Professional Indemnity

by

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The Chairman of the meeting was Mr. R. H. Searby QC.

'There's no such thing as a free million'

Five years ago Australians were authoritatively informed, from the highest level of government, that 'there was no such thing as a free lunch'. It is a truism which nevertheless bears repeating in the context of professional indemnity where some of the parties concerned seem to believe that a 'free million or two' is always available. Several factors have contributed to this attitude and to the rapidly escalating costs of obtaining coverage for medical indemnity which have occurred in Australia in recent years. Only a few of these factors can be considered in the time available, and I propose to examine some of them, under four headings:

1. Patients, the community and the media.
2. The medical profession.
3. Medical protection societies, (in essence not insurance companies but voluntary co-operatives), and finally
4. Some medico-legal aspects and general consequences.

There is little doubt that the community is better informed about medical and medico-legal matters today than in the past, and certainly less reluctant to seek a legal remedy for both mishap and malpractice. Clearly there is a fundamental right to compensation when the standards of skill and treatment fail to reach appropriate (if difficult to define), standards. However reluctantly, the medical profession subscribes to that right, and at the same time takes steps to educate, advise, even exhort, its members to take their responsibilities very seriously, to avoid 'over selling' a drug, an operation or themselves, to explain that any medication has undesirable side effects, and every anaesthetic and operation, even the simplest, has its complications.

The media must be allotted some blame for patients' attitudes and misperceptions. The press, television and radio tend to report all advances in medical treatment as 'breakthroughs', 'wonder' drugs and 'medical miracles', often in emotive even hysterical, and certainly unrealistic and unqualified terms, and frequently enough to persuade the community that there is a miracle cure for practically every illness, and, of course, without any prospect of complications. Most medical spokesmen are careful not to make exaggerated claims, but for reporters, there is nothing newsworthy in soundly based procedures or solid, reliable performance. It is only natural that a public nourished on a diet of remarkable

discoveries should develop unrealistic expectations concerning the outcome of treatment, the nature, even the very existance, of a surgical incision and a subsequent scar. The spectrum of popular beliefs is very wide; and once or twice a year I still find parents who accept the need for surgery for their child, on condition that there will be no scar at all. In Victoria a successful claim has been made against a surgeon who, against all sound surgical principles, acceded to a parent's persistent demands that excision of her child's skin lesion be performed in one stage instead of two or three. With the added tension, the entire area broke down and was eventually grafted, by another plastic surgeon, whose considerable skills nevertheless left a much more obvious scar than would have been produced by serial excision.

Some 'Jehovah's Witnessess' demand a signed undertaking that regardless of medical eventualities, no blood will be transfused into their infant. The religious beliefs of adults regarding their own treatment, or the witholding of it, should of course be respected, but not when those decisions jeopardise the life of another, and a minor. There are, fortunately, effective legal means of dealing with that situation.

The medical profession and the doctor-patient relationship lies at the core of both incitement and prevention of actions for negligence or malpractice. In recent years history of medical practice reviewed in LONDON'S 'Sunday Times' a few weeks ago, the author divided the history of medical practice into three eras: the first from the earliest times until about 1840, the second from 1840 to about 1940, and third: thereafter.

In the first period there was no knowledge of the causes of disease (excluding trauma), and no effective means of treatment. Diagnosis rested for centuries on uromacy and urinoscopy: graduated lines engraved on a matula which represented a kind of clouded crystal ball, in which the diagnosis was read, until well into the seventeenth century.

Matthew Baillie, John and William Hunter's nephew, and last of the six bearers of the 'Gold-Headed Cane', was among the first to relate the symptoms, signs and the putative diagnosis of his patients, to post mortem findings. From 1840 onwards spectactular strides in pathology were made, so that by the end of the century, the nature and the processes of almost all the common illnesses were established, although the actual cause of many of

them was as yet unknown. As Voltaire wrote at the end of the eighteenth century, medical practice was chiefly a matter of 'amusing the patient while nature cures the illness'.

The problem was that apart from digitalis, there were no effective remedies for any of them. True, general measures, such as a sanitarium regime, improved the mortality in tuberculosis (when the patient's family could afford them), even before the tubercle bacillus was isolated and identified as the cause. As late as 1883, Oliver Wendell Holmes wrote that 'if all the materia medica as now used could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes'. For the most part, there were no 'medical specifics' (with the exceptions of digitalis, quinine, and insulin in the 1920s), until the appearance of the sulphonamides late in the 1930s, penicillin in the 1940s and streptomycin in this city in 1945. From the 1940s onwards a remarkable array of ever more potent and effective medical specifics have been developed, albeit each with its own potentially serious, even lethal, side effects.

This brief and oversimplified history of medicine is only presented to sketch the background of medical practice in the three eras defined. In the first, up to 1840, doctors had no idea as to what was going on in their patients, and in any case had almost no effective remedies at hand, in spite of the vast compilations of herbal remedies, dating from Dioscorides in the first millenium AD, and reaching their apogee in the encyclopedic herbals written by Gerard and Parkinson in Elizabeth's reign. They were entirely useless: a sound basis for botany perhaps, not therapeutics, and 'compounded' so that supposed efficacy was measured in terms of nauseating unpalatability. The physician, however, was emerging as a scholarly, august figure, still available only to a few, while the apothecary filled the role of a general practitioner or perhaps more accurately in todays, terms the traditional, kindly and helpful local pharmacist, whose advice and supposed remedies in the sixteenth century were at least affordable.

In the second era, 1840 to 1940, the medical graduate was much better informed about what was going on inside his patients but still very limited in what he could do about it. It was nevertheless the era in which the good listener, the compassionate, and the observant student of human nature, created the image of the wise and caring doctor and took it to its pinnacle. He prescribed

landanum in drops, diets in details, and warm dry climates or spas for the affluent. Above all he was seen to be concerned with his patient's illness. He sat through the crises of pneumonia or typhoid, and was, like Sir Frederick Treves, 'a tower of strength in the time of need', the accolade from the royal family which he commemorated as a 'tower triple-turreted' in his coat of arms.

At another level of society, he was the country practitioner in the much reproduced painting, seated, fatigued but seemingly tireless, beside a sick child's bed at home, in Sir Luke Fields' 'The Doctor' or 'The Crisis'.

It is alleged that since the 1940s the medical profession, now both knowledgeable and well equipped with highly effective medications, as well as high cost, high-technology methods of investigations — has lost sight of its patients as people, lost the skills of practical psychological management and, perhaps above all, the willingness, the time, or the ability to communicate with its patients and/or their relatives. Medicine today is much more a matter of teamwork than a solo performance, but a team must nevertheless have a clearly defined spokesman, to counteract the inherent dispersion of personal responsibility in which continuing rapport can be lost. At 'Cases Committees' of medical protection societies, a review of the basis for the claim, and the writ, usually suggests not negligence, not lack of skill, not necessarily lack of concern, but that someone did not say the right words to the right person, in the right way, at the right time. Complexity of medical science cannot be pleaded as an excuse, for the communication required can and should be conveyed in comprehendable terms, and simple analogies.

Judging by the slow but steady increase in the number of writs, the medical profession in the third era has lost the aura and respect it apparently earned or was accorded in the second era. In some respects that is no bad thing; doctors always were and are human and therefore fallible. I cannot forget a few of the archetypal, quasi-deities, who were my teachers — pompous, pretentious, overbearing and dictatorial to their patients, possessing overwhelming prestige which brooked no questioning, let alone criticism. Were those the attributes that protected them from allegations of negligence? Has a more human face bred more egalitarian perceptions of a profession which, being no more than human, must now be made to pay for real or fancied mistakes?

The reality is that trust has to be won afresh, by competence and credibility, from every new patient and or his or her family, whatever the times, but it cannot be denied that deputising locum services and large impersonal group practices have diluted and idealised close and continuing doctor-patient relationship.

Malpractice litigation in the modern sense seems to have begun, in the English speaking world, in England in the 1850s. In response to actions against medical practitioners in England in the 1880s, co-operative protection societies or associations were formed, surprisingly to defend doctors' reputations from quacks, and only secondarily and later from allegations of negligence or malpractice. Even more surprisingly the first such organisation was founded not by members of the medical profession itself but by two solicitors and 'five gentlemen', and registered as a company: the Medical Defence Union Ltd, in 1885. It was hampered by lack of funds and few members, and at first operated in the narrow field of prosecuting unqualified practitioners.

At a meeting of local doctors in Birmingham in May 1856, the renowned surgeon and ovariotomist Lawson Tait was elected to the chair, and in February 1887 he became the first President of the MDU, and its headquarters were transferred to Birmingham. Tait was a forceful and powerful personality who created as many enemies as friends, and was soon in trouble himself.

He was sued for libel by another surgeon in 1892 and Tait insisted that the MDU support his defence, although then and now, libel actions were and are not normally matters for medical indemnity organisations. In due course the case was settled out of court, with a payment to Tait from the plaintiff, but the MDU was left to pay its own or his costs. Many members of the MDU were disturbed by Tait's view that the Union was an insurance company, and that its funds had been used to the personal advantage of its President, and in a libel action, not a claim of negligence.

Rancour led to Tait's resignation, and the offices of the MDU were moved back to London in 1893. In the interim a group of members also objected to some of the articles of association of the MDU, and in March 1892 a rival organisation: the London and Counties Medical Protection Society, (later the Medical

Protection Society) was formed with emphasis in its articles on autonomous peripheral branches rather than the centralised office for policy and administration favoured by the MDU.

The two organisation in London remain the oldest and the largest, each with 125–135,000 members, throughout the English speaking world, except in the USA and more recently, Canada.

In the 1890s each state in Australia founded its own non-profit voluntary co-operative, and over the years all of these, with the exception of MDU of NSW, have developed 'schemes of co-operation' with the MPS. None of the State organisations is an insurance company; all have discretionary clauses, but the indemnity cover they offer is unlimited. Each, again with the exception of MDU of NSW, pays an annual contribution to MPS which then reinsures with Lloyds or other brokers in London. As a reflection of increasing scale of settlements and legal costs, the Medical Defence Association of Victoria's subscription has risen from $25.00 in 1979 to approximately $800.00 this year and almost certainly more than $1000.00 per annum from July 1987. The number of writs per year has reached a plateau and has increased only slightly in recent years, but the magnitude of the awards and settlements has increased, by 15 to 20% per annum over the last five years. Experience shows that NSW generates the highest risk per capita, and Queensland the lowest. Victoria lies midway between them, and last year costs and settlements reached $1.4 million. Our members are rightly concerned at a subscription of $1000.00 or more; last year one of them sought equivalent unlimited cover from a commercial insurer, and was quoted $20,000 per annum.

To put medical indemnity in perspective, the cost is still much less than professional indemnity for lawyers, architects or engineers. In the USA, the most 'riskful' medical specialties are neurosurgery and orthopaedic surgery, with premiums ranging between $50,000–$100,000 per annum — for those who can get it, and afford it.

It would be presumptuous of me to expound on the points of law which add complexity to medical indemnity, but may I mention only a few relevant matters which may evoke comments in discussion.

1. Legal Aid

All of us would approve of aid to litigants with a genuine case but who are not able to afford appropriate legal assistance. However, an independant legal opinion that there *is* a valid case and well substantiated, would help to eliminate flimsy cases for, when lost, costs cannot be awarded against the plaintiff. The MDAV recently spent $35,000 successfully defending one of its members, and then had to abide its own costs.

2. Contingency Fees

We are indeed fortunate that The Melvin Belli School of Advocacy, in which a 'no-win no cost' system applies, does not as yet exist in this country. Under that system, council for the plaintiff shares the awards or settlements and the American College of Surgeons has estimated that in successful suits, as little as 28c of the 'settlement dollar' reaches the plaintiff. We understand that only ethical standards maintained by the various Law Societies and Bar Councils prevent 'contingency fees' in Australia, but that the subject has recently been debated by lawyers in NSW.

Just as the community's expectations of medical 'cures' has risen, so has its expectations of the level of compensation. In one 2 year period recently, the award for a paraplegia increased from $170,000 to $750,000. Damages and compensation for a brain damaged infant now begin at $1 to $1.5 million, and it is often extremely difficult to determine whether any negligence was involved in the sometimes very complicated and potentially hazardous process of childbirth.

We now have claims and writs for 'wrongful life' following unsuccessful procedures for sterilisation, of either male or female parent. Compensation now embraces the cost of housing, feeding, clothing and education up to the age of 18 or 21.

Well recognised complications inherent in major operations, never completely preventable, are now seen, by patients at least, as *res ipse loquitur* of negligence. This raises the subject of 'informed consent', by coincidence the topic discussed this morning, in this room, at the annual meeting of Victorian members of the Australian Association of Surgeons. The term 'informed consent' has been described as 'American as apple pie' and 'as litigious as the New York Yacht Club', and sits uncomfortably in the context of

British and Australian case law. It may be possible to replace it with 'informal request', or better still 'informed choice', the patient having been informed of the nature of the illness, the remedies available, the risks of the appropriate operation, and the risks of not operating.

The concept of an individual's autonomy, self-determination and control over his or her own future and destiny, lies closer to reality than the 'licensed assault' implied in 'permitting' rather than 'requesting' that an operation be performed.

Paul Gerber has emphasised that the issue should not be what minimum the surgeon thinks the patient needs to know, but rather, the optimum information the patient feels is necessary to make an informed decision.

There are, of course, many other medical and legal problems in the field of negligence and malpractice, and even more in the consequences of the situation which has already been reached in Australia. One hears of 'defensive medicine' and its additional costs. This is not a new thing; at a relatively simple level, casualty officers have been taking, and still take, x-rays of every patient with a head injury, even when the result adds nothing to the management of the patient, and a negative result by no means excludes serious complications, but will this extend to a cat scan for every headache, multiple ultrasound studies in every pregnancy, an ever increasing list of 'routine' tests because their omission has been held somewhere at sometime, as evidence of negligence?

The American College of Surgeons estimates that such practices add millions to medical costs each year. What can be done to assure adequate compensation to patients without enormous expenses for which the community itself ultimately pays? I have little confidence in legislation proposed by the American Medical Association, and in other reports prepared in the USA. In March this year an issue of 'Time' magazine had on its cover the words, 'Sorry, America; your insurance is cancelled'. The focus of the report within, was municipal and county accident insurance. When policies were cancelled or lapsed because premiums were prohibitive, city managers and country commissioners (the equivalents of Mayors and Aldermen and Shire Councillors) resigned in droves when they were informed that they were jointly and severally liable for damages resulting from actions brought against their corporations. The author suggested that when the local

resident/juror sat listening to a plaintiff's claim for a sprained ankle allegedly caused by an irregularity in a sidewalk in the municipality, an award of hundreds of thousands of dollars became much less likely when the juror realised that such neighbourly generosity would be reflected in a corresponding, if proportional, increase in the municipal rates, and would come straight out of the juror's pocket.

Finally, I am a firm believer in human nature, by which I suppose I mean that changes occur most readily when the need for change is seen, understood, and supported at the grass roots. Large sums in compensation, and expensive processes in obtaining them, are the result of misperceptions that someone else is paying. We hear of enormous medical bills in America but little appreciation that subscription to indemnity organisations, or premiums to insurers, have to come from somewhere to 'keep the door open' — and where else but from patients?

All we have to do now is to persuade that legal fiction, the 'average reasonable' man (or woman), that there never was such a thing as 'a free million', and that he himself along with the rest of the community, ultimately pays every penny of it, one way or another, in medical fees, state taxes, insurance or out of federal revenue.