

Medical Malpractice A Collective Responsibility



Peter Rush General Manager Catholic Church Insurances

Advances in medicine, developments in the law and court decisions, the general image of the doctor as a practitioner, as well as social, political and economic influences are all factors contributing to change in public perceptions of the medical profession.

This, coupled by the growing litigious nature of society has lead to a greater demand among doctors for protection to safeguard themselves against the risk of a medical malpractice claim.

The Australian health system is large and very well patronised by the nation's population. Annually there are 209 million Medicare services provided and approximately 5.7 million hospital admissions. Day surgery accounts for 55% of all surgical procedures. The Quality in Australian Health Care Study in 1995 showed that there was 16.6% adverse event rate based on health care activities in 1992. Of these 10.6% were in-hospital adverse events.

RISKS

Any discussion about liability insurance will rapidly lead to discussion about the risks. Let us have a look at the broad areas of the complex world of the medical profession.

The Patient

The doctor-patient relationship is basically one of trust, regardless of the actual success or failure of the medical treatment. One of the main points determining whether a patient is satisfied by his doctors treatment is whether or not they have the feeling of being respected as a person and treated as a human being.

Once dissatisfied, patients are likely to want to make the doctor accountable for failures. Society will support those patients with organisations, self-help groups and "no win-no pay" legal services available to help them with their quest.

The Doctor

Only 15 to 20 years ago, doctors were still surrounded by an aura of infallibility. New drugs, new technology, and an

enhanced understanding of the workings of the human body and diseases' effects upon it make today's medical practitioner a far different person than those of a few years ago.

In keeping with standard professional practice doctors are not subject to directions from others when making diagnosis and selecting treatment methods; they bear sole responsibility to the patient and the patient's relatives.

However in reality, doctors have less and less time to devote to individual patients and it is virtually impossible to comprehensively weigh up all the pros and cons and to discuss them all with a patient before deciding on the best treatment method. This clearly increases the risk as the result is solely dependent upon the doctor's own judgement.

A doctor's work is not comparable to any other job when it comes to the question of responsibility. Decisions, particularly if they turn out to be wrong, have serious and far-reaching implications; they literally affect life and limb.

Informed Consent and Failure to Warn

Prior to 1992, it was accepted that it was the medical profession that decided whether a material risk attached to a medical procedure should be disclosed to the patient to enable the patient¹ to decide whether or not to proceed with the procedure.

Since 1992, at least in Australia, this is no longer what the Courts accept. The High Court in the landmark case of *Rogers v Whitaker* (175 CLR 479 – 1992) determined that it is not the medical profession but rather the patients who should determine whether or not to proceed with an operation after all the material risks have been made known to them. The issue of informed consent again featured in more recent High Court decisions in *Chappel v Hart* (195 CLR 232 – 1998) and *Rosenberg v Percival* (178 ALR 577 – 2001).

From a hospital's perspective, it is therefore very important that all material risks are adequately identified and the patient made aware of such risks so that they are in a position to make an informed decision on whether or not to consent to a procedure. For a patient to be successful in claiming against a hospital, the patient will have to demonstrate that if warned of the material risks, the patient would not have undergone the procedure.

Consent forms are extremely important for the hospital as such documentation will show exactly what was discussed with the patient prior to surgery. Such documentation should clearly describe every possible consent issue discussed with the patient and finally such documentation should be signed and witnessed by the patient.

The Health Care provider

Whether the provider is a hospital or aged care facility or other type of medical facility many further risks exist for the patient.

Many different healthcare practitioners work in these health care facilities, people with differing experience and skill levels. And many different types of medical equipment can be found in these facilities.

Communications and organisational risks resulting from the combined activity of so many people have a direct influence on the medical care received by the patient.

Hygiene plays a key role in healthcare facilities especially in a hospital and more and more, home-based care is being provided for before and after care.

In addition, there are also social and charitable organisations, providing general patient welfare services.

The need for optimum planning, coordination and mutual information is evident in the enormous variety of decisions and decision makers, processes and general rules of conduct.

The Health Care provider as a general service enterprise

The Catholic Directory lists 58 Catholic hospitals, 105 Nursing and Convalescent homes and 221 homes for the elderly. This represents a substantial proportion of the total healthcare facilities available in Australia.

Let's consider the general services provided by these facilities:

- Accommodation - not only are accommodation standards high in the healthcare sector, consider the additional risk presented by fire in the cases of hardly mobile or completely immobile patients, as well as how patients in an intensive care environment, dependent upon lift support, would be evacuated in a case of emergency;
- Catering – not only the normal hygiene requirements but the effect of a wrongly labelled 'special' meal;
- Laboratories – the age, maintenance and regular testing of equipment – every substance, piece of equipment and process constitutes a potential hazard for patients, staff and visitors;
- Emergency medical care – consider helicopter landing pads and ambulance access, all separate areas of potential liability;
- Ancillary facilities – healthcare facilities often keep their own food stores or cafeterias for patients and visitors, there are external subcontractors such as laundries or cleaners, whose staff may not always behave as might be expected. Even though the responsibility for the above can ultimately be passed on in the event of a claim, the healthcare facility is the claimant's immediate target;
- Waste disposal – health care facilities can be a potentially substantial environmental risk, used bandages, needles and other surgical materials are all classified hazardous waste.

Risk of change

The advance in medicine made in recent years and decades have brought new knowledge and treatment methods and new hope to the sick. At the same time, this also entails greater risks.

With these more sophisticated procedures and drugs, there are shorter hospital stays and less observation of results, the trend is showing return hospital visits are on the increase.

Legislation and court decisions

In Australia, there is a host of differing legislation covering health care facilities and that legislation is becoming more and more prescriptive.

Also changes in court decisions have a direct impact on the liability situation in the medical sector.

One is an attempt to ensure Australians have excellent healthcare, the other to ensure when something goes wrong just compensation is available.

¹ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

However, Australians are following the lead of the Americans in embracing litigation as a standard option.

A significant number of high cost claims in the area of medical malpractice relate to baby claims. The most recent high profile claim in this category is the claim by Calandre Simpson v Dr. Robert Diamond (First Defendant) and St. Margaret's Private Hospital (Second Defendant). The Plaintiff suffered athetoid cerebral palsy as a result of complications resulting from an attempted forceps delivery. The claim attracted damages in the region of \$14 million making it the single largest medical malpractice payment in Australia.

The current debate in Australia centres around the concept of wrongful birth and wrongful life. The term wrongful birth describes claims by parents that may result from failed sterilisation or vasectomy, failed termination of pregnancy, failure to diagnose pregnancy, foetal abnormality and intrauterine infection. Claims are also brought following negligent genetic counselling.

Damages in such claims are currently restricted to general damages for pregnancy, labour and delivery, out of pocket expenses and economic loss. The issue of damages being debated is "can parents claim the costs of raising a child?" This issue was recently the subject of a special leave application to the High Court where the High Court granted leave for the matter to be appealed.

²Wrongful life is a claim by a disabled child in cases where but for the negligence the child would not have been born. In these type of cases the argument made is that the parents either would not have conceived or the mother would have terminated the pregnancy.

The claim for damages is premised on the fact that the child has to suffer the disabilities as a result of being born and therefore has the need for special care to live a life with disabilities as well as possible.

The whole issue of wrongful birth and wrongful life claims are as much public policy issues as they are legal issues. There would be vast divergent opinions in these debates and ultimately a decision rightly or wrongful will need to be made. Rather than allowing the Courts to decide these issues, maybe consideration should be given by governments to legislate in these difficult areas, especially in the area of wrongful life.

There are three significant factors which relate to insurance cover for baby claims such as Calandre Simpson's claim;

- Calandre was born in 1979, her claim was lodged in 1984 and it took 22 years before settlement was agreed in 2002.
- Back in 1979 the highest level of indemnity cover taken out by the public hospitals was only \$1 million. At that time the premiums charged by insurance

companies did not anticipate, nor reflect settlements of this size.

- To defend the Simpson's claim, the legal costs for the hospital alone are anticipated to reach around \$1 million.

Influence of the media

The media too, has a substantial impact on the coverage of medical malpractice liability and its outcomes.

Reports on medical malpractice are particularly prone to prompt some members of the public into believing that they too have been injured as a result of improper treatment.

Even television series based on the medical professional, ie: ER and All Saints, play a role in developing the expectations of patients when they attend a healthcare facility.

Financial Aspects

Funding in the healthcare sector is always tight. Any changes in legislation, the economy or government funding may lead to budget tightening which may in turn increase risk.

LIABILITY

Liability of the doctor

Doctors are personally liable for their own activities therefore in most cases, would have their own public liability and medical malpractice insurance. Doctors who are employed by a hospital may be covered by the hospital's insurance arrangement depending upon their contract of employment.

So what is the contract of liability between a patient and their doctor? Does the doctor undertake to produce a certain result successfully? Or does is the doctor contracted to render certain services.

The answer to that question is not clear-cut.

We do know that doctors have an/a

- obligation to inform their patients about the diagnosis and therapy. The information must include a description in a comprehensible manner of the treatment including any risks or dangers, or alternative treatments. This duty of disclosure becomes almost unique to every individuals situation when you consider the variety of possible clinical treatment methods and differing patients circumstances;
- duty to keep records;
- duty to organise and conduct checks;
- duty to obtain information and undergo continuing education;
- duty to obtain the consent of the patient before undertaking the procedure or treatment. Even with valid consent doctors may be liable if they make a mistake.

Hospitals also have similar obligations to

- maintain a suitable infrastructure and material equipment;
- organise and conduct tests, for example the hours worked by individual doctors or nurses;
- to co-ordinate, control and take action, such as emergency and disaster plans and standards for routine tasks;
- Duty to keep records and maintain documentation, eg: sufficiently transparent patient files.

A hospital can be found liable if it has failed to fulfil its organisational duties, or if it has hired or continued to employ unsuitable persons.

Depending upon the circumstances it can take a considerable time for a claim in the medical sector to manifest itself and for its full extent to become clear. For example the extent of the brain damage suffered by a new born baby cannot be detected until there are marked differences in its development as compared to other children of the same age.

Public Liability and Medical Malpractice Insurance

Catholic Church Insurances is a major provider of medical malpractice cover and currently insure approximately 5,000 beds throughout Australia.

Recent developments have severely impacted on the supply of medical malpractice cover in the Australian market.

The major impact is that all insurance companies have experienced heavy losses from providing medical malpractice covers. In 1999 the industries net loss ratio for Professional Indemnity and medical malpractice was 132% or a loss of \$281 million dollars. These results are a direct result of the increase in both number of claims and quantum being awarded by the courts.

Medical Malpractice, like only a few other special classes of insurance, has the potential for considerable claims latency. The periods of time between the action of the doctor, the detection of the injury and the possible raising of a claim for compensation, regular add up to several years or even decades, with a statutory limitation of up to 20 years.

A further consequence has been the demise of HIH and FAI which has reduced the overall capacity of the market.

Over the last 10 years medical malpractice indemnity has been provided by:

- Medical Defence Organisations for doctors
- Crown indemnity such as state government insurance funds for public hospitals
- Private insurers for private hospitals

Also over the last 10 years Australian based insurers have come and gone from the market as follows:

- FAI
- HIH
- GIO
- MMI/Allianz
- QBE
- Gerling direct

Only two now remain:

- CGU, and
- Catholic Church Insurances

Indications are that from 1 July 2002 the only Australian based insurer offering medical malpractice insurance to hospitals will be Catholic Church Insurances.

CGU will limit medical malpractice involvement to cover only nursing homes.

Private hospitals not insured by Australian based insurers have arranged covers overseas, generally through the Lloyds market and mainly through Marketform.

More recently we have seen United Medical Protection (UMP) going into liquidation. This is causing huge problems for the medical profession, the private hospital system and the community at large. Whilst the Federal Government has stepped in and provided cover for doctors that were protected by UMP, this arrangement expires on the 31 December 2002 and the basis of the cover is not entirely clear.

Unless doctors can obtain adequate cover at an affordable level, come 31 December 2002, many have indicated that they will leave their profession or at least will cease referring patients to private hospitals.

Many private hospitals have asked whether their medical malpractice policy can extend to include any additional doctors that they might decide to employ.

For this to occur, the doctors would have to be 'true' employees and not contractors, hospitals would need to be in control and give direction and hospitals would need to carry out the billings. The cost to include additional doctors would be substantial in line with what these specialists would be required to pay through their medical defence fund.

The amount depends on the speciality involved – obstetricians, neurosurgeons, having the highest premiums. Insurers would need full details of the claims experience and loss histories etc of each doctor.

The employment of doctors by hospitals would not solve all issues for doctors as past losses would not be covered. Doctors would still have ‘run-off’ exposure and this would be almost impossible to purchase now that UMP is in liquidation. To date, the Government seems to be silent on this complex problem.

The result is that many medical malpractice insurers have withdrawn their supply from this class of business, and most reinsurers have also withdrawn their supply of cover.

In this situation of limited supply and poor results, premium costs have risen accordingly, where insurance is available at all.

So why is this happening?

During the period from 1997 the insurance industry as a whole has experienced aggregated losses in excess of \$1.8 billion in their liability insurance portfolios.

The industry loss ratio in 2000, which is simply total claims divided by total premiums, was 134%. This means that in the public liability business, for every dollar received in premiums, \$1.34 was paid out in claims.

That leaves insurance companies experiencing these extreme losses.

In the past seven years there has been a dramatic change in the size/quantum of liability claims, as well as a greater likelihood of the claim going to court and the additional costs associated with defending those claims. This also means that claims are taking longer to settle than ever before.

Other factors affecting claim costs are:

- Strengthening of reinsurance rates, even before 11 September;
- Increasing medical technology costs and the increasing cost of doctors practising “defensive medicine.”

However the main drivers of claim costs are:

- Changes in societies attitudes:
 - The increasing tendency within the community to sue;
 - People are more inclined to claim and to litigate;
 - The media publicises the larger and more newsworthy awards thus leading to public expectation of large awards associated with personal injury litigation.
- The high cost of legal action:
 - Lawyers facilitate and promote litigation;
 - Lower courts appear to favour the plaintiff
 - When the insurer is unsuccessful in contesting a claim, legal costs are borne by the insurer often, in the converse, the successful

defendant/insurer is highly unlikely to recover costs from an unsuccessful plaintiff;

The insurance industry has become somewhat the “meat in the sandwich.” One of its commercial imperatives is to offer liability insurance at increased premiums to offset the increasing costs of claims. It is berated for the rises, but the reality is that insurance companies have little influence on the structural and institutional factors such as poor court case management, failure to legislate or regulate to ensure cases are settled early, and governments avoiding concepts of no-fault compensation (often because of the influence of the legal profession’s self interest). Additionally, dramatically rising court awards necessitate further increases in premiums to continue to offer liability products. The spiral, it seems, has no end.

CCI’s position

Catholic Church Insurances has also experienced heavy losses in this class of business but has not withdrawn from this class of business, in line with our mission to service the insurance needs of the Catholic community in all areas of its mission.

Catholic Church Insurances’ medical malpractice portfolio has shown underwriting losses over the last seven years, in line with the industry trend.

Year	Gross Written Premium	Gross Loss Ratio %	Net Loss Ratio %	Total Outstanding Claims
2001/2002	\$8,503,000	116%	497%	\$18,000,000
2000/2001	\$6,597,000	83%	310%	\$15,645,000
1999/2000	\$4,146,392	166%	441%	\$17,801,564
1998/1999	\$3,297,473	180%	263%	\$19,624,719

Whilst claims numbers have been relatively steady, the number of outstanding claims has been increasing therefore, in most Australian jurisdictions, it is settling claims at a slower rate now than in previous years. Also the values of the estimates raised on new claims have increased noticeably during the period, in fact the estimate on any average claim has increased some 319% overall for new claims.

Therefore, the outstanding reserves on known claims have increased by \$17.6 million since 1994/1995.

It is the growing size of claims rather than an increasing number of claims which is driving the poor underwriting experience of CCI.

The values of claims incurred, have increased from \$3.1 million in 1994/1995 to \$11 million in 2000/2001 – a 258% increase. For the same period the premium pool increased by 78%.

Our combined net loss for this period for the liability portfolio was \$36.1 million.

The losses cannot continue to be absorbed into the future and to ensure the long-term viability of Catholic Church Insurances, premium increases are necessary unless the expectations of the community change.

Medical Malpractice – A Collective Responsibility

This bulletin titled Medical Malpractice – A Collective Responsibility because we seem to be caught up together in a trend, driven by society as much as need, whereby litigation against medical malpractice is on the increase and the quantum being given in successful cases reaches new records on a seemingly regular basis.

CCI, will subject to the availability of reinsurance support, continue to provide medical malpractice insurance for the Catholic healthcare sector, but it will be at substantially increased premiums to mitigate the losses.

And the Catholic healthcare sector is growing.

There are a number of ways out of this upward spiral, all of which require us to work together to find solutions which may be risk management related or may need Government support and legislative change to be implemented.

The Future

So, what does the future look like if solutions are not found?

- Prices will continue to increase in order to meet increasing claim costs and higher reinsurance costs;
- The number of reinsurers willing to write this class will diminish;

- Reinsurers will be very selective in where their entry point of cover is;
- Clients will be required to carry higher excesses;
- Hospitals that employ doctors will find that their premiums increase dramatically, especially in the fields of obstetrics; gynaecology, neurosurgery orthopaedics and anaesthesiology;
- Specialists in private practice in rural or regional centres will find premiums unaffordable and will seek solutions such as employment at hospitals.

Conclusion

Catholic Church Insurances will continue to seek ways to offer insurance. But this will require substantial increased commitment by clients to improve clinical risk management.

We need the support of Catholic Health Australia and individual hospitals to achieve this – we cannot and should not accept sole responsibility. We must all take positive and confident steps if we are to reverse the trend. Only then can the number and size of claims be managed better.

It is our collective responsibility to ensure that all efforts are made to limit and minimise the impact of claims.

Disclaimer:

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