Associate Professor Michael Fearnside

The Looming Storm

In 1987, Paul Gerber and John Vallentine wrote a leading article in the Medical Journal of Australia entitled 'The Looming Storm'. They argued that there was little likelihood of a medical indemnity crisis in Australia, contrasting the evils of medical malpractice in the United States with the assumption that we did things differently here. Regarding informed consent they argued:

"While allegations of lack of informed consent are almost invariably pleaded in US statements of claim out of an abundance of caution, only one significant malpractice suit was shown to turn on informed consent in a recent consecutive series of 9,000 claims. In any case this is of no relevance whatsoever in its effect on malpractice litigation in this country where we have accepted the "professional standard of disclosure" test the very test that has in the past been rejected in the United States. In this country, case law on informed consent is absurdly thin on the ground (to our knowledge, there are only three reported cases that examine the issue in any depth). Surely this speaks for itself".

Just five years later, Rogers v Whittaker changed the medical landscape in Australia forever.

Clinicians, patients and the public hospitals

In this paper I will deal with three domains, those of clinicians, of patients and of the public hospital system. I will try to illustrate how I think tort law reform is having, and will have, an effect. By clinicians, I include not only doctors, but also nurses and allied health staff. I will illustrate some of the changes by reference to my own specialty of neurosurgery which bore, along with obstetricians, much of the initial impact of the medical indemnity changes.

The effects are far from clear because insufficient time has elapsed for clinicians and patients to understand the changes in the law and to see them in action. The public sector leviathans of health and law are adapting. At my level, however, the clinical level, we are only beginning to see a part of how they are being interpreted and implemented in the public sector.

I will also argue that tort law reform, which arose out of the medical indemnity crisis is, was but part of a much broader change in the patterns of medical work which is having profound effects on access to, and quality of, medical care and thus patient satisfaction. This paper then is reflective. Of necessity, it is subjective and in part, conjecture.

Was there a crisis?

A study was undertaken of claim trends for the Australian medical defence organisations from 1992 through 2002 by four of the major defence organisations' South Australia, Western Australia (as it was then, now MDA National), Victoria and UMP.

Nine specialties were studied, procedural and non-procedural general practitioners and physicians, general surgeons, orthopaedic surgeons, anaesthetists, obstetricians and gynaecologists and neurosurgeons. These were estimated to represent 60 per cent of the MDOs' membership and 80 per cent of the claims . The frequency of claims had risen 62 per cent in the five years from 1996-97 to 2000-01 and the known cost of claims had doubled.

The aim of the reforms

As a result of this and a number of other well-known drivers, including those mentioned by Allan Hunter, medical indemnity premiums rose. Tort law reform was an attempt to stabilise and render medical indemnity premiums affordable. Coincidentally, it was part of a more generalised debate in Australia, to which Bill Madden has referred, about public liability and individual responsibility, a debate which continues today.

My own specialty of neurosurgery is regarded as one of the high-risk specialties. It was estimated that, in New South

Wales, without statutory capping of indemnity, premiums would have risen to exceed $270,000. Had this occurred, neurosurgical services would have ceased, as we would then have been uninsurable.

A further complication occurred at about that time: amendments to the Medical Practice Act required all practising doctors to have professional indemnity insurance. Had premiums become unaffordable, registration may well have become an issue.

The rate of reported incidents

Incidents reported in neurosurgery have risen from 43 per 100 neurosurgeons in 1992, to 135 per 100 neurosurgeons in 1998. About 40 per cent of these convert to claims, which is somewhat higher than for other specialties. Undoubtedly, the increase in incident reporting is also a result of more awareness of medico-legal exposure and of the need to report untoward incidents. The claim rate per 100 neurosurgeons also increased from 20 in 1990 to 58 in 1996, but has fallen to about 40 this year.

The effects of ageing

Neurosurgeons' age would seem to be a significant factor. Forty per cent of the claims arise from members aged between 41 and 55 years in roughly equal quintiles during that period of high clinical productivity. However, 20 per cent arise from members in the 61 to 65 years quintile. This reinforces my observations, as a member of New South Wales Medical Board, that adverse incidents do increase with increasing age.

The frequency distribution of neurosurgical age versus claims is a normal distribution, that is, a bell curve, with the exception of the 61 to 65 year quintile, where there is a spike. This is a matter of some concern and requires further examination, regarding the assessment of performance by senior clinician, particularly proceduralists.

The approach of the medical and the legal professions in the past was to rely on individuals not to make mistakes, rather than to assume that they would. The idea of periodically testing performance has never really been accepted by medicine or by the law. It may well be that more rigorous assessment of those over the age of 60 should be considered.

The role of peer opinion

Setting aside the dollar amounts of findings and the formulae by which they are derived, for practising clinicians there are a number of important initiatives in the tort law reform package. Of particular significance, as has been mentioned both by Allan and Bill, are peer acceptance as a defence and the application of a 15 per cent impairment threshold in relation to the most extreme case. Other important issues are the formalisation of limitations on findings of causation, a limitation of three years and, importantly, protection for Good Samaritans.

While removal of the Bolam test for medical negligence in the courts has provided a feast for the law, Rogers v Whittaker and subsequent cases deeply disturbed the medical profession because it made uncertain the guidelines by which medical business ought to be transacted. This, in turn, affected clinical decision-making, of which informed consent was but a part. At the level of clinical practice, I was very unsettled by this. My concerns were shared by my neurosurgical and other procedural colleagues, as the guidelines for what was reasonable had disappeared over the horizon.

Further uncertainty was injected by subsequent cases such as Naxakis v Western General Hospital and Anor. This was a case in Victoria where a 12-year-old-boy was hit in the head by a school bag and was referred to hospital by his general practitioner. A neurosurgeon treated the plaintiff for a head injury. He improved and was discharged about a week later. Two days after discharge, he unfortunately collapsed with a subarachnoid haemorrhage from a ruptured cerebral aneurysm. Proceedings were commenced in the Supreme Court of Victoria. At the close of evidence, the judge found that there was no case to go to a jury and found for the defendants. The plaintiff appealed to the High Court.

While the High Court considered a number of issues in this case, Chief Justice Gleeson asserted:

"The test for medical negligence is not what other doctors say they would or not have done in the same or similar

circumstances".

Unrealistic judicial expectations

A number of issues arose from Naxakis which included the notion of "reasonable care". In this case, in my view, the test was difficult to interpret in a realistic manner. The High Court seemed to assert that doctors should always test for all possible causes of any particular symptom, even when the original diagnosis seemed correct and treatment seemed successful. Such findings further frustrated clinical decision-making, because it is, of course, impossible to investigate all the possible diagnoses. Tests not only have a financial cost associated, but also a chance of harm, particularly if the investigation is invasive, such as in the case of cerebral angiography.

The loss of the Bolam test from the courts also removed some of the trust that medical practitioners had in the legal system. That scepticism was reinforced subsequently by a number of other judgments in medical negligence. I believe that the return of a modified Bolam test will permit a measure of return of trust in the system It will be interesting to see how this is applied by the courts in future judgments.

'The most extreme case'

Bill has mentioned the assessment of the threshold of 15 per cent of the most extreme case. This deserves discussion. This is a method of impairment assessment which has generally been used in other jurisdictions in personal injury, such as Workers Compensation and Motor Accidents. This was used prior to reforms in those areas, and after the reforms occurred, the American Medical Association's Guides to the Evaluation of Permanent Impairment was introduced.

I have always felt uneasy about the most extreme case model because it is both subjective and relativist. For example, in considering an injury to a spine, 'the most extreme case' for say, an occupational health physician, a rheumatologist, an orthopaedic surgeon, or a neurosurgeon may be entirely different, depending on the spectrum of spinal conditions they see and treat. Similarly, the choice of 10 per cent, 20 per cent or even 25 per cent often seems to be extraordinarily arbitrary.

The advantage is that the examiner can make an assessment of the disability as well as of impairment of the particular individual and include it in the final figure. I think that it is time this is re-examined and the AMA Guides be considered as an alternative. The advantage of the AMA Guides is that they provide a more objective assessment of impairment. With adequate training, there should be high inter-examiner reliability. The disadvantage of the AMA Guides is that they provide little or no assessment of an individual's disability. This is, however, changing, with the latest edition of the Guides making some allowance for that.

Other recent changes in the medical workforce and practice

There have been major changes to the nature of medical practice over the last five or ten years. It is wrong to infer that these changes are the result only of medical indemnity and tort law reforms. They are part of a much broader realignment of the medical work force wherein indemnity and tort law reform issues are but a part.

These factors include workforce, increasing feminisation of the work force, part-time work, and certainly for younger doctors, lifestyle issues and, for all, practice costs . For example, there are interesting data showing that clinicians are working fewer hours. In 1996, for example, the average number of weekly hours worked by a doctor was 48. In 2001, this had fallen by 2.6 hours for both male and female doctors and across all age deciles. Allowing that there are something like 52,000 medical practitioners in Australia, this results in a huge decrease in the availability of medical services.

Medical risk management

With regard to the changes in tort law reform and the response of the medical practitioners, we have become much more aware of the need to manage risk on a formal basis. The College of Surgeons, the Neurosurgical Society and the New South Wales Government have applied pressure, such that I think that all Australian neurosurgeons and many other practitioners have attended prescribed courses. Doctors understand the process of informed consent better. As a result,

patients are better informed. Unfortunately, the obverse of this may also occur, such that patients become confused by the choices.

Defensive medicine flourishes. It could well be argued that, setting aside costs, this is not necessarily a bad thing. Diagnoses are confirmed by one or two additional tests and second opinions are frequently sought. Whether this is necessary for patient care and good patient management is, of course, an entirely another matter. It is certainly not the most cost-efficient way to run a health system.

In surgery, there is now a clear tendency, in my view, for younger trainees to avoid risky or onerous specialties. It is difficult to attract young surgeons to obstetrics, to vascular surgery, to neurosurgery and to trauma surgery. On the senior end, surgeons are modifying their practices or retiring early. In 2002 a College of Surgeons study of 750 surgeons over the age of 55 indicated that 15 per cent plan to retire shortly if uncertainty regarding medical indemnity insurance persisted.

The exodus from the public hospitals

Most importantly, and I think most subtly, there is now a steady shift by proceduralists away from working in public hospitals and a tendency either to concentrate in work in the vigorous and expanding private hospital sector in New South Wales, or to do less clinical work and to do other things.

Patients, on the other hand, should, by now, be better informed. Patient information brochures are more readily available. Discussions between doctor and patient hopefully occur to a more meaningful degree or level, and expectations of the outcome of therapy should be more realistic.

Cosmetic surgery

In this area, I agree with Bill Madden that cosmetic surgery deserves some comment. It is largely a commercial enterprise where advertising and entrepreneurship are relatively less contained than in more traditional domains of medical practice. It is, of course, subject to regulation under the Medical Practice Act but it is, from my observations, an area where the envelope is stretched. It might well be a fruitful topic for discussion at another scientific session of the society.

Systemic responses

The public health sector is now liable for public patients, past, present and future. It has ownership of a large proportion of medical indemnity. Although this has been so historically in other states, where visiting medical officers were part-time employees, in New South Wales by contrast, for reasons which escape me, they remained independent contractors. It was not until 2001 that Treasury Managed Fund indemnity cover was applied to public hospital staff in New South Wales other than to salaried staff specialists without the right of private practice.

The system is slowly responding. Reporting systems, to identify adverse and critical incidents, are being established in area health services. A steady flow of adverse events regularly crosses the desk of the Director-General, but the loop is far from closed. It is a matter of considerable concern to senior clinicians whether or not there will be an explicit commitment from the New South Wales Government and the Department of Health to provide resources to fix systemic errors where harm has been caused. So far, I don't think that this has been given due consideration. As clinicians ,we fear a lack of implementation of these recommendations when resource issues are involved.

These issues were discussed by Professor Bruce Barraclough in June last year at a meeting of this society and were championed by Professor Ian O'Rourke, the late and sadly missed Chief Executive Officer of the Institute of Clinical Excellence. It remains to be seen whether the Clinical Excellence Commission, which has been established to oversee quality and safety in hospitals, will have the commitment, fortitude and resources to ensure that the changes are made. I think it a very good thing that the public health system has been made accountable, in part, for public liability both at a professional and at a system level, because it is well-known that resources will be made available only if pain is applied.

Too soon for conclusions

In conclusion, Mr President, it is as yet too early, from a medical perspective, to make an assessment of the benefits and burdens which will flow from tort law reform. Matters active prior to 2001 remain in the system and premiums remain related to costs and judgments. It is heartening to hear that there is some downward trend. The medical profession hopes for premium stability and affordability so that we can continue to deliver services to the people of New South Wales.

There remain broader changes, wrought only in part by the medical indemnity crisis and tort law reform, which have serious implications for the public health sector and public policy. Overall, I remain optimistic that good will come from the changes to medical indemnity, but it will be at a price to society. That price will include changes to work practices by consultants, not only in surgery, but across the medical profession, the exercise of vocational options by specialist trainees, and the need to adequately resource a hopelessly under-supplied public health system.

About Associate Professor Michael Fearnside

Michael is a VMO at Westmead Hospital and the Area Director of Surgery, Western Sydney Area Health Service. He was involved, on behalf of neurological surgeons, in negotiations with the Federal Government in respect of medical indemnity. He is a former President of this august society and Past-President of the Neurosurgical Society of Australasia.