

Over the Horizon – The Emerging Risk

Recent years have seen the publication of the early results of risk management activities in Australian medical practices. It is pleasing to note that the outcomes of these studies are in keeping with overseas experience of a reduced frequency of claims and complaints among those practitioners who have adopted these strategies in their day to day practice. Furthermore, most doctors in this country are now well aware of the benefits of risk management activities and many have chosen to adopt the recommendations of their various professional organisations and medical indemnity insurers in this regard.

Current clinical and practice risks are, in general, well recognised but it is the unknown that will create difficulties for the medical profession in the future. It is comforting to note that claims and complaints of negligence against doctors in Australia have been steadily decreasing over the past few years. We would all like this situation to continue. For this reason, it is important to maintain current risk management activities but also to review contemporary medical practice for unrecognised risks. Practitioners, as well as their insurers and medical colleges, need to 'scan the horizon' and beyond for those treatments and procedures that are yet to make their presence felt. Insurers and their reinsurers, in the course of planning their financial reserves, naturally consider the future and are anxious about future developments and their, as yet unknown, associated risks. What is just over the horizon, what are the emerging risks?

Emerging risks are defined as a possible but as yet unproven change in the chance of an unexpected or unwanted incident or outcome occurring. This change in chance may involve



something practitioners already do, something completely new or something they now do less. Examples include:

- new technologies;
- new procedures;
- novel pharmaceuticals;
- e-medicine;
- changes in legislation and community attitudes and practitioners becoming less proficient in an activity due to a reducing workload

As clinicians get older or as they do less procedural work, or treat a particular condition less frequently, there comes a time when perhaps they are just not as skilled as they once were. For the medical profession the risk of unwanted outcomes or adverse events increases in these situations. Thus there comes a time when it is sensible to consider whether it is time to stop doing procedures or managing diseases which are rarely seen and instead to refer the problem on to a colleague who is still very active in this area. This is an important issue for the medical profession to consider.

Any change in the practice environment, whether initiated internally or externally, should prompt a careful review of the issue involved and how it might increase the likelihood of an unwanted outcome, including a negligence claim or complaint. For example, it is important to be aware of the side-effects and drug interactions of a new drug therapy. Similarly, it is important to be cognizant of all the ramifications of legislative changes that affect medical practice. The ability of the medical profession to remain apprised of these issues has a significant impact upon their risk management outcomes.

Eternal vigilance and monitoring the emerging and changing landscape is the key to avoiding the pitfalls of the future. Early recognition is the key to avoiding problems down the line. From the individual practitioner's point of view, early recognition requires:

- learning to recognise barriers to identifying emerging risks (such as group thinking, blind spots, tunnel vision and weak signals);
- personal experience review;
- literature and the internet watch; and
- honesty regarding personal practice experience (when is it time to stop operating or treating certain conditions?).

From the corporate standpoint, managing emerging risks involves being observant of environmental changes in medical practice both here and overseas, the identification of new potential risks, and applying processes to limit any possible adverse events that may arise from them, thus making medicine safer.

The identification of emerging risks is both the responsibility of the individual medical practitioner and the wider profession. It is important to share knowledge and experience so that the likelihood of adverse outcomes is minimised and the benefits of shared knowledge can be maximised.

Dr Jonathan Burdon
MIIAA Chairman

National Patient Charter of Rights

In February 2008 the MIIAA provided a submission to the Australian Commission on Safety and Quality in Healthcare on the development of the National Patient Charter of Rights.

The MIIAA did not have concerns about the wider concept and general content of the Charter or National Patient Charter Principles. The Principles reiterate existing broad principles in place in the health care system and therefore the implementation of the Charter would be unlikely to have any new medico-legal impact on individual doctors.

The MIIAA did, however, comment on the need to adequately outline the responsibilities of patients in the Charter and Principles. The MIIAA believes that the Principles should be strengthened to address more explicitly the patient's responsibility to communicate with their health provider.

The MIIAA also believes that there could be an increased emphasis on the importance of the partnership between the health care provider and the patient.

The MIIAA further suggested that there should be recognition that patients and health care providers have a responsibility to treat each other with respect, and that this would serve as a reinforcement of the importance of the relationship between the patient and health care provider.

A copy of the submission can be found on the MIIAA website at: <http://www.miaa.com.au/submissions.php>

2008 Medical Indemnity Forum

The MIIAA is holding the second Medical Indemnity Forum on 4 September 2008 at the Novotel on Collins in Melbourne.

Details of the Forum will be released as the date gets closer, but the topics to be covered include:

- The major challenges for the Medical Indemnity Sector
- Improving professional competence
- What are emerging risks and what can we do about them?

Details of the programme will be included on the MIAA website www.miaa.com.au as they are available, and a registration form will be circulated in July.

For information contact Ellen Edmonds-Wilson on ellen@miaa.com.au or on 08 8113 5312.

MIAA response to APRA – Refinements to the General Insurance Prudential Framework

In December 2007 the Australian Prudential Regulation Authority (APRA) released its second consultation paper on Refinements to the General Insurance Prudential Framework. In February 2008 the MIAA provided a submission to APRA on the issues which affect medical indemnity insurers.

One of these issues was the transition arrangements for implementation of the proposed changes to the treatment of reinsurance recoverables, which MIAA believes may not be adequate for long tail classes such as medical indemnity. Because reinsurance recoverables from pre-June 2008 contracts in medical indemnity will be significant, it was suggested that the transitional arrangements be extended by a further four years to 2016 for reinsurance policies arranged solely for the purpose of medical indemnity prior to 30 June 2008.

The MIAA submission also expressed concern regarding the proposal for insurers to fully capitalise reinsurance recoverables from non-APRA-authorized reinsurers. The modified proposal by APRA proposed a 100 per cent investment capital factor which would mean that the entire value of the recoverables would be added to the Minimum Capital Requirement (MCR). The MIAA submission recommended that APRA select a capital factor of less than 100 per cent, which would provide a deterrent against placing business with non-APRA-authorized reinsurers

but would acknowledge that there is clearly significant value in their recoveries compared to their non-existence.

The MIAA submission also commented on the following issues:

- Recoverables to be payable to the insurer in Australia
- Investment charges
- Capital buffer
- Time to put security arrangements in place
- Future selection of reinsurers

A copy of the full submission can be found on the MIAA website at: <http://www.miaa.com.au/submissions.php>

Stop Press – APRA announces position on reinsurance recoverables

On 2 April 2008 the Australian Prudential Regulation Authority (APRA) released its final position on the refinements to general insurance following their consultation process. APRA has revised its original position on reinsurance recoverables and investment capital factors.

APRA intends to apply a risk-based scale to the recognition of reinsurance recoverables, based on reinsurer ratings. Past reinsurance arrangements will be 'grandfathered' so that no reinsurance recoverables arising from reinsurance contracts entered into before 31 December 2008 will be affected. No additional capital requirements will be applied to such recoverables (other than the credit risk counterparty capital charges).

APRA will be expecting that insurers, their actuaries, board and management will make explicit attestations regarding the value of the insurer's reinsurance recoverables at each balance date.

A copy of the APRA announcement can be obtained from their website:

http://www.apra.gov.au/media-releases/08_06.cfm

Communication between Medical Boards and Insurers

The Council of Australian Governments recently released an inter-government agreement which proposed to proceed with a national medical registration system from 2010. National medical registration and risk management have important links because of patient safety concerns.

The MIAA Board regularly discusses issues of risk management, and the means by which doctors whose risk is assessed as being higher than their cohort can be assisted. When these discussions occur, the role of the state medical boards and the interaction between insurers, Colleges and the Boards inevitably arises. There are many impediments to the sharing of information between Insurers, Colleges and the Medical Boards, including state and national privacy legislation, but there are instances where there would be great benefit to the community if the relevant organisations were able to share this information.

To ensure that appropriate communications can occur it may be necessary to undertake legislative change. Mandatory reporting of high risk doctors is likely to be a component of the national registration scheme, particularly for matters of serious misconduct, and NSW is set to introduce legislation shortly with a mandatory reporting provision.

Dr Jonathan Burdon, MIAA Chairman and Ellen Edmonds-Wilson, CEO, are currently undertaking a series of meetings with the Medical Boards in each state to discuss the issues of communication between those organisations who are responsible for ensuring the safe practice of medicine.

ROCS percentage to change

The Minister for Health and Ageing, the Hon. Nicola Roxon MP has approved the amendments to the Medical Indemnity (Run Off Cover Support Payment) Regulations such that the rate (applicable percentage) for ROCS SP will be reduced to 5.0% for all insurers in lieu of the current applicable percentages

that range from 8.5% to 9.5625% depending on the insurer.

The reduced percentage follows a review as to whether the previous applicable percentages were either adequate or inadequate to meet the actuarially projected needs of the Run Off Cover Scheme.

These new arrangements will apply from the contribution year commencing 1 July 2008 so that the new rate will apply to all premium income received from 1 June 2008.

The MIAA expects that the financial savings to the medical profession from these amendments will approximate \$10m per year.

2008 Medical Indemnity Forum

4 September
2008

at the

Novotel
on Collins,
Melbourne

Put this date in
your diary now!