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The Medical Indemnity Crisis

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PRESIDENT: Members and guests, welcome. Many of you will remember controversy in the early 2000s, soaring medical indemnity premiums and the backlash by the medical profession to them. To illuminate how the crisis was created, how a solution was brokered and a continuation of medical indemnity reform, we will be privileged to hear from Professor Kerryn Phelps.

Professor Phelps will also address challenges posed by the expansion of integration of complementary medicine practised by a range of health providers of varying levels of experience and qualifications.

Professor Phelps has been a regular television personality, past President of the New South Wales Branch of the AMA, past Federal President of the AMA. She practises as a GP. She is the health writer for the Women's Weekly, writes political commentary for the Medical Observer magazine. She is President of the Australasian Integrative Medical Association.

Professor Phelps was awarded the Centenary Medal in 2001 for service to Australian society and medicine. In 2011, she was named as a Member of the Order of Australia for service to medicine, particularly through leadership roles with the AMA, education and community health as a general practitioner. Please welcome, Professor Phelps.

PROFESSOR PHELPS: Thank you everyone for that welcome. I had better confess up front that I came back from holidays on Monday with a raging case of laryngitis and was not sure that I would have any kind of voice for you tonight but if you will bear with me, I hope you can hear me up the back but this is my husky presence with you tonight.

I think it is a testament to the strength of our

respective professions that there is still a Medico-Legal Society of Victoria or anywhere after the tort law reform debate, you might say, or crisis, of the early part of this century. What I am going to talk to you about tonight is the medical indemnity crisis. It was the disaster that did not happen to the Australian health system.

Tonight I am going to give a bit of the inside story about how the disaster was averted, not despite the dire warnings but because of the dire warnings of the medical profession and I might add not because of the cooperation of the legal profession but despite the resistance of elements of the legal profession, most notably the plaintiff lawyers. Understandably perhaps.

Rising costs of indemnity premiums was without a doubt the most difficult and complex medico-political issue the AMA and more broadly the medical profession had ever had to deal with. The solution had to be extracted slowly and painfully. It made root canal therapy look easy.

The problem had been bubbling away for many years and the medical profession had been playing nice, making submissions, raising the issue, working behind the scenes, forming committees, having meetings. The problem had certainly been recognised as far back as the early 1990s. Back in 1991 the government sent the issue to a professional indemnity review, chaired by Fiona Tito. Setting up a committee or review is one government technique for getting an issue out of sight until after the next election, and so it was with this review, which took four years to come back with a report which concluded

that there was no crisis. Only a small proportion of people who were injured by health care sought or won compensation.

The real crisis was the financial state of the medical defence organisations and their irresponsible financial management. That turned out to be quite prescient. There were 168 recommendations that came out of this four year study and most of them were ignored.

This review took the four years to come back. It did not offer any practical solutions, just lots of further areas to explore. Interestingly, the report did highlight this poor financial management of the medical defence organisations and this was a factor that would later cause the entire system to spin out of control.

Of course, what it did not mention was that many cases were being advised to settle out of court and this was because the medical defence organisations felt that, particularly for the smaller so-called nuisance cases, it was cheaper and more effective in terms of time management to give people tens of thousands of dollars, up to maybe even half a million dollars, rather than run something through the court and highlight the costs in terms of legal costs and time and the stress that it created for the doctors who were going through these cases, regardless of whether they had merit.

So around this time, Michael Wooldridge became Health Minister. He replaced Carmen Lawrence, who was preceded by Graham Richardson and before that Brian Howe, who set up the review. In 1995, in frustration because nothing was happening, the AMA formed a medical legal committee. What else do you do? It tried to form a

committee to press for resolution. Now, that grumbled along for another few years, again with absolutely no progress but we were learning more and more about the system and how it was working and where it was not working.

I will get back to that in a minute. By this time it was 1999 and I was AMA President in New South Wales and along with Victoria this was the pointy end, this was the epicentre of the tsunami of tort law reform that would hit first of all those eastern states. We were going to be hit first and we were going to be hit hardest by what would later commonly be referred to as the medical indemnity crisis, the crisis that did happen, the disaster that did not.

I was given strong evidence that this was an issue that the media would have no interest in whatsoever and those of you who understand how politics work, unless you get the ear and the eye of the media, unless you get the attention of the nation's press, then you are very unlikely to get any action politically because it all depends on the political perspective. It all depends on what the community wants its political representatives to do.

So I heard comments like "Why would the newspapers be interested in a bunch of doctors complaining about having expensive insurance? Who cares?" Now, media was an area where I had a lot of experience. I had worked in news and current affairs since about 1985. I virtually started medical journalism in this country when no one else was doing it, so this was very familiar territory for me. Health, I understood. I understood it very well.

Media, I understood very well. I was a doctor working every day with patients, doctors and other health care personnel, interfacing with universities and colleges and universities. I was getting the real story on the real people working within the system.

The law was another beast to me altogether. From my point of view, I had to do a crash course in tort law. The closest I had come to a court of law was watching a few episodes of Ally McBeal. First of all, I had to work out what tort law was. The only tortes I was familiar with are the one you ordered from the dessert menu served with double cream, or the taut describing a tightly stretched pair of jeans across the well exercised set of gluteals, or the taught describing the things you learnt at school. These "torts" were neither tasty nor tight but we could certainly learn something from examining the system of Australian Law and the impact it was having on the practice of medicine and the future of our health care system.

Now, for those non-lawyers amongst you, tort law, I discovered, is a body of precedents. A tort is a civil wrong other than a breach of contract. Tort law is the way in which the law can intervene in relationships between private individuals to correct a form of conduct or a perceived wrong and since a court can define an existing tort or even recognise new ones through the common law, tort law is learned. I learned that tort law sometimes regarded as "limitless".

Now, this was a bit scary because here we started to see part of the problem. Medical practice in the future was going to be defined by tort law rather than the norms

or the standards of the medical profession itself.

Looking back, the alarm bells really were starting to ring loud and clear with the landmark Rogers v. Whitaker judgment in 1992, and you would all be familiar with that. Quoting Justice Ipp, "In 1992 in Rogers v. Whitaker the High Court departed from the Bolam principle, that being ruled that a medical practitioner is not negligent if he or she acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion. The High Court held that negligence was a matter for the court and not for medical practitioners. This ruling made it easier for plaintiffs to sue their doctor. Rogers v. Whitaker also held that a medical practitioner had a duty to warn patients of a material risk inherent in a proposed treatment. Some doctors now spend more time explaining the risk of the procedure than examining the patient." I have to say some doctors spend more time explaining the risk of the procedure than in actually performing the procedure. The end of the quote was before that.

Hence the emergence of what we now called defensive medicine. Now, this was a term that emerged in the early 1990s. It was not just about doctors spending more than half the consultation explaining every possible thing that could go wrong with a patient's treatment, and I have to say turning a lot of them off having treatment, "What do you mean I can go blind? What do you mean I could become quadriplegic?" "Well, you are just having, you know, a little skin cancer taken off but, you know, sometimes it is possible you could become blind or paraplegic." "Maybe I will just leave the skin cancer there." "Okay."

I engage in hyperbole but it really was getting to that kind of level.

So a lot of time has been spent. It was about doctors making decisions though about investigation and diagnosis and treatment to avoid being sued rather than what was necessarily the purely sound medical judgment, and adding cost and risk related to the extra investigation. This has now been modified in most jurisdictions as a result of recommendations arising out of the Ipp Review but if you cast your minds back to how things were back in the early to mid-1990s, this was a very real concern. Certainly this flowed right over into the mid part of the 2000s, where doctors - and it still is the case - were so terrified of being sued, not necessarily - you know, okay, you are insured and your insurance covers it, but the very stress, the trauma of going through a patient suing you for a bad outcome, it is not only very bruising to your ego because something went wrong, but it's also terribly distressing for doctors because, to be honest, we live to create good outcomes for our patients.

But even this was not the crux of the issue. The truly malignant potential of the emerging situation was that most procedural specialities were becoming uninsurable and unaffordable. We were starting to talk about obstetricians paying $200,000, $250,000 a year in indemnity premiums. We were hearing stories coming out of Florida where there were no obstetricians. If you wanted to have a baby, you hightailed it out of Florida to the next state, where they had a different tort law system, because there were no obstetricians delivering babies in

that state. Not just because it was retirees. I mean, there were young people in Florida who wanted to have babies. There were people who were advertising in the newspaper in New York to find a doctor prepared to deliver their baby under certain contractual requirements. And so things were becoming pretty ridiculous. We were seeing the writing on the wall in the US and it was happening here.

Almost worse than that, the medical indemnity providers were starting to look at bankruptcy. We did not know that yet though. Now, as we suspected, when my comments were first reported the response of the plaintiff lawyers - some of my best friends are plaintiff lawyers - focused on my questioning a patient's right to sue. It was a case of we had to establish who the good guys were here.

One critic was J A Tooma, the then president of Queensland Law Society. He went on a bit of a letter writing campaign around Queensland and he cried foul with this comment, "The call by the AMA President Dr Kerryn Phelps for the axing of patients' basic rights to sue doctors for medical negligence is an appalling admission of doctors' belief in the god-like position they think they hold in society."

Well, I am pleased that he got that one wrong but what we did need to say was where was the money going. Now, according to the Tito report, about 50 per cent of the money that was awarded or settled paid for the legal costs of both sides. So this is where doctors' premiums were going and doctors' premiums of course had to be added onto medical fees so what we were charging our patients,

we had to then add on the added cost of the insurance premiums. Half of what we were paying in premiums was going to legal costs. Another at least 16 per cent of the then annual total operating costs of $103m of just one of the medical indemnity insurance companies was going to their administration.

So about 75 per cent of doctors' subscriptions were not actually reaching the people it was intended to compensate. You can see where there was a ripple of panic through the ranks of the plaintiff lawyers. But this was a movement whose time had come. We had to overcome the perception that doctors were just trying to avoid accountability. This was easily done when we articulated the many pathways to health care complaints, medical board processes and a doctor's own professional responsibility to our patients.

To be absolutely clear, the intent of my remarks was let us move away from a system predicated on a patient's right to sue, and move to a system predicated on a patient's right to proper care and rehabilitation in the event of a medical mishap. The core message from a media perspective was not doctors do not want you to be able to sue them, rather than the public deserves to know there won't be doctors to deliver your babies in a few years, or the neurosurgical brain drain will mean that there won't be enough neurosurgeons to operate on brain tumours, aneurysms and spinal injuries.

That year nine out of 27 neurosurgical training positions were unfilled. These are the people who are training the brain and spinal doctors of the future. In that one year they have 27 training places available. A

third of them they could not get people to even sign up to train as neurosurgeons. Why, I asked the young doctors. They said medical negligence insurance costs were a significant factor in them deciding against the specialty.

So the nub of the crisis was always the dual lane, a sustainable medical workforce to provide care for Australians into the future, and a fund for the care of injured or disabled patients. As we saw it, you could not separate those two things. You could not change tort laws so the patients did not have the same mode of access to sue without providing some recourse in terms of doctors being accountable for misadventure and mishap and particularly for negligence, but the really important part of this was what about the people who are injured? If you remove their right of access to the courts to the same degree, how are they going to get the care that they need? This fund was always going to be an essential part.

We knew the crisis was going to hit New South Wales first and hardest. In May 2000 the AMA New South Wales organised a seminar in Sydney to bring together doctors and lawyers to thrash out the issue. I told that seminar tort law reform is a crucial issue for the Australian medical profession. It would not be an overstatement to say that the situation has reached boiling point. Over the past 18 months there has been a growing chorus of calls from the AMA to work with government to do something to address the blowout in medical indemnity premiums.

This was brought to a head last year, that would have been 1999, with a call from the Victorian Medical Indemnity Protection Society, MIPS, demanding a full year's subscription from all members. If you remember

that, you were asked to pay the subs and then another whole year of subs, and then we did not know how many times that was going to happen into the future, so people started to get pretty nervous.

We have reached a situation where clinicians in a number of fields are obliged to carry an unrealistic premium burden. This cannot be sustained on a long-term basis. The effects are already being felt. Anecdotally we were aware of many obstetricians who are leaving obstetrics. One of the first group to down tools are the rural obstetricians. These rural services are not easy to replace. The communities in rural areas are already frustrated and angry about their declining health services.

If we look at the trends in the United States it is clear that the writing is on the wall for us here in Australia. The American experience is a prediction of things to come in Australia, and we would do well to take note. That was directly taken from my speech that I gave to that seminar in May 2000, just before I became Federal AMA President, and I think it really outlined exactly where we were at. I think that one of the reasons that people started listening to us is that we were completely honest and truthful about what our observations were.

I even took journalists on a trip up to the Hunter Valley and we visited obstetric units, got them to imagine that they were in labour and then we drove them to the nearest obstetric GP, the nearest person who might deliver their baby in the middle of the night, across rocky dirt roads, past the hospital that used to have a GP and on to the next hospital which used to have a GP, and then to a

hospital where they actually had an obstetrician who would deliver their baby, and just to imagine what that trip was going to be like for somebody. Those are the sorts of things that really rung true for the journalists.

Two months later the president of the Plaintiff Lawyers Association at the time, Peter Cashman, described my tone as "overemotional". I am not often described as overemotional. He said, "There appears to be increasing hysteria within the medical profession of the so-called medical indemnity crisis", still thought it was a so-called crisis then. "Various groups are now actively lobbying to restrict victims' rights and to reduce damages."

At a recent seminar on tort reform - that was the seminar I was talking to you about - we invited him to speak about it and he did, organised by the Australian Medical Association. Various doctors spoke of their increasing disquiet. Courts were said to be imposing liability on the medical profession in the absence of any element of fault or negligence. Judges were described as modern day Robin Hoods and some described them as Santa Claus.

Offensive medicine was said to be on the increase. However, a number of research studies both in the United States and Australia have confirmed that only a very small percentage of injured patients or relatives of patients who have died as a result of apparent negligence ever sue. Rather than weaken our position, I thought this point of view clearly reinforced the injustice of the existing dysfunctional system.

So for those people who genuinely needed care were

being denied that care because they could not afford access to the court system or because they could not prove fault. So those who could afford to persist with litigation, who engaged a no win no charge lawyer and could prove negligence were the winners, but most injured or disabled patients were not in that category and they were the big losers. Add to that the crisis in procedural specialties and there were vastly more losers than winners.

It was also important, although not something for general consumption, the process of being sued for a doctor is personally and professionally devastating for a doctor who believes that they practise in their patient's best interest and to the best of their ability. There are far more healthy ways of ensuring health quality and safety of practice.

The next thing I remember, and I really had to dig deep into my archive for this because remember that this is all happening over 10, 12 years ago, so being a bit of a personal hobby archivist I have actually kept every piece of paper that came past my desk as AMA President, including notes that were taken at meetings, they came in handy at times. So I dug around in my archives and I remember this meeting I had with my AMA CEO, Laurie Pincott.

He went to speak to Richard Tjiong, remember Richard Tjiong who was the head of UMP at the time, and he was leading UMP and we came away with this terribly uncomfortable feeling that all is not well in the organisation, despite his monologue that went for about 50 minutes telling us how fabulous things were.

We thought we were being kept in the dark about something. We could not quite nail down the nature of the problem, but very soon it became obvious that the state of medical indemnity dysfunction was a problem way beyond the scope of a single state or a single medical defence organisation. We were going to need coordinated national action. So the medical indemnity crisis was the issue that took me to Canberra and to the Federal AMA Presidency.

By the time I became Federal AMA President in May 2000, on a day where it snowed in Canberra in May and there was a coup in Fiji as I recall, the situation was becoming critical. We knew it but it was another matter to get the Federal Government on board with a solution. We knew about the problem of recruiting neurosurgeons. I spoke to you about that before.

A survey of O&Gs in February 2001 had found that a quarter of trainees were not going to continue obstetrics as part of their specialty because of the fear and costs of litigation. So of all the people we were training to be obstetrics and gynaecology specialists, a quarter of them were only going to practise gynaecology, things you could do in the waking hours, things you could do with minimal insurance. A quarter of them were not even going to deliver a baby once they graduated. That was because of the fear and cost of litigation.

Confident that the scope of this problem would be absolutely self-evident to a Health Minister who was himself a doctor, I naively approached Dr Michael Wooldridge, the Health Minister at the time. He tried to brush me off like a pesky blowfly on a hot summer's day.

He dismissed the medical indemnity issue as the State's problem. We argued, you may have seen that. The problem was that we needed an unprecedented coordinated Federal and State approach. He did not agree.

We did get a bit of a breakthrough when the New South Wales Government, who I had been working on for about a year through Craig Knowles, he called me up very excitedly at home one day and said, "We have got a breakthrough, you are going to be so happy with this, Kerryn". He said, "The New South Wales Government is going to announce amendments to tort law and caps on compensation payouts in some areas of practice". They were going to cover the obstetricians for all their public work, that was fantastic, they were going to cover the neurosurgeons for their public work, but they wanted compulsory indemnity insurance.

You do not have to tell doctors to get indemnity insurance. You really do not because no one wants to practise without it, unless they go completely bare and put everything they own in their wife's name or their husband's name or the kids' names but even then they can get you. We want to have insurance but the problem was, if you have to have compulsory insurance, if you then became a doctor who conducted very high-risk procedures, then it was up to the medical indemnity company to decide whether they would insure you or not.

If it was then compulsory and you were denied insurance, you became unable to work because you were uninsurable because you were not able to get the compulsory insurance so we had to fight that one off and we eventually did, but at least New South Wales was on the

ball and they were putting some money into this thing but no other State government showed any interest in reform at the time.

Interestingly also at this particular point we had a Liberal Coalition Federal Government and we had every single State and Territory government at this moment in time was Labor and so we had a window of opportunity that was almost miraculous, that we could actually harmonise across the States and Territories if we got them all singing the same song because they were not going to fight with each other publicly. The storm clouds were gathering.

In March 2001, and for those of you who were around at the time do you remember HIH went into liquidation because what they were doing was that they were trying to undercut in terms of the re-insurance market all of the other insurance companies so all the re-insurance for all of the MDOs all fell to pieces because the re-insurance was not able to be purchased because HIH went into liquidation, then in late 2001 we found out what Richard Tjiong was not telling us, and that was they had not been recording $455m worth of IBNR claims. Now IBNR we gave the nickname the tail, because we thought the tail was wagging the indemnity business at this time. The tail were all the claims that were going to happen that had not been reported yet. They were all the things that - let us say somebody has a problem in surgery today but they do not find out about it for a few months. We know that that has got to be accounted for and there are actuarial ways of accounting for that but in order to keep the premiums low to be competitive against the others in the market UMP

were not counting their IBNR and it had counted up to nearly half a billion dollars. Where was this money going to come from because what happened was that the doctors who were insured with UMP, me being one of them, if something came up during that period of time of the so called tail, then you were not covered even if you had been paying your insurance premiums all along. So we had to do something. We really had to do something more to get some attention. Mostly we needed Federal political leadership because ultimately the survival of the largest indemnity provider would rest on the Federal government providing a capital guarantee while they raised the funds to survive. The Minister persistently refused to deal with the AMA.

It was time to come out fighting. We had to find a way to get the government's attention. I wrote to the Prime Minister and I wrote to every member of the House of Representatives and I wrote to every senator and I signed personally every one of those letters. And we briefed the press of course, a lot. We beat a path up and down the Parliamentary press gallery. I know them all personally, took them out to lunch, spoke to them at great length.

Medico-political groups at the time, mainly us, were accused of adopting militant union-style tactics reminiscent of the notorious AMWU, the Builders Labourers' Federation. I told a journalist offhand one day that I thought it was a bit of an insult to the AMWU and he printed it, so that was funny. It jut shows that there were some commentators who actually failed to understand the difference between industrial action and consciousness raising. I thought what we are doing was consciousness

raising. They claimed that we were engaged in industrial action. Nobody ever downed tools though.

On the other side of the ledger, without the actions of the BLF in the 1960s and 1970s many of Australia's heritage icons like the Rocks and Queen Victoria Building in Sydney would have been reduced to piles of rubble by developers, like the Australian health care system would have been if a workable long-term solution had not been found.

The AMA's disagreement with the government was painted as a bitter personal feud between Michael Wooldridge and me, and on one level that was quite accurate because I did actually threaten to sue him for defamation over some of his less prudent remarks. I just drew a line in the sand. We never intended to go through with it but we certainly made the point.

This takes us through to June 2001, so we had been knocking on the doors of this indemnity problem for a solid year, federally at this stage. That is not counting the 10 years beforehand with the Tito review and everything else.

There was a bitter stand-off between the Health Minister and the AMA, not just because we were suing each other for defamation. The Prime Minister John Howard decided it was time to intervene. He put his foot down, he did. The Prime Minister called Dr Wooldridge and me into a meeting in his office to resolve the stand-off. Somehow the press got wind of it and photographed us going in.

I remember very clearly we sat in those green Chesterfield chairs in his office and the Prime Minister,

as he is wont to do, explained to us why he had called us there and explained the entire situation and then said that he hoped that there would be a truce. I explained the problem that we were having with the indemnity issue. Mr Howard, being a lawyer, actually understood the nature of the problem but he wanted the Health Minister to deal with it.

I later explained to him that it was way beyond the scope of the Health Ministry and had to do with a whole lot of other issues as well that would have crossed many portfolios, and ultimately that is where the solution came. But even after that meeting, we did not get far on the issue but we were working hard behind the scenes to formulate workable practical solutions. Then we got a breakthrough of sorts when Dr Wooldridge resigned from politics in September 2001.

After Dr Wooldridge resigned, the Prime Minister, through his Chief of Staff at the time, John Perrin, came to see the issue as a matter of national importance, needing national leadership. Finally, we were getting somewhere. The public was on board, they had been for some time. The medical profession was hanging in there. We had made a lot of effort to bring the public on the journey with us and they got it. Women in country towns understood that their GPs, who had been delivering babies for generations, were no longer prepared to pay these insurance premiums to do it.

I will go back to Justice Ipp's comments. He said, "By 2002 there was an insurance crisis not just affecting the health system. Some insurers had left Australia. Others refused to provide indemnity cover. The cover that

was provided was expensive and often difficult to obtain. Consequences were serious. Some obstetricians and neurosurgeons gave up practice. Hospitals, or parts of hospitals, closed. Local authorities were forced to close roads and swimming pools. Volunteers refused to continue transporting the infirmed and elderly, and some social activities ceased."

Now, do you remember that time? I remember it really well. People were stopping having school fetes because they could not get public liability insurance when HIH went belly-up. So it was not just about doctors and obstetricians and neurosurgeons. Suddenly, every community group was saying, "We can't hold a scone stall in case there is something in a scone that someone eats and it makes them sick because we can't insure ourselves and they will ruin the school."

So it really got terribly serious. It was almost like the social life of Australians ground to a complete halt because we could not insure ourselves against day to day activities. People were not going to scout camps. It was crazy. I remember my father was working as a volunteer, taking people with cancer, driving them to and from chemotherapy because they could not drive themselves. He said he was going to keep on doing it and he ended up getting his own insurance to do it because the hospital could not get the insurance for their volunteer drivers to be able to drive people to these things. He was just doing it as a favour to people. In retrospect, at some risk.

So the PM and a couple of friends there, he got involved. He finally met the AMA's pleas to intervene and

he announced, thank goodness, that a medical indemnity summit would be held in 2002, in April. The issue of this IBNR tail loomed large but if you have a look, and I won't bore you by going through all of these issues but we had a very clear agenda. We wanted to review this whole idea of throwing out the Bolam principle so that the medical profession again was in charge of our standards. We needed consistent tort law reform in all states and territories, all at the same time. Not this piecemeal, "We are going to do a little bit here in the Northern Territory," and over there in Western Australia, "We will do a little bit more," and I think Queensland, "We will do something different." We wanted harmonised national coordinated tort law reform. A national standard statute of limitations of three years for adults and six years for minors. You will also remember at the time that in some states, you could run a case 25 years after the fact. So this tail that we were saying was wagging the medical indemnity dog would have been going on for a quarter of a century. We wanted assessment of liability by properly accredited experts, not these guns for hire, people who made it their career to discredit other doctors by giving a very biased point of view. Proper risk management strategies. A community-funded national care and rehabilitation scheme as a minimum for the severely disabled at a set level of impairment.

Now, this thing was in every single thing that we put forward to any government because we have to be able to look after the people who can't access tort law. Effectively management of the so-called tail and it had been looking for a donkey to pin itself onto, and there

were lots of reasons that the tail of over $400m, the estimated cost of injuries that had never been reported, in essence became the real problem and this long lag time of 25 years was one of those reasons.

So that was the plan that we took to the national summit which took place on April 23, 2002. There was at this summit, hurrah, universal support for the need for a fair and effective tort and procedural law reform and in particular for the concept of a nationally coordinated long term care and rehabilitation scheme for the severely disabled from medical accidents.

What we pushed for, for years had finally been accepted at all levels of government, every state and nationally and the medical professional and ultimately, although reluctantly, the legal profession. It was a priority for action. 30 April we met with Helen Coonan. That is the piece of paper that I kept from the plan that the AMA put forward, that is the speech to the Medical Indemnity Summit, that was our position statement. We met with Helen Coonan, the Assistant Treasurer at the time, and fortunately she was a lawyer as well of some significant experience and she really got it.

She was sure that there would be buyer for UMP, this is the bit she did not get, because several companies were looking at their books and we assured her that those companies were just kicking the tyres because no one was going to buy UMP because we looked at the books too. She promised the medical practice would not be disrupted. She may have lived to regret that promise because after tough negotiations and a near walk-out by us, we issued a joint statement. They were going to issue legislation to back a

guarantee. A commitment was given to give priority to the development of a national scheme for the long term care costs of the severely disabled, cost accounting for the blow-out in the amount of large claims.

The AMA warned Health Minister then Kay Patterson and Helen Coonan that the government's failure to extend its guarantee to UMP would actually bring the crisis on. And so it came to pass that a week after the summit, UMP went belly-up. A provisional liquidator was appointed. There was uncertainty over outstanding claims and settlements. I was getting doctors and doctors' partners ringing up in tears at the AMA to talk to us to say, "We have got this claim that is outstanding. We are not covered. It is going to court and we have been told that we will lose our house." So we really had to get this - and we worked nearly 24/7 trying to get this thing in place.

So faced with a crisis upon a crisis, the Federal Government had no choice but to work hard and fast. We worked with them. Because we had done this extensive preparation, the government agreed to plug the gaps in insurance cover to doctors so it was safe for everyone to keep practising until we sorted something out. So the Federal Government, even though they were reluctant starters, actually put up the guarantee funds to keep UMP going and keep doctors working while we tried to work something out.

So the government was then in the cart because they put up the $35m guarantee. They were now a major participant, so this was a very significant moment. We almost, I guess, if you like, manoeuvred into a position

where they were brought in.

The PM announced an enhanced guarantee which extended things until the end of 2002. So we had a little bit of time up our sleeve. Exactly six months after the summit, the Prime Minister announced the medical indemnity rescue package, which extended things for another 12 months, so we got an opportunity to then raise the funds from the medical profession while the government propped things up, so that we could then pay off this tail over a period of time and cover all of those IBNRs, all of those things that had happened that nobody had reported but that would have caused a bit of a disaster had they not been covered.

So we welcomed the package. The AMA worked closely. The government then set up a task force and participated in the Australian Health Ministers' Advisory Council process. What we did, we got them to put together, and this is working with the Department of Prime Minister and Cabinet, a very high level task force within the Department of Prime Minister and Cabinet. They included the heads of health, treasury, finance and the Attorney-General's department. Things really got serious once the heads of treasury became active. The heads of treasury we named the HOTs of the treasury, or the "hotties". They became active in the process and soft solutions were abandoned for really hard-hitting ones with funding behind them.

The government had their task force, we had ours and we worked together with their task force at federal and state level because we also had state task forces set up and well briefed at that level. We also went around to

every state and spoke to the premiers and the treasurers in those states as well, to talk to them about why this needed to happen the way we said.

So moving towards a solution, I love the comment on the bottom of that, "Minister of Communications Helen Coonan and friend". She was working with us, she was assistant treasurer. Six days after the summit, as I said, UMP went into liquidation and by May 2003 we were able to declare, if you like, at least to an extent, mission accomplished. Then the PM called on the states to continue their efforts on tort law reform.

The Federal Government appointed an Eminent Persons Panel to recommend a package of national tort law reform that might provide the states with a template, and this was eventually very successful.

The Prime Minister, in his accompanying announcement back in 2003, said, "The Commonwealth will continue to participate in state and territory processes, examine the current and possible alternative arrangements for providing long term care for those who have suffered catastrophic injury." He said it can't move on that matter without the states. The states can't remove future care costs from common law awards of damages until a statutory scheme is in place. If they do not want to fund it, the stalemate has to be overcome. Both federal and state governments are committed to pursuing the matter in the long term.

So State and Territory Governments introduced a bit of inconsistent tort law reform. Some of them had to be dragged kicking and screaming to even acknowledge there was a problem. Federal Government was a reluctant

starter, as I said, but shifted to top gear on an issue that was not of their making and in whose hands a substantial part of the solution rested. In the end, the government decided that the country could not afford past years compensation generosity and legislation was passed in the Commonwealth and every state and territory. Again to quote Justice Ipp , "The uniformity of purpose, extent and rapidity of these reforms was unique. I do not think we have ever seen anything and I doubt that we will ever see anything like it again."

Which brings me to unfinished business. Following the introduction of the 2003 reforms, medical litigation dropped by over 95 per cent. I think you would have to call that effective. At that time, we called it something different but a national disability insurance scheme was flagged. So this leaves us with the unfinished business of the medical indemnity crisis that has now been bubbling along and at times boiling over for two decades. That unfinished business is what to do to provide care and financial support needed by people who do not have access to doctors' medical indemnity funds. This was always a problem for people who are injured but who could not afford the legal process, or couldn't prove that someone was at fault.

You will recall, all the way through the speech that I have been giving you tonight I have been talking about part of the package from our point of view, from the Federal Government's point of view, from the State Government's point of view, always is how to look after these people. So there was always an inherent injustice in the system that provided windfalls for some but left

the majority struggling. We did not want anyone left to struggle. The solution that the medical profession foresaw at the time, in the early part of this century, was a government funded scheme for the care of catastrophically injured or severely disabled people, regardless of whether there was fault in the causation of the disability.

In recent times, we have seen the emergence of these acronyms NDIS and NIIS and they stand for the proposed National Disability Insurance Scheme and the National Injury Insurance Scheme to describe the current Federal Government's proposal for providing this support. These schemes were proposed by the Productivity Commission report on disability care and support.

The National Disability Insurance Scheme, the NDIS, would cover people who have a disability, that it was likely to be permanent and they would have to meet one of the following conditions; of significantly reduced functioning in self-care, communication, mobility or self-management and require ongoing support; or be in an early intervention group comprising individuals for whom there is good evidence that the intervention is safe, significantly improves outcomes, and is cost effective. The NDIS would provide information and referral services and individually tailored support for services other than services that are already available to the wider population, such as health, public housing, transport, education and open employment services.

The National Injury Insurance Scheme would provide for people with catastrophic injuries from motor vehicle, medical, criminal and general accidents under a no fault

arrangement. The NIIS would cover all medical treatment, rehabilitation, home and vehicle modifications and care costs. An expert panel with the NIIS would decide questions of eligibility for people catastrophically injured following medical treatment, using evidence-based and external experts. Any person with non-eligible catastrophic injury would move to the NDIS.

The current AMA President Steve Hambleton described the NDIS as "The transformational reform for the benefit of the most vulnerable people in our community." For me, what remains to be seen is whether the Federal and State Governments are prepared to apply sufficient funding to provide the level of care and support these vulnerable people need. We are already arguing about it. They argued between the State and Federal. They have put some money into a trial now. If you look at how this was reported, the Premiers made it clear in July they saw the battle over the funding formula for the NDIS as a battle for their fiscal survival, they would not accept the Prime Minister's suggestion they pay 60 per cent of the cost of the launch sites.

The Premiers and State Treasurers said they fear such a precedent would spell financial ruin once the full NDIS was rolled out. They were happy for the medical profession to fund it but they are not happy for them to fund it at a cost of up to $15b each year, or about double what the States currently spend in support of disabled people. They said they were worried that the full NDIS, if not properly designed, could compromise their credit ratings and push up the cost of borrowing for vital infrastructure.

So when I talk about unfinished business, you can see it is really unfinished. Anything to do with a Commonwealth/State agreement, or I prefer to call it the Commonwealth/State disagreement because I have yet to see them agree on anything, is always going to be unfinished business. So if the NDIS/NIIS is the unfinished business from the past decade of tort law reform, what of the future health care landscape from the medico legal perspective?

Now, at this point I switch hats from AMA past president to current AIMA, or Australasian Integrative Medicine Association, President. I just want to go through a little bit about how I see the changing health care landscape in the future.

We have recently in the last year or two seen the development of the Australian Health Practitioner Regulation Agency. This is a new national body that is responsible for national registration of health care practitioners and they support 14 national boards in the development of registration standard codes and guidelines and they work with the Health Care Complaints Commissions in the states and territories. It is still finding its feet.

I think most of us have had a few issues with AHPRA. They are still deciding who they will and won't register. July this year, following the successful Victorian model, traditional Chinese medicine practitioners became registered nationally for the first time under this system. The naturopaths are still struggling to get recognition. Chiropractors and osteopaths are under this umbrella.

Some of the complementary medicine practitioners, also called complementary or allied health practitioners, fall under the AHPRA banner but some do not. So we have a landscape where we have some registered medical and health care practitioners and some unregistered health care practitioners. This in itself makes things difficult on a medico-legal level.

Complementary and alternative medicine is a broad domain. I do not like that terminology and I think the moving out of that terminology into something that is going to look more like IMCM or Integrative Medicine Complementary Medicine to better describe the integration of different types of treatments that are working together for the benefit of the patients, and based on patients' preferences and choices. So I think integrative medicine is a far more accurate description because it better describes the conduct of the vast majority of health consumers in combining different modalities of treatment.

One of the definitions comes from the US, "Integrative medicine is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence and makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing."

I should mention at this point that with every great movement forward, it is fairly Newtonian, isn't it, there is an equal and opposite reaction. So what we have seen is this conservative so-called backlash from a group that self-styles itself as the Friends of Science in Medicine, and many of my friends who work in the science of medicine

say with friends like these, who needs enemies.

There are a lot of big names in this and they have very few members who've been seen at integrative medicine conferences, so a lot of the comments that they make are based on a gut feeling that they do not like it, or because it does not sound like it will work. They have quite inconsistent and destructive agendas and at one stage they were seeking to have all complementary medicine education removed from universities, including traditional Chinese medicine, which as I said has just been registered as a specialty medical area under AHPRA.

So if you look at the direction that the Australian health care culture is taking, with our multi cultural nation, with people who come from an ethnic and cultural background where the norm is traditional Chinese medicine, or ayurvedic medicine, or where the norm for that person is western herbal medicine, for example somebody who grew up in Germany would know that if they go to their doctor they are more likely to be prescribed a herbal preparation than a pharmaceutical preparation because that is the culture within countries like Germany where doctors are trained in western herbal medicine as part of their course. In America increasingly there is a movement towards integration of different types of modalities.

So when you see this name Friends of Science in Medicine, they are not very friendly and they are not very scientific. We don't see them around integrative medicine very much. So just be a little bit wary of the things that they are saying.

I want to alert you to the good guys, the Consortium of Academic Health Centres for Integrative Medicine. This

is an amazing group in the United States. I went over representing AIMA and Vicki Kotsirilos is here who is actually the founding President of AIMA who set the whole thing up 20 years ago, so very visionary. The Consortium of Academic Health Centres for Integrative Medicine, it is based in North America and Canada and I will just run you through some of the universities who are now adopting a model of integrative medicine for their medical schools.

Austin University, Harvard Medical School, Tufts Mayo Clinic, Columbia Duke, Cleveland Clinic, Oregon Health and Science University, University of Washington, Georgetown Johns Hopkins, University of Maryland, University of Hawaii, Yale, University of California, Stanford, Master and so on.

Jump on to their websites, you will see the medical schools who are now embracing integrative medicine as the model of health care for the future. AIMA is now moving forward, and we will be announcing this at our conference in Melbourne next week, the development of an Australasian consortium modelled on the North American group and we already have a significant number of universities and health care schools in Australia who have signed up to this consortium. We will be providing support and a fantastic collegiate environment for the advancement of education in this area.

Because it is a new landscape, it is going to bring with it a whole lot of new challenges. Some of the things that I think we need to be alert to, both in the medical and the medico-legal area, are that doctors and other practitioners need to continue to ensure accurate and timely diagnosis. I think one of the big pitfalls is

going to be where some of these newly registered health care practitioners perhaps might delay diagnosis by not engaging in appropriate investigation. So working together with doctors, I think, and having the doctor as the central part of the integrated medicine model I think is essential because we are trained in diagnosis.

Doctors need to become familiar with the potential benefits of integrative practice. Even the doctors who are a bit resistant to it, once they start getting experienced enough and hitting enough roadblocks they start looking for what else might work for their patients and quite often it is a personal epiphany for a doctor who themselves or someone in their family become sick. You have no idea, and Vicki will tell you about this, too, the number of senior doctors and surgeons who quietly send me their members of their family because they do not know what else to do with them and then suddenly they realise that there is this whole other world of health care that they can offer, that people can actually get better, that your 18 year old doesn't have to suffer with chronic fatigue syndrome from glandular fever for five years, that you can actually do something to help them here and now.

So becoming familiar with integrative medicine and doctors and other practitioners have to be alert to minimising the risk of complications through the combination of pharmaceuticals and non-pharmaceutical interventions. I think doctors need to be aware where non-pharmaceutical interventions, which are less risky, are going to be more effective for their patients, or as effective perhaps, over a longer time frame. Doctors and other health care practitioners have to be alert to the

risk of combining different types of products. All health care practitioners have to enquire about what people are taking, no matter what it is coming from or where they are buying it. I think labelling is going to be very, very important there.

I would just like to run you past this bubble graph because it fascinates me. The great big bubble, the big red bubble there, this is about the individual risk of death in Europe, the great big red bubble is preventable medical injuries in hospitals. Cancer is the big green bubble. Smoking or being grossly overweight is the purple bubble. Alcohol related is that purplish bubble. Can you see the herbal remedies and food supplements bubble? I will have to show it to you. It is not even big enough to fill in the bubble.

So I think when we are talking about risk and relative risk, just keep that bubble graph in mind and think to yourself, "Maybe there's safer ways of handling, particularly chronic, disease," and we have seen so many disasters and near disasters with pharmaceuticals in the last particularly five or six years with Celebrex and Vioxx and HRT with the breast cancer risk and join a process with the osteoporosis medications and osteoporosis with antidepressant medications and so on and so on. I think we really do have to start thinking very differently and way beyond standard medical treatments at the moment.

Now, part of this whole business about doctors becoming familiar with the potential benefits of integrative practice is going to be determined by having good resources, educational resources. So I spent about

four or five year writing this textbook on the left "General Practice: The Integrative Approach", with Craig Hassed from Monash here, so that we could say to our GPs, "You want to learn more? You want to learn and work in a somewhat different way, adding to the way you practice medicine now? Here's the textbook that will help you get there." Over on the right, Vicki Kotsirilos, Luis Vitetta and Avni Sali, their textbook, "Integrative and Complementary Medicine", and in the middle also two Melbourne writers "Herbs and Natural Supplements" by Lesley Braun and Marc Cohen.

So those three volumes I keep on every desk, home and in my clinics, to make sure that we have resource materials available to all of our practitioners because I think it is so very important that we do have those resources and then when somebody says, "Well, where is the evidence," you just have to point.

What about the future? We are in the post tort law reform environment and Elizabeth Brophy is here as well. Elizabeth wrote a chapter in my textbook, the orange and blue one, about the medico legal aspects and I commend that chapter to you, it will be coming out in electronic format soon, which is very elegant, far more elegant in legal terms than I could possibly hope to bring to you of the medico-legal aspects of integrative practice.

So we are in a post tort law reform environment, so the future is going to be about setting minimum standards of education and practice, encouraging excellence, and attention to risk management and safety. I would like to think that we were going to see a health care and a medico-legal landscape based on quality care and not so

much of an adversarial system. There is always going to be the need, because I do a lot of second opinion work I see the need, for patients to have recourse to legal action where appropriate but it really needs to be a last resort and not a first resort. I think we can move very confidently in the future but I do think that we need to, at this point, develop a very careful framework for the medico-legal environment of the future when it comes to this future landscape of integrative medicine. Thank you.

PRESIDENT: Professor Phelps has indicated that she would take some questions if any members of the audience have them. We have got a microphone and if you can wait for the microphone and then speak your name and ask your question.

PROFESSOR PHELPS: I am happy to answer questions on any subject, by the way, so do not be shy.

MALE SPEAKER: Thank you for an interesting presentation. I need to declare that one of my hats is working as a medical adviser to a medical defence organisation and certainly tort reform has, as you rightly point out, reduced litigation and it is stable. But unfortunately, complaints to health complaints organisations, including AHPRA, are going up. So that may explain to some doctors why their premiums have not completely gone down.

I would also like to support your comment about diagnosis. Many of the complaints that I try to help doctors with are situations where prescribing has occurred but when you ask the doctor what was he or she actually treating, they are not so sure, particularly on the issue of chronic pain. They often have no idea what they are treating, or thought they knew what they were treating.

So one of the issues to me is that sort of fourth

item on your new landscape, which relates to the interaction - that's right - between pharmaceuticals and complementary medicine. The question I would like to ask you, how do we actually ensure that we reduce these particular risks because sometimes patients are not really quite sure what they are actually getting, particularly if they are directed to a specific place to get certain medications. Often I find in asking the history, you have to ask it three or four times to find out because they do not want to tell a regular doctor that they might be taking things other than pharmaceuticals. Thank you.

PROFESSOR PHELPS: Thank you. You make a really good point and that is actually almost the subject of an entire lecture on its own but I will try and deal with it in this way.

I teach medical students. I teach them one on one in my clinic and I teach at the university in a bigger group in the Harvard method. One of the things that I encourage students to do is to demonstrate an open-minded language when they are dealing with patients because there are a number of barriers to patients disclosing the sorts of things that they are doing or taking.

One of them is this feeling that they are going to be harshly judged or criticised, or made fun of because they have engaged in - and sometimes it is hard because, I mean, for example, a patient will come along to me and say, "Look, my acupuncturist said to come and see you because I am a bit low in my kidney chi," and if I did not know that that was a particular language, you wouldn't know what the patient was talking about and it is easy to be derisive of something you do not particularly

understand.

So I think doctors are going to have to become more familiar with the language of different treatment modalities and I think also practitioners of different varieties are going to have to find a common language with each other. I suspect that western conventional medicine will be the language of default, which I believe that every health care practitioner should at least learn so that we can at least speak the same language.

But understanding that different modalities of treatment, like the law and like any profession, will have their own jargon. So I think familiarisation with the jargon is something that needs to be taught from medical school onwards. Once you have the jargon, you can then have a sensible conversation with patients about the sort of treatments they are undertaking.

The other thing that doctors are going to need to do is to familiarise themselves with the various ingredients of different, for example, herbal and nutritional supplements because a lot of patients out there - if you just look at the statistics on cancer patients, for example, up to 90 per cent of cancer patients are taking something in the nutritional or herbal area while they are undertaking their cancer treatment, or in between.

So we have to know what people are doing because it is very material to particularly interactions. It is also material to best quality of treatment because - you know, I had one young cancer patient who was in her 30s and she had breast cancer and she said that she went along to her oncologist, she was also seeing an integrative doctor, and she said that she went along to the oncologist and the

oncologist said, "I cannot believe how well you are tolerating the chemotherapy." But the oncologist never asked the next question, and the next question was "What are you doing that is different to all of the other patients who are not tolerating it so well?" She said, "I have told her." Sometimes the question is not being asked, "What else are you doing?"

As you say, quite often I will do a medical history and I'll say to people, "Tell me about your medications," and they'll tell me their blood pressure pills or their antacid medication or their heart pills and then you might say, "Are you on the contraceptive pill?" "Yes. Is that a medication?" "Yes, it is," and so we add that in. Then you will say, "Well, are you taking anything else, herb supplements, anything at all?" "No, no, no. Not unless you count fish oil." "Yeah, I count fish oil," so we put that in. And on it goes, you know, "Do you take anything else?" "Well, only at night. I take this thing, what is it? That thing that starts with a V?" "Valerian?" "Yeah, that one." "Yeah. Okay, we will put that in, too."

So when you get down to it, sometimes you get a pretty long list and some of them interact and some of them don't. Some of them interact beneficially and some of them interact in a bad way. So a lot of what we do is rationalise what people are taking but if you do not know these other 15 things that people are taking, you've got no idea what is going to be interacting with what.

I think education and communication are two really important things and non-judgmental questioning by the doctor. But if then the doctor has all this information

and they do not know what to do with it, then that is a bit of a challenge as well.

So I think we're at an important sort of time of flux - I know it is a long answer but it is a long question. I think we are at a time of flux where doctors are recognising and surveys tell us that doctors are recognising the need for them to have this knowledge and they want the knowledge. They do not necessarily know where to get it. Vicki has been chairing a current working party between the College of General Practitioners and AIMA to try and develop a post-graduate qualification so doctors can actually do that in modules in an unscary way through their own college. I would like to see that go through every single college. I think ultimately there is going to be a medico-legal requirement on doctors to have that knowledge and we have to start it in medical school.

MS SIMONIS: I am Magdalena Simonis. I am a general practitioner and I think that one of the concerns in general practice for doctors who do not administer integrative medicine or alternative medication, because it is medication, herbal remedies are medication, is that we as general practitioners very often see the mismanagement of cases and therefore we feel prejudiced in ways against various types of treatment.

For instance, examples that I can recall that are very recent in my own practice is the 62 year old woman who is taking non-medical hormone therapy who is menstruating again, and the patient who presents with pyelonephritis has been taking supplementary therapy for urinary tract symptoms and they often present to the

general practitioner with a really advanced state of their problem, of disease and that is one of the prejudicial aspects of, you know, this sort of complementary medicine which does not seem to complement medicine, it sometimes interferes with appropriate treatment that practitioners who maybe do not have a clinical background as well as we do and do not advise patients adequately.

PROFESSOR PHELPS: You make an important point and I think a lot of this comes down to perspective because where I sit, and most integrative doctors sit in this position too, is that we see patients who have been not well treated by various so-called healers or alternative practitioners or whatever who are not adequately trained and who are perhaps stepping outside of their brief.

But I also see people who have been messed around medically. You know, I had a young girl recently who came to see me who had a shocking adverse reaction to a very common medication and she had had MRIs and she had had CT scans and she has seen professors of neurology and nobody could work out what was going on with her. I took her off the medication that they had doubled and the problem went away.

So you know, I think what we have to do is to see this as a level playing field and to see that we need minimum standards of competence no matter what your modality of treatment is, whether that is medical - and I am saying GPs need to upskill in areas because patients are wanting - they are not wanting to abandon their medical treatment. All of the evidence tells us the patients are wanting to appropriately and carefully and responsibly intermingle or integrate the treatments that

they're undertaking for their benefit. They want to minimise side effects. They want to maximise wellbeing.

I am writing a book at the moment which is coming out in February and I was thinking back to my grandmother's day. My grandmother is what you might have called a traditional healer, mainly because she had no access to education, she had no access to money and there was no such thing as a pharmaceutical when she was growing up. So all they had were their poultices and their potions and their natural therapies and they did the best they could. Of course, when pharmaceuticals came in, penicillin between the wars, it was an absolute revolution and suddenly, between then and the 1970s, there was this sort of 60 year massive rush in the development of pharmaceuticals. It was like, "You name a condition, we will give you a pill." It almost gave the Baby Boomer generation the excuse that you can do whatever you like to yourself, we will find a pill or give you an operation to fix it by the time you're 60 or 70.

But it does not work that way because what we are now realising is that all of this other stuff that you need to do, like exercise and not smoke, this is all part of integrative medicine as well. It is not just about ingestibles. It is about activities. The way you live your life, the way you think, the way you move, exercise. It is not just about therapies done to you. It is about the responsibility you take for your own health.

So the more we can look at the detail around things like exercise prescription - you know, your patient who is taking the HRT, awareness that the bio medical, you know, bio identical hormones are hormones made by a

pharmaceutical company. You can put whatever sort of spin on it you like but the risks are the same as taking one that is made by a pharmaceutical company. So that that is an area that is highly problematic in view of that light.

But I think that, again, education and communication does not just apply to doctors. It also applies to people who want to call themselves a naturopath. They need to have minimum standards and they need to have minimum education and ongoing education.

I think it is also very, very helpful if we can have joint meetings. I have two practices. I have one practice which is all doctors, 15 doctors and a dietician, I think that is an essential part of health care, and I have another practice where we do have very highly qualified psychologists, naturopaths, an acupuncturist who does traditional Chinese medicine herbs. We have doctors who all work in an integrative model but are not necessarily highly educated in herbal medicine or whatever but they are happy to speak the language and work with the other practitioners. This is one model.

Another model is having a virtual team where you pick a good natural therapies practitioner so that you can communicate with them. You ring them up and you talk to them and say, "Look, I have got this patient who is going through cancer treatment. Do you have a protocol and is it something the oncologist would be okay with?" These are the sorts of things, you know. Do you have an exercise physiologist you refer to? Do you have a dietician you refer to? It is a matter of expanding your team with what you are comfortable with. But also for your own purposes developing a language so that you can

converse with the patients and with the other therapists about what the patient is going through.

So I think we need to look at a more level playing field, if you like, in terms of risks and benefits and recognise that medicine, if you go back to my bubble graph, hurts a lot more people than natural therapies practitioners do. As much as we do not like to admit it, there is your bubbles.

MALE SPEAKER: Mr President, it was fascinating to hear the story behind the medical indemnity crisis. I was not aware of that and I think as an opthamologist with the rapidly escalating premiums at that time I am very grateful to Kerryn and to other people involved in producing the litigation and the cost of premiums coming down to a reasonable level. I think particularly obstetricians and gynaecologists, and there are a couple here tonight, and the neurologists will be very grateful to you of the work done there.

On the complementary alternative medicine side, I have always had quite a strong interest in this field and I feel that as a background in science and medicine, I have got quite a good position to be able to judge what is good and what is bad about complementary medicine. I think I do anyway. But my feeling is that a lot of the general public, they do not feel they are in that position.

I believe that the organisations which promote complementary and alternative medicine should be in a position to say, "This is good. This is bad." I think they are very good at saying what is good and I think as kerryn told us tonight of some of the good things.

Mind/body medicine and I think some forms of massage and maybe acupuncture but I think there are also other very questionable therapies and if you look at the national medical website, they list over 100 different forms of complementary or - medicine and varieties of it and obviously not - some - a lot of them are very good and some of them are bad.

I think we need to in some way sort out which are good and which are bad. In particular, I find problems with things like homeopathy, iridology, reiki massage, ear candling. I feel that these, it is very hard to find any evidence whatsoever to back up these therapies. With regard to homeopathy, I think it is - the AMA has brought out some - the Australian Medical Association has said that evidence is clear that homeopathy is not an effective treatment, that was in April 2010. This is supported by the United Kingdom National Health Service and by the American Medical Association and also by the Federation of American Societies for Experimental Biology, and there is 26 members of that. And yet we find that it is still on various websites with people practising this sort of form of treatment.

Another thing which I have less problem with is chiropractic. They are against attitude to vaccination is a problem. We all know that polio, smallpox, are effectively eradicated from the world by vaccination and that it is very effective in the treatment of other diseases, measles, mumps, rubella, whooping cough, diphtheria. And yet the Chiropractic Association won't take a stand on it. They won't - a lot of chiropractors are very against it, even the Chiropractic Association

will not say that it should be done. They say it is risky.

So I feel that organisations which are promoting alternative or complementary and alternative health should be making it very obvious to the public that there are dangers in certain forms and they should avoid them. I am very happy for them to promote those conditions which are effective.

So that is my thoughts on the matter and I think at this stage I would just like to thank Professor Phelps for her particularly interesting and thought-provoking talk. Please join me in thanking Kerryn. Thank you.

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