

# **In whose hands rest the future of medical indemnity?**

**Medico Legal Society of Victoria**

**9 October 2010**

I plan to take you through a journey covering a range of topics including:

- ❖ What is this thing called medical indemnity?
- ❖ What are the origins of medical indemnity in Australia?
- ❖ What caused the industry to nearly implode in Australia and what policy shifts saved the industry?
- ❖ What are some of the features of international medical indemnity models and what might an optimal model look like?
- ❖ What might you do to enhance our current medical indemnity model.

The answer to '*what is this thing called medical indemnity*' is a system for redressing adverse health care outcomes arising from medical treatment in which standards of care are breached. Medical indemnity systems essentially serve three related purposes:

- ❖ Covering the liabilities of medical practitioners and health organisations;
- ❖ Compensating victims of injuries sustained from medical procedures; and
- ❖ Deterring medical malpractice.

The delivery of medical indemnity differs vastly between jurisdictions in relation to funding practices, levels of coverage, concepts of accountability, burdens of proof and claim triggers.

In answer to '*what are the origins of medical indemnity in Australia*' it all began on 17 June 1887 at a meeting of doctors in Sydney when one particular doctor was presented with a purse of sovereigns totalling £125 by his colleagues to help him meet his legal expenses for answering a charge of criminal assault made against him by a woman. That charge was dismissed by the Courts, with the woman and her accomplices curiously then arrested, found guilty of making false allegations and themselves imprisoned.

The lesson that the assembled doctors recognised back in 1887 is that doctors should bear each others' burdens, and so the principle of mutuality was established and shortly thereafter the first of the state based medical defence unions was formed in Australia.

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The initial annual subscription of one guinea was used to establish a defence fund with the object of and I quote "to protect medical men against vexatious actions at law arising out of the practise of their profession". I understand it was only in 1891 in this state and 1893 in New South Wales that the first medical women graduated in Australia hence the reference in the object to medical men.

In the 1899 Annual Report of one of the Medical Defence Organisations (MDOs) it was observed perhaps prematurely and I quote "that actions at law against medical men are now becoming infrequent. The existence of the medical union to which practitioners look for support, is apparently sufficient to prevent blackmailing and vexatious action".

For the next 100 years remarkably all members paid the same subscription and as recently as 1984 that subscription was by way of example \$25.00 for Queensland doctors. Premiums then rapidly rose and in 1989 a then well known insurance broking house called Willis Faber Robbins and Higgins offered General Practitioners a significantly reduced subscription rate that forced the MDOs to abandon the true principle of mutuality and introduce differential subscription rates in order to retain their General Practitioner members.

Whilst the late 1990s represented a period of increasing claims costs and increasing premiums it was in or about 2000 that a major medical indemnity crisis unfolded not only here in Australia but in the United States and in several European countries. The crisis was truly global. For example:

- ❖ In the United States, premiums in several states had been increasing at an annual rate of 30% per annum. By 2001, some obstetricians in the State of Florida were required to pay over US\$200,000 in annual premium. At or about this time the St Paul group of companies which enjoyed over 10% market share exited the US market overnight. As a commercial insurer this was an easy decision but they left thousands of physicians scrambling to find alternate and affordable cover.
- ❖ In France, a law was enacted introducing a mandatory requirement for insurers to cover medical liability risk without a specified ceiling. This led to a massive withdrawal of insurers and a rapid increase in premiums of up to 600%.

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The medical indemnity industry in Australia had kept very much under the radar screen until a number of trigger events in 2001 precipitated Australia's largest medical indemnity insurer, UMP, being placed into provisional liquidation. Those trigger events included:

- ❖ Firstly the collapse of HIH Insurance, which provided reinsurance almost on a captive basis to many Australian MDOs including UMP.
- ❖ Secondly the impact of 11 September 2001 which resulted in substantial reductions in capacity in the global reinsurance market and significant premium increases.
- ❖ Thirdly a significant increase in the number of claims for negligence made against medical practitioners partly driven by the announcement of the tort reform measures set out in the Health Care Liability Act 2001 (NSW) many months before its inception date.
- ❖ Fourthly an increase in the size of damages awards including the celebrated Simpson v Diamond case which at first instance delivered a verdict of \$14.2m in favour of the plaintiff.
- ❖ Fifthly a new requirement that MDOs provide on their balance sheets for those unknown liabilities relating to incurred but not reported incidents which are fondly known as their IBNR liabilities.
- ❖ Sixthly and finally insufficient premium pricing and reserving consequent upon spiralling damages awards such as Simpson v Diamond.

At this time some medical practitioners were paying over one-third of their income for indemnity cover and threatened to leave the profession or cease certain high risk procedures where indemnity cover was overly expensive such as obstetrics.

The net liability position of the five MDOs in Australia at 30 June 2001, including their IBNR liabilities, was a deficit of about \$400m and despite making calls on their members they were essentially on an unsustainable financial footing. The industry was in crisis mode.

The consequence of the medical indemnity crisis was that the Federal Government announced plans to reform the medical indemnity industry in order to ensure affordable medical indemnity insurance and a viable and ongoing industry. In doing so the Federal Government saved UMP which after 18 months in provisional liquidation successfully re-

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established itself. Curiously nearly three quarters of UMP members maintained their loyalty through the turbulent period of provisional liquidation.

Before discussing Australian initiatives it is worth pausing to consider what initiatives were taken globally in response to the crisis? Typical responses focussed on one or more of the following options:

- ❖ firstly modifying the definition of “negligence”;
- ❖ secondly reforming the tort system to limit or cap various payments. Examples included capping the time between incident and claim with by way of example California requiring a claim to be filed within three years of the incident or one year of discovery. Another example were caps or bans on contingent legal fees. In the US, many states enacted a sliding scale for the maximum amount of contingent fees a lawyer could charge expressed as a percentage of the settlement cost or as an absolute amount. In the UK, contingent fees were banned by law and instead lawyers were forced to charge an hourly rate. Also in the US, 24 of 51 states enacted caps on non-economic compensation payments, typically within the range of \$350,000 to \$650,000;
- ❖ thirdly rearranging the funding structure. For example in the State of Wisconsin practitioners were only required to purchase cover up to \$1,000,000 per claim and \$3,000,000 in a year with claims above that level being covered by a statutory fund and in many states not at all;
- ❖ fourthly introducing no-fault schemes or no fault elements to the overall scheme. For example, in Florida, the Birth-Related Neurological Injury Compensation Association was introduced being a no-fault compensation scheme that covers injuries that leave an infant permanently and substantially mentally and physically impaired.

The key policy reforms to the medical indemnity industry in Australia that saved not only UMP but in reality the whole industry were six-fold.

The first reform was that the Government pledged to fund the IBNR liabilities of participating medical defence organisations that did not have sufficient funds to cover these liabilities as at 30 June 2002. The aim of the scheme was to ensure that the liabilities of MDOs could be met without exposing their individual members to claims against them arising from the unfunded IBNR liabilities. The cost to the Government of funding these liabilities was to be recouped through a levy on medical practitioners. Curiously as at today’s date UMP

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members have paid more in levies than the Government has been required to pay in meeting these unfunded IBNR liabilities.

The second reform was the introduction of the High Cost Claims Scheme to reduce the cost of large claims to insurers thereby stabilising medical indemnity premiums. Under this scheme, the Government undertook to reimburse medical indemnity providers 50% of all claim payouts above \$300,000.

The third reform was the introduction of the Run Off Cover Scheme (ROCS) introduced in response to medical practitioners concerns about their ability to pay for run off cover when they left the workforce and were no longer earning an income. This scheme is funded through an annual levy charged to medical indemnity providers who in turn are entitled to pass on the levy to policy holders which today is calculated at 5% of annual premium. Under ROCS insurers are obliged to give eligible doctors medical indemnity cover on the same terms and conditions and for the same range of incidents, as the last cover they had prior to becoming eligible for the scheme.

The fourth reform was the introduction of the Premium Support Scheme (PSS) to limit the cost of medical indemnity cover for those doctors who face premiums above 7.5% of their gross private medical income to 20 cents in the dollar beyond that limit. The target audience was ostensibly firstly obstetricians and gynaecologists who were paying large premiums and secondly those practising in rural and remote areas who face similar premiums to their city colleagues but enjoy less pricing power.

The fifth reform was the Federal Government encouraging State governments to enact Tort Law Reform legislation with a view to reducing the number and size of personal injury claims including medical negligence claims. Those reforms relevant to the medical indemnity industry flowed in no small part from the report prepared by Justice Ipp and included:

- ❖ Reforms to the standard of care required by doctors.
- ❖ Caps on damages for pain and suffering and economic loss.
- ❖ A minimum threshold for impairment for an entitlement to claim general damages.

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- ❖ Changes to the limitation periods for personal injury cases.
- ❖ Increases in discount rates to apply to claims payouts.

The sixth and final reform was the enactment of the Medical Indemnity (Prudential Supervision and Products Standards) Act 2003 which provided that from 1 July 2003 medical indemnity insurance had to be provided in the form of an insurance contract between an authorised insurer and the medical practitioner. This brought to an end the ability for MDOs to offer unlimited discretionary indemnity protection and extended APRA's prudential supervision to encompass the medical indemnity industry. From that moment all medical indemnity insurers were forced to comply with APRA's prudential standards just as they apply to general insurers. APRA's prudential standards are extensive and increasingly extensive and include standards relating to the holding of minimum levels of capital, investment portfolio management, claims management, reinsurance and more.

One might ask have these six reforms introduced in 2003 achieved what they were intended to achieve?

At the time this package of reforms was introduced it was predicted that the cost of the Federal Government's initiatives to combat the then difficulties in the medical indemnity market would cost around \$65m a year. These predicted costs excluded the costs of the Government funding the IBNR liabilities that I mentioned a moment ago.

The reality is that Government has not faced anything like these costs. To put some meat on the bone from the perspective of Avant as one of four MDOs we have paid on behalf of members:

- ❖ \$37.7m in stamp duty in the last 3 years
- ❖ \$35.8m in GST in the last 3 years
- ❖ \$42.7m in corporate tax in the last 3 years

which adds up to \$116.3m being significantly more than the government has paid to us or our members under the various schemes.

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Interestingly the approximate \$400m net deficit at 30 June 2001 among the five MDOs is likely to be a net reported surplus of approximately \$900m at 30 June 2010 with Avant shortly to announce net assets of \$628m at 30 June 2010. An astounding turnaround on any analysis!

According to the ACCC gross premium revenue which was \$310m in FY03 fell to \$306m by FY08 reflecting stable if not reducing premiums.

When one pauses and considers the actual cost of premiums paid by doctors coupled with the actual cost to the taxpayer of the government schemes one might well ask whether we have achieved the optimal balance between a system that is cost effective, delivers fair compensation to injured patients and best serves the medical profession and the community at large? This is a question worthy of debate and discussion.

Since 1 July 2003 when all of these measures were put in place the industry has changed shape and of particular note there has been:

- ❖ the entry of a commercial insurer into the market in 2005 backed by QBE Insurance reflecting a vote of confidence as to the perceived opportunities of being an insurance provider in this historically MDO dominated market; and
- ❖ the merger of two of the then five MDOs being MDAV and UMP to form Avant in 2007 which had central to its objectives providing enhanced financial security and enhanced ability to deliver stable premiums to members. .

Some industry observers consider four MDOs are too many and I agree with these observers.

I will now focus on some of the features of other medical indemnity models as the delivery of medical indemnity differs vastly between international jurisdictions in several respects.

Those features include:

- ❖ choice between a tort liability system or a 'no fault' scheme;
- ❖ funding sources;

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- ❖ coverage, and level of compensation benefits; and
- ❖ degree of burden of proof.

Countries with a common law system, such as Australia, the US and the UK, have traditionally relied on the tort system to handle negligence cases, including medical malpractice. Schemes based solely on causation exist in several countries, most notably in Nordic European countries (Sweden, Denmark, Norway, Finland) and in New Zealand. These countries typically have a cap on claims such as Sweden at about \$750,000. Hybrid fault/no fault models also exist in some countries, such as France where a no-fault system is in place for injuries resulting in incapacity of at least 25%.

There are a small number of structured settlements in the UK for personal injury cases each year. Usually the form of a structured settlement is as follows: the defendant's insurer, having agreed a lump sum figure, will arrange to convert part of that sum into a series of periodical payments "structured" to accommodate the claimant's individual needs. To fund the arrangement, the defendant's insurer purchases annuities from a life insurer, and assigns the benefit of them to the claimant. Unlike the income that arises from the investment of a lump sum, the regular payments are free of tax in the claimant's hands. Structured settlements are not as popular as they ought to be due to vested interests. Plaintiffs want their hands on all the cash they can even though we regularly hear of settlement sums being frittered away leaving the Plaintiff on taxpayer funded disability benefits. Insurers and in particular any reinsurers sitting in the background want closure and not ongoing uncertainty as to when annual payments will cease. However if we wanted an optimal model we would find a way to make structured settlements a mandatory feature of major claims outcomes.

Health care in Sweden is a public sector responsibility. Medical indemnity compensation is provided on a "no fault" basis under the Patient Torts Act. Under this Act claims are handled under the legal system but only causation needs to be established. Compensation is provided on a "top up" basis as medical costs and long term care costs are covered by the social security system, however there remains a possibility to sue through civil law to obtain higher levels of damages. Payments are capped. The system means there is prompt redress and cheaper legal costs than in other types of compensation systems like our own.



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So what is the future of medical indemnity in Australia?

As night follows day doctors will need medical indemnity to protect them for financial losses arising from actions brought against them as a result of the performance of their professional duties. Optimally of course the medical indemnity industry would have no future but it would seem improbable that we will ever live in a world where doctors become so able at diagnosis, procedures and patient communication on the one hand, and that patients on the other become sufficiently rational as to their expectations that there are no medical indemnity claims.

Increasingly doctors see medical indemnity as much more than defending them in the circumstances of them facing a civil claim of negligence. One of the consequences of tort reform has been an explosion in non-civil claims. One in twenty doctors are the subject of a complaint each year and a doctor who has had one complaint made against them is statistically 75% more likely to have another complaint relative to a doctor who has had no complaints.

Doctors are turning to their MDO to support them when they face such complaints. These complaints are typically due to patient perceptions that the doctor has either demonstrated bad attitude starting with uncommunicative behaviour, through to being abusive, or demonstrable bad outcomes starting with a less than expected outcome, through to death.

Circumstances where doctors seek support today as opposed to five or ten years ago include these circumstances:

- ❖ Firstly when they are alleged to have misused Medicare items where they face a range of outcomes including fines, potentially a requirement to place a sign in their reception area to share with patients that they have been found guilty of misusing Medicare items through to losing their right to practise.
- ❖ Secondly bringing claims for unfair dismissal on behalf of doctors who seem to be regularly sacked by NSW Health for failures in the eyes of NSW Health.

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- ❖ Thirdly facing off the ACCC who have doctors in their sights. This year the ACCC issued a publication titled 'Professions and the Trade Practices Act' and activity levels are on the increase.
- ❖ Fourthly defending allegations of criminal manslaughter. The conviction in July this year of Dr Patel of the manslaughter of three patients whilst not the first manslaughter conviction of a doctor has rapidly become the most famous. In fact last year the DPP in Queensland unsuccessfully brought a like charge against a Queensland doctor that fell over in week four of the trial. It would seem that there is a determination to use the laws relating to manslaughter against doctors not only here in Australia but of course in recent times we have witnessed the charge of involuntary manslaughter against Dr Conrad Murray arising from the death of Michael Jackson where it is alleged that Dr Murray whilst serving as Jackson's physician, provided the singer with a lethal cocktail of sedatives, including dangerous amounts of the anaesthetic propofol that is only supposed to be administered by an anaesthetist in a medical setting.

The Dr Patel case is interesting to reflect upon. Despite the New York State authorities requiring Dr Patel to surrender his licence to practise in 2001 he did not face any credentialing process prior to commencing work at Bundaberg Hospital in 2003. He performed 1,202 operations before Queensland Health paid for a one way business class ticket to the United States in the first half of 2005.

Dr Patel was convicted of manslaughter of three patients and grievous bodily harm of another. The manslaughter convictions under s288 of the Queensland Criminal Code were achieved by virtue of Justice John Byrne interpreting the Code more broadly than was previously contemplated by extending the Code to treatments and not just surgical operations. What Dr Patel was seemingly found guilty of was actually a combination of gross negligence in the decision to offer and perform the operations upon the three patients due to Patel's known difficulties with similar operations, the inappropriateness of doing such major operations in a regional hospital, the high likelihood of complications due to the particular circumstances arising and an absence of proper consent from the patients in that they were not advised of the difficulties Patel had experienced with major surgery in the United States.

The aftermath of Dr Patel's case include more restrictions on International Medical Graduates working in Australia, hopefully better scrutiny of references and past work experience and lastly, but not unimportantly, mandatory reporting.

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- ❖ Fifthly and finally defending a doctor where another healthcare professional asserts he or she is performing in a manner that represents a significant departure from acceptable standards and by so doing is putting patients at harm. This is the new world of mandatory reporting which commenced on 1 July this year. Those who report in 'good faith' will be provided protection from civil and criminal liability.

Pursuant to the Health Practitioner Regulation National Law Act of 2009 the Medical Board of Australia may take immediate action in relation to a registered health practitioner if it reasonably believes that a practitioner poses a serious risk to persons because of the registered health practitioner's conduct, performance or health, and it is necessary to take immediate action to protect public health or safety. Whilst the registered health practitioner has the right to make submissions under Section 157 of that Act before the Medical Board can take action the Medical Board especially in Queensland from our experience is making decisions in the absence of having heard from the medical practitioner which all of us would regard as likely to expose the Medical Board to judicial review and deservedly so.

We expect that doctors will seek our support tomorrow in new and additional ways reflecting our evolving health care environment. An example of the same is that we expect more litigation flowing from the new insurance scheme that commenced on 1 July 2010 providing compulsory professional indemnity cover to independent midwives who have a collaborative agreement in place.

Turning to what an ideal medical indemnity scheme might look like one might aspire for it to find an optimal balance between the competing interests of patients, doctors, insurers and the broader community. The key features of an ideal scheme might include fair compensation, a national litigation model, timely compensation, available and affordable cover, accountability and encouragement of good medical practice, an apology framework, data reporting and no fault benefits for profoundly injured people. Whilst each of these features deserve some commentary it is likely that we might all have different views on which feature is more important than the next.

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## **1. Fair compensation**

There is tension between affordability of a scheme as a whole, and individual compensation. One can trivially ensure affordability by only paying out very low amounts. A successful scheme should appropriately compensate victims. This means that the amount should be sufficient to cover the victims' incurred expenses and losses. To the extent that compensation is restricted, a successful system should ensure that compensation provided is predominately to those with the greatest need. An ideal system would also minimise system transaction costs such as legal expenses.

## **2. A national litigation model**

I am not sure whether it is my role to answer these questions on your behalf but my own sense of an optimal national litigation model includes:

- ❖ A compulsory mediation within 18 months of proceedings being issued.
- ❖ Mediations that do not start with 'statements of fact' that have the potential to cause the parties to form entrenched views at the start of a mediation that typically is an unhelpful starting point.
- ❖ Hearing dates only being given after the mediation process has failed in the eyes of the mediator.
- ❖ Hearing dates being given not less than six months after nor more than twelve months after the mediation process has failed; and
- ❖ A less adversarial approach to the taking of expert evidence which I will expand upon in a few minutes.

## **3. Timely compensation**

Compensation should be provided as soon as possible after the discovery of the injury. Moreover, payments should be made as they are needed. While minor injuries may warrant individual lump-sum payments, more serious injuries should be compensated via periodic payments for specific needs using structured settlements.

## **4. Available and affordable cover**

Cover should be available for all medical professionals who meet the required standard. The premiums should be affordable for the practitioner.

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## **5. Accountability and encouragement of good medical practice**

Practitioners should be held accountable for injuries that they cause. Accountability should be separate from compensation. The optimal scheme should act to improve the standard of care so as to reduce claims.

## **6. An apology framework**

An open disclosure standard was released by the Australian Council for Safety and Quality in Health Care (now replaced by the Australian Commission for Safety and Quality in Health Care) in 2003. This is a national standard for open communication in public and private hospitals, following an adverse event in health care. The elements of open disclosure in that standard are an apology or expression of regret, a factual explanation of what happened, an explanation of potential consequences and an explanation of what is being done to manage the event and prevent its recurrence.

However, state laws have been inconsistent around protection in the event of open disclosure and the Australian Commission on Safety and Quality in Health Care has recently announced long overdue efforts to find a 'legal clear path' for open disclosure in Australia.

## **7. Data reporting**

Medical indemnity data is provided to APRA but it is difficult to interpret largely due to its aggregation with other professional indemnity products. The ACCC have prepared six annual reports on the industry focusing on monitoring of premiums to test that they are actuarially justifiable but the ACCC has not been requested to prepare a seventh. The Australian Institute of Health and Welfare provide some data in their annual reviews.

In my view this modest reporting is inadequate. There is no national database accessible by insurers in a form that can provide useful learning, so this element of an ideal scheme is not being achieved in the medical indemnity industry.

## **8. No fault benefits for profoundly injured people**

One potential Government reform that may represent a further major plank of reform to medical indemnity is the current Productivity Commission inquiry into the provision of long term essential care and support for people with severe or profound disabilities however acquired. The Productivity Commission is due to report to the Federal Government in July 2011.

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I personally support such a scheme and have done so since the first case I was involved with that went to verdict for the then State Insurance Office of Victoria in 1983. That case known as Paynting v Incorporated Nominal Defendant involved an allegation by Mr Paynting that a car coming towards him near Faraday on his journey to Bendigo had its full beam headlights on causing him to be temporarily blinded whereupon he smashed his car into an embankment suffering a contusion injury that led to him losing his sight, his taste and his smell. My task was to seek to prove to the Jury that there could not have been another car and I worked with great enthusiasm to achieve this objective until the first day of the hearing when Mr Paynting emerged with his seeing eye dog and one had to wonder why it really mattered whether there was or was not that oncoming car.

If the long term care scheme becomes real it will most likely eliminate the future care cost component of medical indemnity claims for those who are severely or profoundly disabled, which we would expect will significantly reduce settlement costs and court awards and dare I say it substantially erode the financial benefits for plaintiff law firms to bring medical indemnity claims.

Everyone in the room has the potential to play a role in enhancing the court system that is integral to the efficacy of the medical indemnity sector.

If you are judge you might reasonably ask yourself questions like do you really understand complex medical conditions like cerebral palsy and have you availed yourself of the right to appoint your own expert to enhance your understanding as you are entitled to do under the Supreme Court Rules.

To quote Gavan Duffy's presentation on the topic 'The doctor in the witness box' to this Society on 21 May 1932 "Among the changes I have heard suggested by medical men are, first of all, that it might be a good thing to have matters that were technical in their nature, tried and decided by experts." That is one suggestion.

In the old days of the Admiralty Court a system was followed where the judge sat with assessors who were retired naval captains and no expert evidence was allowed to be called. The facts were simply given and the assessors, when any question involving expert knowledge arose, advised the judge.

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Sir George Jessel, M.R. stated in the case of *Abinger v Ashton* in 1873 (L.R. 17Eq; at pages 373 and 374) and I quote:

"Expert evidence of this kind is evidence of persons who sometimes live by their business but in all cases are remunerated for their evidence. An expert is not like an ordinary witness, who hopes to get his expenses, but he is employed and paid in the sense of gain, being employed by the person who calls him."

In 1937 Lord MacMillan, in a work entitled 'Law and other things' made his view clear as follows and I quote:

"Of one thing I am certain, and that is that no scientific man ought ever to become the partisan of a side; he may be the partisan of an opinion in his own science, if he honestly entertains it; but he ought never to accept a retainer to advocate in evidence a particular view merely because it is the view which it is in the interest of the party who has retained him to maintain. To do so is to prostitute science and to practise a fraud on the administration of justice".

Professor King in a joint presentation with FR Nelson QC on 6 December 1952 to this Society on the topic "The doctor as an expert witness" opined and I quote "it would seem that the rational procedure would be to call an expert witness as a witness of the court, not as a witness for or against any individual or individuals".

In the modern day workings of the Supreme Court of New South Wales all expert evidence is given concurrently in medical cases unless there is a single expert appointed by the Court or the Court grants leave for expert evidence to be given in an alternate manner. Concurrent evidence means two or more expert witnesses giving evidence at the same time thus gaining the descriptor of 'hot tubbing' as experts 'get into the witness box together'.

Hot tubbing frequently commences with a joint conference of experts in the lead up to the trial and a report is produced with agreed matters and agreed areas of dispute with some judges asking counsel to produce an agenda for the concurrent session.

Specifically the hot tubbing process looks like this:

- ❖ Experts are usually grouped together by specialty.
- ❖ They are all sworn in together.

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- ❖ Experts sit at the bar table facing the judge with counsel usually sitting at each end of the bar table.
- ❖ The judge plays more of an inquisitorial role than the traditional method of examination in chief followed by cross examination followed by any necessary re-examination.
- ❖ The judge typically asks a question of Expert 1, then Expert 2 etc on the same topic usually starting with the plaintiff's expert or experts first.
- ❖ Counsel can ask questions on the topic and can cross examine but this tends to be much less adversarial in this environment indeed we have had one experience where one expert has come to the rescue of another expert under fire.
- ❖ Experts can ask questions of each other on the topic.
- ❖ The judge then typically sums up as to those areas of both agreement and disagreement.
- ❖ Then, the judge takes the experts to the next topic and the process is repeated although there can be jumping back and forth naturally between topics and issues.

So what are the advantages and disadvantages of concurrent evidence?

The advantages include the following:

- ❖ Firstly experts prefer it as it is less adversarial and more respectful to them as people and they have a sense that they are truly assisting the Court and not promoting the interests of one party over the other because of their more direct interface and dialogue with the judge.
- ❖ Secondly experts are all asked the same question so there is no room for doubt as to what their views are on the issue compared with them being subtly asked different questions either advertently or inadvertently as is the traditional method.
- ❖ Thirdly lesser quality experts tend to fail as they find it difficult to justify making outrageous assertions in the presence of their colleagues.
- ❖ Fourthly and not insignificantly trial lengths can be significantly shortened and in our experience some cases that might otherwise have taken six weeks are being completed in half the time.



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The disadvantages of concurrent evidence include:

- ❖ Barristers typically do not like it because it takes away their adversarial role thus reducing their notional control over witnesses.
- ❖ There is the risk that an expert with greater persuasive skills relative to his or her peers but not necessarily possessing greater expertise will dominate and be preferred even though judges inevitably suggest that they are not seduced by the advocacy of experts and are best able to assess the quality of their views.

In the wash it is my view that concurrent evidence lends itself well to the medical expert environment and there are many more advantages than disadvantages. It is interesting to contemplate how concurrent evidence would work in Victoria before a jury and I will leave that to you to contemplate.

- ❖ Secondly Judges might also turn their minds to shifts in Government health policy. For example General Practitioners are increasingly encouraged not to refer every patient for pathology and/or radiology testing yet Judges often remain a lag indicator conveniently finding negligence against a General Practitioner for not doing so on the balance of probabilities.
- ❖ Finally Judges might consider how accessible should a Court hearing be? By way of example we recently resolved a claim in Canberra at a mediation in no small part because after the plaintiff was offered a hearing date in September 2011 with a likely resolution of the claim well into 2012 the plaintiff felt compelled to accept our offer. Equally is it acceptable that a plaintiff can get a hearing date in New South Wales without having participated in a mediation?

If you are a doctor in the room you could reasonably ask yourself questions like:

- ❖ How can you further reduce the likelihood of someone being injured. By way of example in a number of European countries maternity teams are doing collaborative training on CTG monitoring aimed at reducing the incidence of claims regarding babies born with cerebral palsy.

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- ❖ How can you enhance your communication skills so that in the event there is an injured person your display of empathy and care ensures that you fall into the category of doctors who are not sued even though an injured person has a right of action to sue you.
- ❖ If you are an expert witness are you applying a fair test on the doctor in question, or are your expectations of your peers unrealistic.

If you are a medical educator in the room you might reasonably ask yourself questions like:

- ❖ Am I enrolling the right people into the medical faculty? There is mounting evidence that students who exhibit a narcissistic personality have a heightened risk profile as medical practitioners. A study of Papadakis in 2005 concluded that unprofessional action as a medical student such as severe irresponsibility and/or diminished capacity for self improvement were predictors of disciplinary action by the relevant Medical Board. So one might ask why offer them a place in a medical faculty?
- ❖ Are we training medical practitioners to communicate? A 2002 study by Ambady et al demonstrated that a 20 second audio of surgeon communication with a patient was an excellent predictor of litigation risk.

If you are a lawyer in the room you might reasonably ask yourself questions like:

- ❖ Why do you tolerate different litigation models in each State of Australia and what is the litigation model that offers the best balance between the interests of the plaintiff and the defendant?
- ❖ Why do you accept mediation models that have a poor track record in achieving an outcome relative to a mediation model that achieves a higher success rate?

In conclusion medical indemnity continues to evolve partly by natural evolution and partly by the actions of all of us in this room this evening as well as the actions of patients, governments both state and federal, insurers, lobby groups and others. It is that curious combination of forces that is the answer to 'In whose hands rest the future of medical indemnity?'