CHAPTER 10

LITIGATION AND OBSTETRIC PRACTICE AND PROVISION

Introduction

10.1 The Inquiry's terms of reference did not directly raise the issue of litigation and its effect on obstetric practice in Australia. Nonetheless, many practitioners and other witnesses raised concerns about the impact of litigation on birthing service practice and provision. Due to the frequency with which the issue was raised and its marked impact on practice and provision of services the Committee has included this discussion of litigation issues in its Report. Aspects of litigation are also discussed in chapters 2, 5 and 7 of the Report.

10.2 The alleged effects of litigation include:

- both obstetrician/gynaecologist specialists and GPs leaving obstetric practice because of the level of medical indemnity premiums;
- obstetrician/gynaecologist specialists and general practitioners leaving obstetrics because of **fear** of litigation;
- an aggravation of an already existing shortage of rural birthing service providers; and
- the practice of so-called 'defensive medicine', particularly in relation to the performance of Caesarean section but also in relation to other procedures such as ultrasound screening.

10.3 All these issues were discussed in some depth in the Final Report of the Professional Indemnity Review (PIR) in 1995, which concluded a four and a half year review of compensation and professional indemnity arrangements for health care professionals in Australia.[1] Many of the conclusions of the PIR were supported 18 months later by the conclusions of the Victorian Law Reform Committee.[2] Both these reviews arose partly out of the same concerns as those expressed to this Committee. For example, the Victorian Committee's Chairman's Forward stated that the inquiry:

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1 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - A Final Report*. (PIR Final Report) AGPS Canberra November 1995 (Australian Government Publishing Service) AGPS Canberra : chapter 10. Copies of this chapter and the rest of the report are available at the following location on the Department of Health and Aged Care's web-site: http://www.health.gov.au/pubs/hrom/theainsu2.htm.

2 Parliament of Victoria Law Reform Committee. *Legal liability of health service providers*. Final Report. (VLRC Report) May 1997 Victorian Government Printer Melbourne.

> arose out of Government concern that the increasing cost of professional indemnity insurance could affect access to medical services, particularly in provincial and rural Victoria.[3]

Publicly available data on litigation

10.4 Unfortunately, the Committee faced many of the same barriers as the PIR did in trying to assess the validity of most of these assertions. There is still no publicly available national data on the frequency, cost (including payouts and legal fees) and causes of medical negligence litigation in Australia. As an urgent starting point to a truly informed debate on these important issues, the Committee supports recommendation 9 of the PIR which proposed:

> the establishment of a national minimum data set for health care negligence cases, which 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 be able to benefit from the intervention of active prevention strategies. The contributors to the data base should be all MDOs, any insurers providing health care professional indemnity cover either to individual practitioners or facilities, and all State governments and private sector self-insurers.[4]

10.5 Without such information no sensible decisions can be made about the increase in litigation, sometimes referred to as a 'litigation affliction,' said to be adversely affecting birthing services in Australia may well be inappropriate. There are also no other readily accessible public sources of data on medical litigation. The courts generally do not keep separate statistics for medical litigation, though the period since the conclusion of the PIR has seen the establishment of a separate 'medical list' in the County Court of Victoria in January 1998. While the list also includes litigation against related professionals, such as chiropractors, dentists and veterinarians, it provides some limited information.[5] The head of the list reported at a Workshop of the Royal Australasian College of Surgeons in October last year that:

> At the commencement of the list there were 300 matters on it and some 10 months later there were just under 430. Five to ten cases were being resolved per month.[6]

10.6 While the data is relatively limited, being from one court in one state only, it provides some support for the assertion that overall an increasing number of cases are being brought against doctors, though the number of cases remains relatively low.

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3 See VLRC Report at note 2 : p.xvii.

4 See PIR Final Report - note 1: para 2.93, p.31.

5 Tito F. "Royal Australasian College of Surgeons Workshop on Medical Litigation - Alternative Processes - Friday 30 October 1998: Summary of Proceedings" in *The* Quarterly Journal of the Royal Australasian College of Medical Administrators March 1999 vol 32(1): p.6.

6 Ibid, p 5.

Data on litigation from Medical Defence Organisations

10.7 Although there have been some limited inroads by private insurers in low risk areas of the medical profession, medical defence organisations (MDOs) still provide the vast majority of professional indemnity cover for medical practitioners in Australia. Their operations are described briefly below.

10.8 Despite requests from the Committee, MDOs were unwilling to provide data on the frequency, cost and causes of litigation against both specialist obstetrician/gynaecologists and general practitioners providing obstetric services.

10.9 Even their own members have been unsuccessful in gaining access to this information. Following a recent 'call' on their members by some MDOs, a meeting was held between the AMA and the MDOs in Melbourne on 27 November 1999. At this meeting options to gather nationally aggregated, deidentified data were once again raised with the MDOs, with the options of collection by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare being raised. The AMA is still pursuing this national option.

10.10 The urgency of the issue has surfaced recently with at least two of the MDOs, MIPS and MDAV, making 'calls' on their members to address chronic underfunding of their 'incurred but not reported' (IBNR) liabilities. For obstetricians/gynaecologists in MIPS, this call means their contribution this year will be $54,000 (double their annual contribution of $27,000 for 1999/2000) though the MDOs are allowing members experiencing difficulty in meeting the call to contribute over a 4 year period to lessen its immediate impact. There is a requirement for a practitioner to pay at least 20% of the call this year. This would make the amount payable this year to MIPS for a specialist obstetrician/gynaecologist up to $32,400, which is still below the NSW United Medical Protection (UMP) contribution of $41,400.

10.11 Even at these levels, specialist obstetricians/gynaecologists are rightly concerned that contribution levels may continue to rise. For example, UMP were reported as claiming that their $41,400 contribution still involves significant cross subsidisation with other parts of the medical profession. Without this cross-subsidisation, UMP has claimed that these contributions would be over $60,000. Without better data, publicly available and available to their members, the accuracy or otherwise of these estimates is impossible to judge.

Obstetrician/gynaecologist concerns about data

10.12 Obstetricians/gynaecologists have themselves expressed scepticism about the accuracy of subscription estimates, which are made without reference to publicly available data. They base their concerns upon their recent experiences in NSW. NSW specialist obstetrician/gynaecologists campaigned late last year to get the liability for negligence actions relating to public patient births covered by the NSW Government's professional indemnity arrangements, rather their own private MDO coverage. They

claim that they had been led to believe that this would result in a decrease in contributions.[7]

10.13 However, following the obstetricians/gynaecologists successful campaign, the principal MDO in NSW (UMP) further increased its subscription rate for specialist obstetricians. This resulted in significant anger in the specialty group. The UMP claimed that if the specialists' campaign had not been successful, fully funded contributions would have exceeded $90,000. Without publicly available data and open member scrutiny, doctors argue that the validity or otherwise of any of these assertions cannot be tested and their financial positions are subject to the untested whims of the relevant MDOs. They also argue that without this information they cannot properly direct their risk management efforts.

10.14 This is consistent with concerns raised in the PIR's Final Report, which showed that, in terms of the frequency of litigation, the number of cases involving specialist obstetricians/gynaecologists', gynaecological business far exceeded the number of cases involving their obstetric business, in particular, the number of cases involving so called 'brain-damaged babies'.

> Because of the large cost effects of this very small number of claims, public discussion on these issues has wrongly linked the frequency of suit to brain-damaged baby litigation. In fact, 80% of the cases numerically made against obstetricians and gynaecologists relate to their gynaecological practice.[8] Almost one quarter of these claims related to complications following hysterectomy, while the next two most frequent groups of claims relates to failed sterilisations (18%) and laparoscopic complications (15%). The next two biggest groups – each around 10% – related to missed or delayed diagnoses and problems associated with intra-uterine contraceptive devices. The remainder consisted of a mixed bag of complications of various operative procedures, accidental sterilisations, failed terminations, burns, drug errors and retained swabs/instruments.
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> Of the remaining 20% of cases, relating to their obstetric practice, slightly less than half related to damage to the mother in the birthing process, and just over half related to damage to the baby.[9]

10.15 The reverse is true in relation to the costs of litigation, with the very small number of successful 'brain damaged baby' cases contributing disproportionately to

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7 Statements made by Dr Phillip Cocks of the National Association of Specialist Obstetricians and Gynaecologists at the joint RACOG/NASOG conference entitled 'In the Trenches' held in Sydney on 24-25 April 1999.

8. The PIR reported that 'This data on claims made between 1980 and 1993 was kindly provided by the Medical Protection Society - other MDOs were unable or unwilling to provide this information, though none have provided any contrary information to this. The view has been conveyed by several that this is broadly similar to their experiences'. It is understood that the perception is that the pattern remains similar in more recent years.

9 PIR Final Report - see note 1: paras 10.52-10.53, p.275.

the costs of MDO premiums, and driving the costs of premiums for those specialists who practice obstetrics significantly above those who do not in most MDOs. In terms of prevention of the frequency of litigation, this kind of information is invaluable, but it is not currently available.

10.16 The Committee understands that the AMA is currently attempting to obtain access to such data on a national, anonymous, aggregated basis across all areas of medical practice to enable much better targetting of preventive risk management effort. The Committee believes that the current secrecy surrounding the operations of the MDOs is unacceptable and that the MDOs should be open to public accountability and scrutiny.

Recommendation

The Committee RECOMMENDS that the Australian Institute of Health and Welfare establish national comprehensive data on medical defence organisations to cover negligence cases and include such data as premium payments, number of cases, number of claims, number of out of court settlements, size of payments and size of fund reserves.

The MDO Industry

10.17 There has been some consolidation in the medical defence industry since the mid 1990s. At the time of the PIR there were 10 MDOs operating in Australia. This is now down to 6:

- United Medical Protection (UMP), which competes nationally and has almost all MDO business in NSW and Queensland;
- the Medical Indemnity Protection Society (MIPS) which operates in Victoria;
- the Medical Defence Association of Victoria (MDAV) which operates in Victoria;
- the Medical Defence Association of South Australia (MDASA) which operates in South Australia;
- the Medical Defence Association of Western Australia (MDAWA) which operates in Western Australia; and
- the Medical Protection Society of Tasmania (MPST) which operates in Tasmania.

10.18 The two large British based MDOs – the MDU and the Medical Protection Society (MPS) – have essentially withdrawn from the market. There have been some minor incursions into the territory of the MDOs by private insurers, but most of the market is still operating under the traditional MDO discretionary mutual arrangement.

10.19 The distinguishing feature of the operations of MDOs is that the 'cover' of their members is not considered to be an insurance contract. As such, their discretionary operations are not regulated by the Insurance and Superannuation

Commission and are not licensed under the *Insurance Act 1973*. In its purest form, members of MDOs pay subscriptions and the MDOs exercise their discretion to pay out on any claim made against a member. The concept of discretionary cover was explained in the PIR's Final Report in the following manner:

> *Discretionary cover* describes the indemnity cover provided by medical defence organisations (MDOs) and a small number of other health care professional discretionary mutuals operating in Australia at the moment. No contract exists whereby a member is guaranteed payment of their professional indemnity liabilities, though there appears to be only a few examples where MDOs have exercised their discretion not to cover an individual doctor or group of doctors.[10] Recent statements from one MDO have indicated that they may exercise their discretion adversely against certain kinds of cases such as negligence cases involving sexual impropriety.[11] The nature of this indemnity means the organisations offering it are not insurance companies, and so they operate outside of the regulatory framework covering insurance.[12]

10.20 Some MDOs now offer a combined arrangement, where there is a 'claims-made' insurance policy with a discretionary 'claims-incurred' supplement. Where these arrangements exist, MDOs often provide the 'claims made' insurance component of their business under a solely owned subsidiary company which holds an insurance licence (a so-called 'captive insurer'). This component of their business is required to meet the prudential requirements of the Insurance and Superannuation Commission, but the core discretionary component of their businesses remains without external regulation.

Some operational principles for MDOs

10.21 To understand these arrangements and the most recent 'crisis' in the industry, it is helpful to understand the difference between 'claims made' and 'claims incurred' cover, and to understand the concept of 'incurred but not reported' (IBNR) claims and 'run-off cover'.

> *Claims incurred cover* provides indemnity for any claim which arises from an incident which occurred while the health care professional is either a member (in the case of an MDO) or has paid their insurance premium (in the case of an insurer). This variety of cover is sometimes called *occurrence-based* cover, and is the type of cover which applies to the majority of personal injury insurance in Australia – that is, employer's

10. Some examples where MDOs have exercised their discretion against a doctor or class of doctors has been the retrospective exercise of the discretion after Dr Harry Bailey's death by suicide in relation to claims arising from his activities at Chelmsford by the NSW Medical Defence Union, and the refusal by the Medical Protection Society to pay claims incurred but not reported at the date of cessation of membership for past members who transferred to the Medical Defence Association of Victoria or the Medical Defence Association of Western Australia.

11. Public statements by Dr Megan Keaney, United Medical Defence.

12 PIR Final Report - see note 1, para 9.5, pp.225-226.

liability and third-party motor vehicle personal injury insurance. It is also the product offered by MDOs in Australia.

IBNR or Incurred But Not Reported liability arises with claims incurred cover. It refers to those claims where an incident has already occurred (that is the liability has been incurred), but the claim has not yet been reported to the risk carrier. Estimates of these are made using historical claims reporting data.

Claims made cover provides cover for previously unreported claims made in the year a premium was paid or membership held. This form of cover is generally provided for economic loss insurance, such as professional indemnity for financial professionals. It is also the kind of cover generally offered by insurers and insurance brokers for health professionals.

Run-off cover arises with claims made products. When a health professional, who has claims made professional indemnity cover, stops practising, they need to buy cover for any new claims which come forward from the period they were in practice. This is called run-off cover.[13]

10.22 MDOs in Australia have traditionally provided 'claims incurred' cover for doctors. This form of cover is the most beneficial for both doctors and patients, as it covers them securely for all future liabilities which arise from any particular year of coverage. Gaps in coverage can more easily arise with claims made cover, which is why the PIR recommended that unlimited claims incurred cover provided the best option for consumers and doctors.[14]

10.23 The practical difficulty with 'claims incurred' cover is in estimating the appropriate reserves for the IBNR liability. In an unregulated market, such as exists in the MDO discretionary sector, there is also a great temptation to set premiums at a rate which does not adequately reserve for these contingencies. This is even more likely in a business like medical negligence cover, where the payment of damages often occurs a long time after the incident which gives rise to it. For example, at the time of the work of the PIR, almost 60% of cases were not finalised within seven years of the occurrence.[15] The theory is that in the time from when the claim becomes known and the time payment needs to be made, sufficient additional contributions can be collected to ensure that the MDO will be able to make the payments.

10.24 This 'catch up' played a big part in the rises in MDO premiums in the late 1980's and early 1990's. At that time, what data was available showed that rather than a recent massive increase in the number of claims immediately beforehand, there had

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13 PIR Final Report - see note 1 : paras 9.8-9.11, p.226.

14 PIR Final Report - see note 1: recommendation 137, para 9.90, p.239; and recommendation 136, para 9.80, p.237.

15 Review of Professional Indemnity Arrangements for Health Care Professionals. *Compensation and Professional Indemnity in Health Care - An Interim Report.* (PIR Final Report) February 1994 AGPS Canberra: para 6.86, p.162.

been a gradual increase over the previous 15 years, which had, to a large extent, been unfunded. While claims rose, contribution rates had remained low. In 1989, this led to several MDOs needing to make calls on their members. 'Calls' are where the MDO seeks an additional amount from all members to ensure its continuing capacity to exercise its discretion positively and 'cover' its members. Most of their constitutions limit the size of calls to an additional year's subscription.

10.25 This has remained a significant issue throughout the 1990s, with actuarial studies funded by the PIR estimating that the MDO industry was underfunded to the extent of between $100 and $250 million.[16]

The recent 'crisis'

10.26 A number of MDOs have recently made calls on their members and there is speculation that all will be required to do so. This situation has arisen partly because of the continued shortfall in IBNR funding and partly for other reasons. In its Fact Sheet for members, the MIPS gave the following explanation for why they had decided to make the call at this time:

- In an increasingly consumerist society, it is inevitable that litigation rates (and costs) will continue to rise.
- Legislation has been foreshadowed, in Victoria, which would require each doctor, as a condition of registration, to provide proof that he or she is adequately indemnified for professional liabilities.
- The Australian medical defence organisations (MDOs) collectively are not fully-funded at the present time – i.e. their total reserves may be sufficient to fund their known (reported) and accepted liabilities but are not enough to in addition fund the currently *unknown* professional liabilities of their members, those liabilities which will arise from incidents which have occurred but have not yet been reported. This is despite the very significant increases in subscriptions over the last decade.
- The introduction of the GST will affect the MDOs' costs of meeting their members' liabilities.
- A new accounting standard has been proposed which would require the MDOs to declare both their known and currently unknown liabilities in their annual reports. (Currently only the known liabilities must be taken up into their balance sheets.)[17]

10.27 The Fact Sheet goes on to acknowledge that the MDO industry operating in Australia has been considerably underfunded for many years, specifically in relation to IBNR liability. It then refers to the PIR's estimates listed above and states that:

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16 PIR Final Report - see note 1: para 9.179, p.255. Also see more generally paras 9.178-9.187, p.255-256.

17 MIPS. Back Funding Contribution Fact Sheet, November 1999: p.1.

> There is no published evidence to suggest that this figure has fallen in recent years...Litigation rates and costs have increased significantly in recent years, and across the industry it has been difficult to keep up with the hyperinflation in reported claims, let alone to make adequate provision for the IBNR liabilities.[18]

10.28 The Fact Sheet provides a thorough outline of the financial and prudential reasons for the call and provides transparency about the financial operations of an MDO. While there has been much media speculation about a new 'crisis', the MIPS Fact Sheet makes the chronic industry-wide nature of the issue very clear. This emerging openness in the industry is to be supported and encouraged.

10.29 Improved funding of the IBNR liability also places organisations which adequately reserve for their IBNRs in a strong competitive position, if and when Governments decide they should be regulated, as recommended by the PIR. Bodies which do not reserve to meet these liabilities will be obliged to make calls on their members at that time, and will not have the advantage of the income-earning potential of the reserves in the meantime.

10.30 Other MDOs such as UMP argue that they are collecting additional subscriptions each year to improve their IBNR funding without having to make a call on their members. The President of UMP stated that their annual contribution rates now fully fund their occurrence-based cover each year and includes an additional amount of premium for the unfunded IBNRs into each year's premium, with the intention of 'insuranising' their business over time.

MDO subscription increases

10.31 It is impossible to tell from currently available data the relative contributions that different factors have made to increased MDO contributions, both across the medical profession and within specialty and practice groups. Some of the factors are a rising rate of claims, rising claims cost (well above inflation and principally driven by costs of future care), increased prudential reserving and a reduction in the internal cross-subsidisation of contribution rates between different groups of doctors. As was asserted by the PIR, while there is clearly widespread fear of litigation among medical practitioners, it is not based on any evidence. This was confirmed by the later work of the Victorian Law Reform Committee which concluded in 1997 that:

> The Committee has found that the perception of the medical profession concerning recent increases in the cost of professional indemnity insurance is not reflected in a significant increase in either the quantity of claims or their quantum. Rather, a number of high profile cases, particularly in New South Wales, 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 premiums that is impacting on

18 MIPS. Back Funding Contribution Fact Sheet, November 1999 : p.2.

> service delivery, or is likely to impact in the near future. Present premium levels are not oppressive.[19]

10.32 Equally, it is difficult to be certain exactly what impacts any of these are having on practice changes, when all the other influences are looked at as well. For example, there were many fears expressed to the Victorian Law Reform Committee about the impact of litigation on rural practice. However, the Law Reform Committee concluded that:

> there is evidence of a widespread fear of litigation among doctors generally. However, there is no evidence of a significant increase in medical litigation. The shortage of doctors in some areas of practice has not been shown to be a consequence of any rise in the cost of obtaining professional indemnity insurance. Rather the Committee has received extensive evidence to the effect that the shortage of doctors in rural areas, for example, is due to other social and economic factors.[20]

10.33 What is absolutely clear is that there has been a rapid rise in professional indemnity contributions in some states over the past decade. For example, medical indemnity subscriptions for specialist obstetricians/gynaecologists in NSW have risen from $7,200 in 1990 to $41,400 in 1999. A selection of MDO contribution rates for specialist obstetrician/gynaecologist and for gynaecologist only practitioners appears in Table 1 below. As can be seen from Table 2, these increases have also affected GPs providing obstetric care, which is a particular issue for rural health care, where a larger proportion of private sector deliveries are provided by GPs and where GPs may be more likely to be providing public hospital birthing services as well.

10.34 The Committee is concerned at the enormous variety between the states and the variations between MDOs even within states, as illustrated by these tables. Some of the variations may be a consequence of differences in behaviour so far as litigation is concerned. NSW is claimed by doctors to be the most litigious state and UMP operates mainly in NSW. However, the litigation experiences are generally assumed to be similar between NSW and Victoria, because both have law firms and barristers who specialise in this area. However, there are significant differences in the costs between UMP and MIPS and MDAV, all of whom operate in Victoria. It also seems that it is unlikely that all the difference between these states relate to differences in levels of damages. While some of the differences between MDOs may relate to different claim profiles and different IBNR reserving policies as outlined earlier, it is difficult to know exactly why these differences arise. In all cases, there is insufficient publicly available data to make any definitive statements about the reasons for the differentials.

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19 VLRC Report - see note 2 : p.xviii

20 VLRC Report - see note 2 : para 9.68, p.230.

Table 1 : Selected MDO contribution rates for Obstetrician/Gynaecologist and Gynaecology Only Medical Practitioners

1994/5 to 1999/2000

MDO[a]	Contribution Category	1994/95 $	1995/96 $	1996/97 $	1997/98 $	1998/99 $	1999/2000 $
MIPS	O/G	9,900	14,000	15,000	20,000	22,000	27,000
	G only	4,500	6,600	10,000	13,500	15,000	18,000
MDAWA	O/G	25,000	25,000	27,750	29,140	30,050	32,000
	G only	11,500	11,500	12,800	13,450	13,870	15,750
UMP	O/G	17,900	19,500	25,000	30,000	36,000	41,400
	G only[b]	16,700	14,500	18,000	16,500	22,500	25,875
MDAV	O/G	7,500	11,000	15,000	20,000	22,000	25,000
	G only	3,400	6,500	10,000	13,500	14,850	17,500
MPST	O/G	4,300	5,500	6,600	7,500	9,400	11,050
	G only	4,300	3,600	4,550	5,200	6,700	7,800

a The MDOs are listed in paragraph 10.17.

Table 2 : Selected MDO contribution rates for General Practitioners practising obstetrics

1994/5 to 1999/2000

MDO	1994/95 $	1995/96 $	1996/97 $	1997/98 $	1998/99 $	1999/2000 $
MIPS	2,990	5,500	7,000	7,500	8,250	9,500
MDAWA	5,000	5,000	5,750	6,040	6,480	7,500
UMP	4,050	4,650	5,800	6,950	8,750	9,796
MDAV	2,700	5,500	7,000	7,500	8,250	9,000
MPST	2,000	2,550	2,750	2,500	3,500	4,150

Is there a 'litigation crisis' in obstetrics?

10.35 In the face of these rises, some doctors have continued to assert that there is a 'litigation crisis'. As was noted earlier, one of the real impediments to any proper analysis of this issue is the total absence of useful data on the incidence and costs of claims against medical practitioners, whether they are involved in birthing services provision or not. The uncertainty and speculation arising from this situation has changed very little from when the PIR Final Report said, with some frustration:

> Publicly available information is so scarce that counteracting what could be seen as a fear campaign among health care professionals is very difficult. When data is sought to back up the public statements, it is frequently delayed, if it can be found at all. In the case of MDOs, there have been alleged to be concerns about revealing information to competitors. The availability of data on such basic things as the number of claims made and the number of claims where a plaintiff is successful have fostered an environment of crisis, when the absolute numbers of claims appears to be still very low in Australia.[21]

10.36 The particular reasons for sharper rises in obstetric related contributions compared to other groups were outlined in the PIR's Report and it appears that they have changed little since then.

> The data which is available in relation to birthing service provider actions in the 1990s indicates a steady, very low level of claims. One MDO publicly confirmed this in 1993 – "the number of actions in which it is asserted that severe neurological handicap has arisen from an obstetrician's negligence appears to be both low and rising only slowly".[22]
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> Rather than increased claims, the three main reasons for contribution increases have been:
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> - the move away from a single flat rate contribution payable by all doctor members, whatever they practised and wherever they practised, which had applied to MDO business over the first 80 odd years of this century;
> - the need to address long term underfunding of liabilities, which was caused by indemnity subscriptions being held at an artificially low level for many years, particularly in the 1970s and 1980s, when the frequency of claims increased dramatically from a very low level; and
> - larger awards for future care costs for severely disabled people and the need to adequately reserve for these costs in future cases.
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> The reasons for the disproportionate effect of subscription rises on birthing service providers are described above – obstetrics generates a very small

21 PIR Final Report - see note 1: para 2.63. p.26.

22. Nisselle P. Murray J. 'Obstetrics in crisis?' 1993 *Medical Journal of Australia*, vol 159, pp.219-221: 219.

> number of very expensive claims, and gynaecology generates a significant number of generally low value claims.[23]

10.37 Available data provides inadequate evidence from which to draw conclusions about the existence or otherwise of a litigation crisis. What is clear is that litigation and medical defence subscription rates are issues of continuing significant concern to doctors, and that the fear of litigation, whether it is based on reality or not, is affecting the practice decisions of at least some doctors. None of the recommendations of the PIR, which sought to ensure better information was available to assess these claims, have been acted on and so the Committee is in no better position than was the PIR to reach any definitive conclusions on these issues.

The way forward

10.38 The Senate Committee has been concerned to discover the extent of the secrecy surrounding the operations of the medical defence organisations. They are not publicly accountable. They do not have to provide information either to the public or even to their members on basic aspects of their operations such as the size of their reserves, the criteria governing the size of their premiums or the extent of the cross subsidisation which, they claim, affects premium levels. The obstetrician/ gynaecologist specialists claim that without such scrutiny 'their financial positions are subject to the untested whims of the relevant MDOs'. Such a situation is clearly unacceptable.

10.39 Better information on these issues requires greater investigation than has been possible during this Inquiry. In addition to greater understanding of the reasons for subscription rises, there is a need to consider a wide range of other issues in more detail, including:

- the impact of fear of litigation on the quality of care provided to birthing women eg through defensive medical practices;
- the impact of premium levels and types of cover on the availability of services from other practitioners, such as self-employed midwives;
- the impact of birth related litigation on State Government health departments' liabilities, given that the majority of births occur in that area;
- the evidence that is continuing to emerge that, in the vast majority of children affected by cerebral palsy, there is little or no link to sub-standard obstetric care, and the need for further evidence based research to look at whether there are specific characteristics of the condition in children where sub-standard obstetric care (either in pregnancy, labour or birth) was the likely cause of their disabilities;

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23 PIR Final Report - see note 1: paras 10.62-10.64, p.278.

- the use or otherwise of such evidence by lawyers and judges in determining whether a child is entitled to damages, including issues such as the use of expert evidence and clinical practice guidelines;
- the models which are operating in jurisdictions such as Virginia, Florida and some Scandinavian countries, where no-fault regimes are substituted for compensation based on negligence;
- the various different ways state governments have made changes to their indemnity arrangements to accommodate the fears of medical practitioners providing birthing services in the public system, particularly in rural areas[24];
- the emerging public recognition of the importance of adequate care for all children and adults with significant neurological impairments and the inadequacies of community- funded services for these people;
- the impact these service and assistance inadequacies have on the incentives for families to litigate and whether this is in fact occurring;
- the impact of litigation on both practitioners and the families of children born with significant disabilities, whether litigation is successful or not; and
- the impact of assisted reproduction technologies on the incidence of children born with cerebral palsy and the relationship between this and litigation (if any).

10.40 These issues need further investigation.

Recommendation

The Committee RECOMMENDS that the Commonwealth Government establish an independent inquiry into medical indemnity and litigation, including the impact of litigation and indemnity on the provision and practice of obstetric services, alternative approaches to the funding of medical litigation and alternative approaches to the funding of compensation for disability.

24 For information on the Victorian Government's special arrangements, see VLRC Report, paras 9.63-9.68, pp.228-230.