiry into the Legal Liability of Health Care Providers. These inquiries reflect the national importance of medical indemnity insurance issues and the long standing recognition of the need for reform in this area.

APPENDIX I

Table showing the premium rates of Australian MDO's for 2001. The table was created by Cathy Saunders for the *Australian Doctor*, 15 December 2000, p 4.

APPENDIX II
3% and 5% present value tables for calculating discount on
future economic loss damages