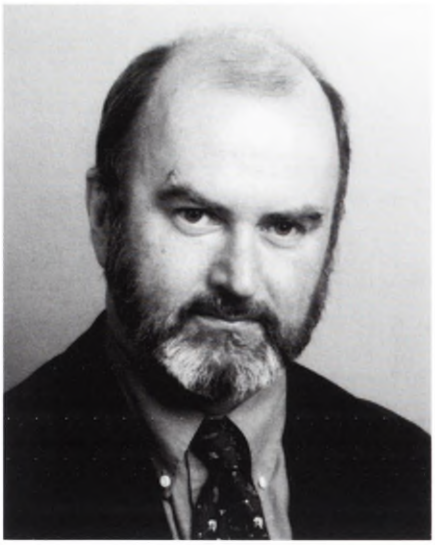

Tort reform

There appears to be increasing hysteria within the medical profession at the so-called medical negligence crisis.[1] Various groups are now actively lobbying to restrict victims' rights and to reduce damages. At a recent seminar on tort reform organised by the Australian Medical Association (NSW) Limited, in conjunction with the United Medical Protection Limited, various doctors spoke of their increasing disquiet about the medico-legal crisis. There was said to be an exponential increase in the number and cost of claims. 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 who were said to be giving money to patients damaged through misfortune rather than negligence. Professional indemnity insurance premiums were said to be unaffordable. Doctors were said to be leaving certain areas of medical practice because of the fear of liability and the increasing cost of insurance. Defensive medicine was said to be on the increase. Perhaps surprisingly, many of the speakers, including the President of the AMA (NSW) spoke strongly against compulsory professional indemnity insurance.

In New South Wales, an interdepartmental working group from the Attorney General's Department and the Department of Health is currently considering reform options.

The New South Wales Attorney General, the Honourable Jeff Shaw QC, in addressing the recent seminar on tort reform, spoke of the need for reliable empirical data and stated that there was no quick or easy solution to the apparent problem. The opposition Shadow Attorney General in NSW, Chris Hartcher, told the recent state APLA conference that the opposition would consider caps on damages in medical negligence cases.

The fact that there has been an increase in claims and an increase in the cost of resolving claims is not surprising, although the empirical data does not appear to be publicly available. There is no evidence that damages awards are excessive. According to Medical Protection Society data, the litigation rate, expressed as the number of new claims commenced per 1000 doctors per annum, is said to have doubled between 1983 and 1988, stabilising through to 1992, and then further increased across Australia by about 50% between late 1992 and 1996. (Nisselle, "Managing Risk In Medical Practice", 7 Journal of Law and Medicine 130, November 1999). The average value of a concluded claim is said to have more than doubled over that same period.

What is truly surprising is not the increase in claims but the fact that relatively few of those who suffer serious injury or death as a result of medical negligence ever seek compensation through litigation. A number of research studies, both in the United States and in 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.

In the United States, a recent National Academy of Sciences study revealed what its authors described as "stunningly high rates" of medical errors in hospitals ("To Err is Human: Building a Safer Medical System": accessible via the Internet: http://www.nap.edu/books/0309068371/html/). The study found that between 44,000 and 98,000 hospital patients die in the United States each year as a result of errors that can be attributed primarily to an inadequate health care system and inherent opportunity for blunders, rather than to individual fault on the part of doctors and other medical professionals. Daily mistakes included stocking patient care units in hospitals with full strength drugs, even though toxic unless diluted; illegally handwriting orders that may result in giving patients drugs to which they are allergic; and incorrectly operating or programming increasingly complex medical devices.

Recommendations from the United States study were intended to encourage the health care industry to take the actions necessary to improve safety. The Committee's recommendations to curb avoidable errors include (a) the creation of a federal agency to establish and monitor progress towards national medical safety goals and to act as a clearing house for objective information on patient safety; (b) the creation of a national reporting system, including both mandatory and voluntary reporting arrangements, in order to monitor

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medical errors so that practitioners and the public can learn about mistakes and take remedial steps; (c) increasing responsibility by state licensing boards in respect of professional competence and adherence to safety practices and (d) the creation of a "culture of safety" in health care settings by implementing improved systems designed to prevent, detect and minimise hazards and the likelihood of error.

Those concerned about the so-called medical negligence crisis in Australia should take heed of these recommendations and the proposed direction of reform. Proposals for restrictions on patients' rights and the reduction of damages are unacceptable and will be opposed vigorously by APLA and its members.

Interestingly, the authors of a recent article published in the Medical Journal of Australia have suggested that the "tort reform" solution to the problem is unlikely to succeed politically or in practice in Australia. As the authors note, typically the response of the medical profession and the medical defence industry to what appears to be an ever-increasing problem with malpractice litigation and the consequent rise of indemnity premiums is to call for "tort reform", that is changes in the legal system to limit the legal or financial exposure of doctors to litigation (Wilson and Fulton, MJA 2000; 172; 77-80). The observations of Wilson and Fulton echo the experience of many APLA members: medical defence organisations often attempt to vindicate the doctor rather than settle the dispute, a strategy which is expensive and often results in an escalation of the cost of resolving claims and substantially increased payouts to victims. More disturbing is the authors' observation that risk management is disorganised or absent in most hospitals. As they note, hospital managers lack incentives for risk management because the costs of litigation do not come out of their budgets. Also, there are no sanctions for non compliance with sound risk management practices. The authors express the view that the implementation of improved risk management activities in hospital is the immediate responsibility of hospital management, not doctors. The Tito report also highlighted the absence of effective risk management programs in hospitals.

APLA and its members will support initiatives for improving safety in the health care system. However, APLA will strongly defend the right of injured patients to hold hospitals and individual doctors responsible for their negligent mistakes. The frequently expressed view within the medical profession that liability is imposed on doctors and hospitals without proof of fault is a serious misconception. Sections of the medical profession also seem oblivious to the fact that in any medical negligence it is not the views of plaintiffs or their lawyers that win cases, but the considered opinions of independent experts and members of the medical profession itself which support legal findings of liability based on proof of departure from the reasonable standard of care.

There also appears to be a serious lack of understanding within the medical profession concerning the important role played by plaintiffs lawyers in screening out unmeritorious cases and in diverting litigation away from the medical profession towards drug companies in many of the situations where medical consumers suffer serious injury or death as a result of drugs, medical devices or other health care products. Although many members of the medical profession are no doubt remiss, and potentially liable, for failing to advise their patients of the possible adverse effects of a multitude of drugs and devices, including IUDs, breast implants, pacemakers, artificial heart valves, etc, much of the litigation in Australian arising out of illness and injury as the result of use of such products has been directed towards the pharmaceutical industry rather than to the medical profession.

APLA will oppose any proposed reform which would shield misconduct or restrict remedies when medical negligence results in serious personal injury or loss of life. Existing damages entitlements are already "capped" at levels which are too low, eg. for pain and suffering and are virtually nonexistent (except dependency and economic loss) in the case of wrongful death. PL

Footnote:

1 More detailed information on the medical negligence issue is to be found in the APLA position paper "Stopping Cruel Cuts: Injured Peoples Rights in Medical Malpractice" August 1999, available from APLA, or on our website at http://www.apla.com/member/library.htm