EXPERT WITNESSES

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total) to be accepted. The primary interest of all parties is for the facts of the case to be identified as early as possible so the parties can then determine whether the matter should be settled or defended.

However a court can only make a determination based on the oral submissions of counsel and the evidence (including the expert evidence) that is presented to it. If "hired guns" could be removed from the system, perhaps compensation could be paid to those who are deserving and denied to those where their claims have no merit.

The Federal Court and Supreme Courts in various states have Codes of Conduct which expert witnesses are required to follow. There has been recent judicial comment on independent experts. Various bodies and commentators have prepared useful documents. These include the NSW Law Reform Commission Report on Expert Witnesses June 2005, Better Expert Reports ASIC February 2005, ASIC Practice Note 42.

Allan Tattersall
Chairman – MIIAA Risk Management and Claims Committee

EARLY RESOLUTION OF DISPUTES

There is increasing interest by medical practitioners and their professional associations in the use of early resolution techniques designed to reduce the incidence of formal complaints, investigations and claims.

A number of professional associations have introduced dispute resolution processes which seek to resolve disputes between their members and patients. The process usually involves the establishment of a dispute resolution team, investigation, determination, mediation and in some cases the doctor may make a payment (for example for the patient to receive further treatment).

There is clear evidence that early non-adversarial based dispute resolution can be effective and economic, and such schemes are to be encouraged and are likely to become more widely used.

The MIIAA has developed a policy position in relation to dispute resolution schemes to ensure that:

- The actions taken by medical practitioners who participate in such schemes do not prejudice or otherwise impact on their insurance protection; and
- Both individual practitioners and professional bodies participating, developing and or running such schemes are fully aware of any insurance implications.

The MIIAA has recently released its position statement which recognises the efficacy of a well executed early dispute resolution process and the importance of such schemes acknowledging that insured doctors have obligations to notify insurers of incidents and claims. The individual terms and conditions of a policy will vary, but in general the insured doctor is:

- Obliged to disclose to their insurer (or prospective insurer) every matter known to them, or that could be reasonably expected to be known, relevant to the insurer's decision to accept the risk and issue (or renew) a policy; and
- Once the policy is issued to notify the insurer of incidents and claims, so that the insurer can take action to protect the insured, and where appropriate minimise or mitigate any potential loss.

The types of matters of which insurers typically require notification (subject to individual terms and conditions), may include the following types of health care incidents:

EARLY RESOLUTION OF DISPUTES

- A patient suffers a major complication;
- An error made in providing health care;
- An adverse outcome which results in significant anger in the patient or their family; and
- The practitioner is concerned that something has happened (including a complaint, investigation or inquiry) which is thought may lead to a claim.

The handling of a matter by a dispute resolution scheme in which the insurer is not involved does not change the practitioner's obligation to advise their insurer of the incident. The failure to do so may have an impact on an insured's right to indemnity.

Should a practitioner make a payment under a dispute resolution scheme without the prior approval of their insurer, then subject to the terms of their individual medical indemnity insurance policy, they may:

- Be in breach of their obligation not to admit liability. Note this is different to the giving of an apology; and
- Not be able to recover such payment from their insurer should they later wish to do so either because their policy specifically excludes payments made without the insurer's consent or because the matter is not a valid claim under the policy.

The making of a payment without advice to the insurer may mean that a doctor is not covered or that their right to indemnity may be reduced.

The MIIAA recommends that professional bodies seeking to establish dispute resolution schemes ensure their processes are referred to individual insurers to ensure that insurance obligations are taken into account in the scheme.

The MIIAA also recommends that medical practitioners who participate in a dispute resolution process advise their insurer of any incident in accordance within their obligations under their insurance policy.

There is clear evidence that early non-adversarial based dispute resolution can be effective and economic, and such schemes are to be encouraged and are likely to become more widely used.

The MIIAA is keen to ensure that practitioner led dispute resolution schemes are established which assist in a reduction in complaints, investigations and claims and at the same time ensure the insurance protection of medical practitioners is not adversely impacted.

A copy of the position statement can be obtained by contacting Ellen Edmonds-Wilson on 08 8113 5312 or ellen@miiaa.com.au

Ellen Edmonds-Wilson
MIIAA CEO

MIIAA
MEDICAL INDEMNITY INDUSTRY ASSOCIATION OF AUSTRALIA

NEWSLETTER

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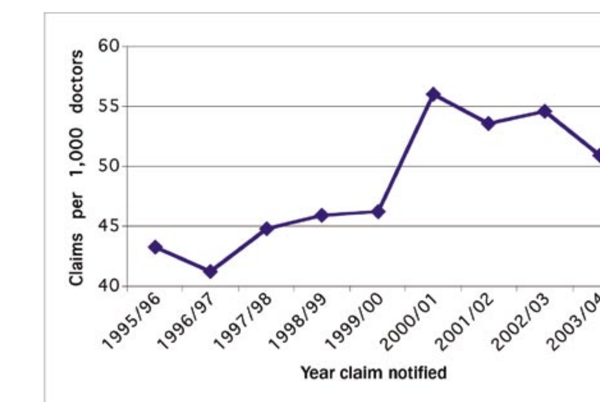
TORT LAW REFORM NEEDS TO STAY

Tort reform has been an important component of the stabilisation of the medical indemnity industry in recent years. Though tort reform is in the hands of state governments, which has inevitably led to some inconsistencies across Australia, the reforms have had a positive impact on the affordability and accessibility of medical indemnity insurance and benefited the community as a whole.

Tort reform occurred as a result of a number of factors, including the increasing incidence of high cost claims, in addition to increasing claim frequency nationally, as figure 1 below indicates:

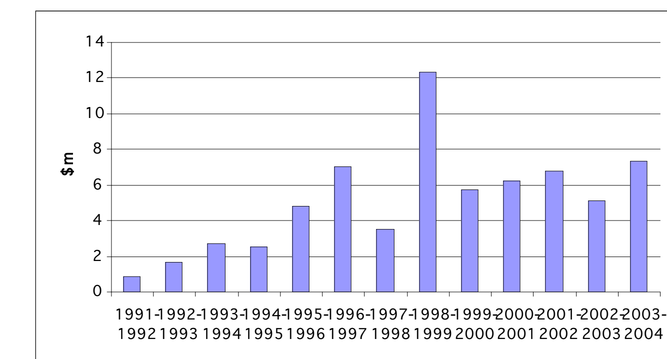
Figure 1 – Claim frequency by year



For all practitioners insured by MIIAA members, the claim frequency (or number of claims reported per 1,000 insured practitioners) was between 41 and 47 for the five years from 1995/96 to 1999/2000. These figures jumped 20 per cent to 56 in 2000/01, reflecting the NSW experience that seems to have arisen from the claims 'spike' as a result of tort reform. It has been decreasing since that time.

The size of claims was also increasing, as is shown in figure 2 below:

Figure 2 – Largest Claims Settled



Since early 2001 tort law reform was instituted nationally, with most reforms being aimed at constraining the number and size of personal injury payouts. Though not consistently applied nationally, the major reforms included the introduction of:

- Caps on damages for economic loss and non-economic loss;
- Minimum threshold of impairment to access damages for non-economic loss settlement awards;
- Changes in the limitation periods for personal injury cases;
- Increases in discount rates that apply to claims payouts; and
- A cap applied in legal fees in NSW, which anecdotally has had the impact of reducing the number of smaller claims.

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TORT LAW REFORM NEEDS TO STAY

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Tort reforms are still being tested, as the nature of medical indemnity claims is that there may be many years between the period for which cover was provided and the date when medical indemnity claims are finally settled. Though the reforms have reduced limitation periods, the long tail nature of medical indemnity insurance means that insurers must identify the likely cost of all future claims and build this into the premium structure. The prudential regulation of insurers requires that there be a safety margin built in so that they have enough capital to meet these anticipated claims, and are prepared if estimates are short of the real cost in years to come. This provides security for the future of the medical profession and for patients who need to access compensation.

The Australian Competition and Consumer Commission (ACCC) report in February 2006 on medical indemnity insurance indicated that the ultimate cost of claims, claims frequency and ultimate average size of claims had decreased in recent years. The report also indicated that the actuaries who advise the insurers were giving different weightings to the impact of the reform to tort law. The level of savings assessed by each insurer varied, and therefore the effect on the cost of providing medical indemnity insurance varied. The ACCC indicated in its report that it considered the cautious view of tort law reform was actuarially justified, but encouraged insurers to undertake a detailed analysis of tort law reform on claims experience for the 2006-2007 underwriting year.

Tort reforms are in the implementation phase and have not been widely tested in the courts. The history of legislative reform would suggest that it could take up to ten years for equilibrium to occur. In the meantime, tort reforms should be protected from roll back and where possible made consistent across jurisdictions.

There are important but less obvious flow-on effects of litigation, such as the loss of medical workforce who retire after experiencing the tort process. The decreased burden of minor and vexatious claims will also mitigate these effects.

Since early 2001 tort law reform was instituted nationally, with most reform being aimed at constraining the number and size of personal injury payouts.

Inappropriate concessions to the anti-reform lobbyists on these much needed reforms will result in increased costs to doctors, patients and the community.

Dr Andrew Miller
Chairman - MIIAA

EVERYONE IN THE TEAM NEEDS REGULATED INSURANCE

In late 2005 the Department of Treasury released a discussion paper on the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003. The MIIAA provided a submission to the review of the Act, with the March 2006 edition of the MIIAA newsletter featuring a summary of this submission. A full copy of the MIIAA submission can be found on the MIIAA website: www.miiaa.com.au.

Treasury has been consulting widely on their proposals, and the MIIAA has been pleased to provide advice and input to Treasury. The consultative approach undertaken by Treasury has been welcomed and their willingness to recognise the concerns of the medical indemnity industry is appreciated.

However MIIAA members remain concerned that the proposed changes to the Act may expose doctors to increased claims and higher premiums.

The Treasury paper canvassed limiting the requirement for prudential supervision to doctors, while the current Act applies to all health care professionals (as defined). While it is not mandatory for many health care professionals to have insurance cover, in the event that they do take out a policy it must meet the requirements of the Act. Amongst other things, this means it must be with an APRA regulated insurer.

If other members of a health care team are exempted from the requirement to have prudentially regulated insurance, the potential exists for doctors to be seen as the insurer of last resort (ie they will have the 'deepest pockets') and therefore are likely to have more claims made against them. Some health care professions have a higher risk profile than many doctors but, without adequate insurance, will be less likely to be sued in the event of an adverse outcome as the plaintiff will determine where the highest likelihood of success may be.

The flow on effects of doctors being the only adequately insured member of the team are significant. If the potential to apportion contribution to the outcome is removed, doctors and their insurers could be exposed to the full cost of a settlement irrespective of their contribution to liability.

The risk to consumers and patients is also greater if doctors are the only appropriately insured members of a health care team.

The cost to the insurers and the government via the High Cost Claims Scheme [HCCS] and Exceptional Claims Scheme [ECS] may increase as a result of this. As the cost of claims increases for the medical profession so will the cost of insurance and ultimately doctors will pay more.

The risk to consumers and patients is also greater if doctors are the only appropriately insured members of a health care team. The federal government introduced prudential regulation to provide consumers and patients with security by ensuring their capacity to pursue and obtain damages should a claim of medical malpractice be proven. There is a risk that patients will not be adequately compensated if it can be proven that the doctor did not contribute to the outcome and other members of the health care team are not adequately insured. The health care professional could be personally exposed to risk if they are not insured, if they have inadequate cover, or if their insurer at the time of the incident no longer exists and they do not have ongoing cover to protect them.

There are potentially serious implications of the proposal by Treasury, and the principal outcomes are likely to be:

- Reduced consumer protection
- A reduction in the long term strength of the healthcare indemnity industry.

The proposal by Treasury is at odds with the thrust of government policy to protect consumers and ensure that indemnity insurance is affordable and accessible. The proposal has a risk of undoing many of the positive outcomes achieved by the government and medical indemnity insurers in the past three years.

Ellen Edmonds-Wilson
MIIAA CEO

EXPERT WITNESSES

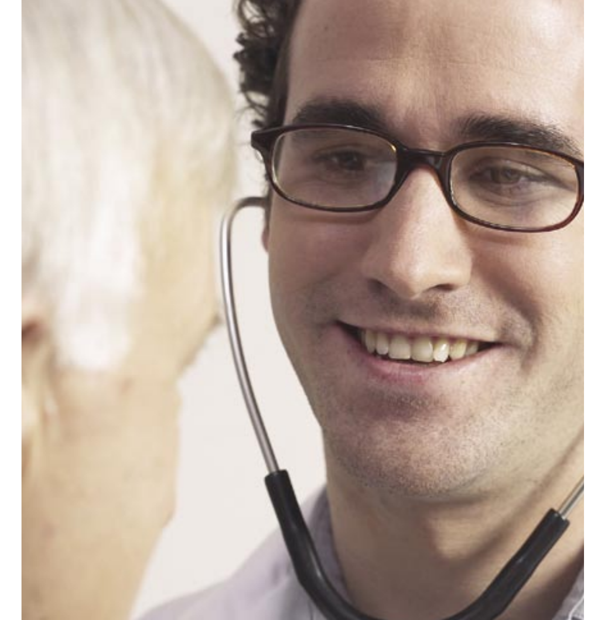
The outcome of any medical negligence matter is inextricably linked to the strength of the expert opinion that is brought forward. The strength of the expert opinion not only relates to the medical expertise of the expert, it also relates to their ability to deliver their opinion.

There has been a recent trend for some of the medical colleges to develop medical expert accreditation schemes. It is a positive step that anyone required to give evidence understands what is expected of them. However, the test of the success of such schemes will be whether they encourage those medical practitioners who are truly expert in their chosen field, to come forward and provide evidence. It will be less than successful if it only makes a less competent "expert" appear highly competent in the delivery of their opinions.

In providing an expert opinion in a court, the expert must always be aware that their duty is to the court and not to the person who retained them as an expert. The various jurisdictions have practice notes to assist expert witnesses. For example the Federal Court's Practice Direction for Expert Witnesses, which can be found at: www.fedcourt.gov.au/how/prac_direction.html#current.

In many cases, claims do not proceed to court. However, even in the case of an unlitigated matter, it is still the professional duty of the expert to remain impartial and to provide an unbiased assessment. In giving an opinion, the expert must remain impartial and not act as an advocate.

A significant concern in relation to the provision of expert evidence is how the expert's area of expertise relates to the medical issues that need to be addressed. A polished performance from an "expert" who has minimal knowledge about the specific area of medicine could well appear to be more compelling than evidence provided by person who is regarded by their peers as the "expert", but may be less skilled in the delivery of evidence. It is therefore essential that the expert's credentials are clearly communicated to ensure that his/her expertise can be clearly differentiated from the expertise of other experts so that the difference is well understood by the court.



It is also essential that the relative expertise of the defendant be measured against the appropriate standard of care of a peer; i.e. a defendant GP's standard of care must be measured against the standard of expertise expected of a GP. In what can only be interpreted as a significant concern in the management of a trial was a recent experience where a judge seemingly could not see any issue in assessing a GP's standard of care against the expert evidence provided by a cardiologist.

Early resolution is in the interests of the parties (both the patient and the medical practitioner). This is particularly the case for any Medical Indemnity Insurer (MII) – it is crucial that they obtain relevant expert advice about the case to ensure they can resolve those matters where the standard of care is below the acceptable standard. The concept of a "hired gun" in such circumstances makes no sense at all. In a judicial system that is without bias, what value is there in using an expert who provides a less than expert opinion?

It is probably true that at some point all parties involved in claims matters have used experts who may be perceived as "hired guns" in order for the respective side to put the best light on their case. While judges and barristers are very aware of the "hired guns" and treat their evidence with little or no probative value, it is still possible for their opinions (in part or

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