Look Before You Leap: Reform of Medical Malpractice Liability

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Introduction

In 1988 the South Australian Task Force on Patients' Rights was requested by the Australian Health Ministers' Conference to develop a model for a national or uniform state no-fault liability scheme for medical misadventure. The Task Force's Report, brought down in March 1989, accepted that "the tort system is too costly, too cumbersome, too prone to delay and too capricious in its operation to be defensible"[1] and concluded that, subject to cost analysis, a no-fault scheme had the potential for considerable benefits.[2]

In the United States and United Kingdom no-fault schemes for medical injuries have been the subject of considerable academic debate. In the United States (and to a lesser degree the United Kingdom[3]) the medical malpractice crisis has renewed interest in no-fault schemes.[4] The forces which motivated England and America to consider no-fault schemes are of less significance in Australia. According to the usual measures of medical malpractice crisis, there has been no crisis in Australia.[5] Although there have been substantial increases in the frequency and severity of claims (see below), this increase is not generally perceived as a malpractice crisis.[6] The issue was brought into

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1 Report of the Task Force on Patients' Rights, *No-fault Compensation for Medical Misadventure* (March 1989) p3.

2 Ibid.

3 Simanowitz, A, "Medical Accidents: The Problem and The Challenge" in Byrne, P, (ed) *Medicine in Contemporary Society: King's College Studies* (1986-7) p120.

4 Note the angry response by the AVMA group (Action for Victims of Medical Accident) that no-fault is being advocated by the medical profession as a means of relieving them from complaints, negligence claims and accountability and that the whole debate has given little scope for victims to put their case, Simanowitz, A "No-Fault Compensation — Short-Term Panacea or Long-Term Goal" in Mann, R D and Harvard, J, (eds) *No-Fault Compensation in Medicine* (Proceedings of a Joint Meeting of the Royal Society of Medicine and the British Medical Association, 12-13 January 1989) at 145.

5 Gerber, P and Vallentine, J R (1989) 6 April *Med J of Aust* 337. Contrast Moore, M C, "Professional Negligence" (1988) 16 *Aust & NZ J of Opthalmology* 137-142, and the fearful predictions of Dinnen, A, (1987) 147 *Med J of Aust* 368.

6 NSW Dept of Health, The Complaints Unit, *Professional Indemnity Insurance for Medical Practitioners, A Discussion Paper* (August 1988) at 8; Report of the Task Force on Patients' Rights, above n1 at 16. Increased awareness of medical malpractice, early reporting of incidents, growing confidence to discuss matters with patients are regarded as helpful in reducing malpractice claims, (ibid). The insurers for the public health system in South Australia report that there has been no basic change in the last decade in the range of claims, except for some new claims arising out of new technology, such as endoscopy and

public debate in Australia by the 1983 Sax Report which in the course of reviewing patient's rights, recommended consideration of no-fault compensation to overcome the inadequacies, unfairness and negative features of common law claims for negligence.[7]

It is the purpose of this article to examine first the extent of iatrogenic[8] injuries and secondly whether a case can be made for the introduction of a broadly based no-fault scheme for medical misadventure. The first step in the process is to determine the extent of injuries resulting from the provision of medical services. There is no known empirical evidence showing the rate of iatrogenic injury caused by Australian medical service providers. One starting point is to look at the number of malpractice claims made against medical providers although it should be noted at the outset that the claim rate is likely to be only a small percentage of adverse injuries sustained and that substantial numbers of claims made will not result in payment of any compensation.

Part A
Iatrogenic Injuries

In this part there are three central areas examined. First, the statistical information relating to medical malpractice claims against medical practitioners, hospitals and other medical providers. The second issue examined is how far these statistics are indicative of the actual extent of negligently caused patient injury and whether there are significant legal, financial, social and psychological barriers inhibiting claims for negligently caused harm. Thirdly, this part examines the available evidence on the number of medically caused patient injuries both negligent and non-negligent. It is this information which is critical to any assessment of the viability of a no-fault scheme which would seek to compensate all patient injuries whether caused by negligence or not.

1. *Malpractice Claims*

(a) Statistical information

Statistical evidence relating to medical malpractice claims distinguishes between the number of claims made per annum (the claim rate or claim frequency), the number of claims per annum in which the plaintiff receives some compensation (the paid claim rate) and the severity of claims (the average and/or median amount paid). Difficulties are encountered in collecting statistical evidence, determining claim frequency and the paid claim rate because of substantial time lags between the time of injury, lodgment of a claim and final settlement or withdrawal of the claim. Available evidence rarely gives sufficiently detailed information to allow an accurate assessment and is usually limited to material obtained from annual reports from Medical Defence Associations and Unions. Doctors (particularly those in private practice) usually obtain professional indemnity through member-

laser surgery, (id at 16).

7 *Report of the Enquiry into Hospital Services in South Australia* (Adel, Sept 1983, Sax, S, Chairman), the *Sax Report* p106.

8 Injury caused by the provision of medical services; it includes both negligent and non-negligent injuries.

ship of medical defence associations and unions.[9] Other medical service providers such as private hospitals, nursing homes, 24-hour clinics, day surgery centres, pathology and radiology practices can obtain insurance through insurance companies. Paramedical Associations frequently provide insurance programs for their members.[10] Public hospitals carry insurance either with private insurers[11] or through government owned insurance offices.[12] There are a variety of insurance arrangements entered into by public hospitals in the various states.[13] To obtain a comprehensive picture of malpractice rates it would be necessary to obtain detailed information from all of these sources.

(b) Claims against medical practitioners

With respect to medical practitioner members of Medical Defence Unions and Associations, the claim frequency (at least in Victoria and South Australia) is probably in the region of 3-4 claims per 100 Defence Association members. Available statistics do not indicate the paid claim rate but it is likely to be about 40-50 per cent of claims made.[14]

Such statistics as are available for New South Wales also indicate a low claim rate with no published information establishing the paid claim rate.[15]

The South Australian statistics relating to claims against medical practitioner members of the Medical Defence Association of South Australia also indicate a low malpractice claim rate.[16]

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9 Practically all malpractice liability protection for medical practitioners is provided by Medical Defence Unions and Associations. Depending upon the particular terms of the rules governing the Union or Association, like their British counterparts, the Australian associations will not be insurers as there is no obligation to indemnify members, *Medical Defence Union v Dept of Trade* [1982] 1 Ch 80; *Oswald v Bailey* (1987) 4 ANZ Insurance Cases, 60-704, 60-705, 60-807. Very little, if any, insurance is obtained by medical practitioners outside the medical defence organisations. The latter offer a wide coverage at a price insurers are unable to match. There is apparently no insurance company willing to offer unlimited defence.

10 For details of coverage provided by the AMP Society, see Haycock, D T, Operations Director, Aust Admiral Underwriting Agency Pty Ltd, "Insurance Structures and Schemes for Practitioners and Hospitals", Medical Negligence Conference, Sydney, 1989.

11 Ibid.

12 In New South Wales, from the 1 July, 1989, public hospital liability is handled by the Government Insurance Office under the Treasury Managed Fund rather than through Insurance.

13 Haycock, above n10. For example in South Australia, the South Australian Health Commission's policy extends to cover medical and paramedical staff, matrons, nursing staff, student doctors and/or other medical practitioners and student medical practitioners employed by and honoraries engaged in the insured institution, id at 9. In South Australia, Northern Territory and New South Wales, an employer held vicariously liable cannot recover an indemnity from an employee, *Employees (Indemnification of Employers) Act* 1982 (NSW); *Wrongs Act* 1936-1975 (SA), s27C; *Law Reform (Miscellaneous Provisions) Act* 1956 (NT), s22a. Note also that where insurance cover extends to a third person not a party to the contract of insurance both at common law and by statute, that third party is entitled to an indemnity under the contract of insurance, *Trident General Insurance Co Ltd v McNiece Bros* (1988) 165 CLR 107; *Insurance Contracts Act* 1984 (Cth), s48.

14 Victorian statistics can be found in Medical Defence Association of Victoria, *Annual Report*, 1987, 1988 at 6, 11 respectively. The association reported that as at June 30, 1988, there were 8,239 members which represents 80% of medical practitioners in that state *Annual Report* 1988, at 11, Defence Update, March 1989, at 2.

15 NSW Medical Defence Union, *Annual Report* (1988) at 5; *Annual Report* (1989) p7.

16 Report of the Task Force on Patient's Rights, above n1 at 14.

The statistics relating to approximately 2500 members of the Medical Defence Association of South Australia which are said to comprise 90 per cent of active general practitioners in South Australia are as follows:

Year	Number of Claims	Claims Settled
1980	16	4
1981	18	10
1982	29	11
1983	33	9
1984	28	12
1985	40	17
1986	41	30
1987	91	29

(c) Claims against hospitals and other providers

Regrettably, there is no real information relating to claims made against public and private hospitals and other medical service providers. Such evidence as there is suggests substantial increases in claims made in the 1985-1988 period. In South Australia claims against South Australian public hospitals rose from 49 claims for 1980/81 to an estimated 229 for 1987/88.[17] Claims against New South Wales public hospitals are reported to have had moderate increases over the past four years (1985-1989).[18] There is some evidence from the Medical Defence Unions, the Victorian Health Department and the private insurance industry regarding the number of claims that result in payment of compensation and the distribution of those claims in Victoria.[19] It is estimated that in 1986 in Victoria there were approximately 100,000[20] incident reports relating to health-care. Up to November 1989 just over 300 incident reports involved successful claims for medical negligence in 1986.[21] The insurance industry explains this large number of reports not resulting in a claim to involve administrative problems, or other matters which do not greatly disadvantage the patient and do not involve a claim for compensation.[22] The English and United States studies referred to below must suggest a variety of reasons other than these for this failure to claim. On the available Victorian statistics for 1986 hospitals have the largest number of claims against them:[23]

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17 Report on the Task Force on Patient's Rights, above n1 at 13, set out the following statistics relating to claims against South Australian public hospitals: 1980/81, 49 claims; 1981/82, 20; 1982/83, 35; 1984/85, 96; 1985/86, 164; 1986/87, 227; 1987/88, 229 (estimated).

18 Personal Communication, Greer, R, GIO NSW 6 September 1989.

19 The figures following are taken from the Insurance Council of Australia, *Response on Behalf of the Australian Insurance Industry to the Task Force on Patients Rights Report on No-Fault Compensation for Medical Misadventure* (November 1989) at 5.

20 This is the correct figure. Any event causing physical distress to a patient is reported, for example, loss of a patient's dentures.

21 This figure is after correcting for non-members of the Medical Defence Union. The expected figure when all claims are in is likely to be about 900; later claims tend to be smaller in the $10,000 category, Personal Communication, McIvor, A, FAI Insurance, 13 November 1990.

22 Id at 5.

23 In the United States just over 80% of claims closed by insurance companies in 1984 concerned injuries sustained in hospitals, with approximately 13% of injuries occurring in

Table 1

Distribution of Medical Negligence Claims, Victoria, 1986

	Hospital	Doctors	Others*
% of Total Paid Claims	75.5%	23.4%	0.009%
Anticipated final average cost $ per claim	$13,200	$49,280	$31,800

*Other chiropractics, naturopaths, pharmacists, etc.

There is no statistical information regarding injury rates per procedure or in relation to the number of hospital admissions.

These figures may be contrasted with the position in the United States. For the year 1984 the insurance industry estimates based on random sampling were that approximately 73,500 malpractice claims were finalized against 103,300 health providers. Eighty per cent of these claims related to injuries sustained in hospitals with about 13 per cent occurring in doctors' offices. Forty-three per cent of the closed claims led to the payment of compensation. The median payment was $18,000. The average payment was skewed by a small proportion of high compensation payments. In 1984, 9 per cent of paid claims receiving compensation over the quarter of a million mark raised the average payment per claim to $80,741. The largest recorded payment by insurers in 1984 was $2.5 million.[24] The largest United States malpractice liability insurer reported a claim rate of 17.3 claims per 100 insured physicians in 1985 dropping to 13.0 in 1988.[25] There is some evidence that the claim rate has decreased.[26]

(d) Claim failure rate

According to the 1984 US figures just cited, some 57 per cent of claims made do not result in compensation.[27] In a study by the Oxford Centre for Socio-Legal Studies on compensation and support for illness and injury, some 45 per cent of claims for compensation were abandoned mainly because of evidentiary difficulties in proving fault.[28] The statistics made available to the

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doctor's offices, US Gen Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984*, (GAO/HRD-87-55 April 1987) at 25, table 2.8.

24 Id at 2-3, 18, 25 (table 2.8).

25 The St Paul Fire and Marine Insurance Company. The statistics are cited in *Medical Malpractice* prepared at the request of the House Committee on Ways and Means, USA 19 April 1990 at 12. The frequency of claims varies with the specialty, eg, in 1985 there were reported to be approximately 26 claims per 100 specialists practising obstetrics and gynaecology, (approx 8 per 100 in 1987, 15 per 100 in 1988) in contrast to 10 claims per 100 of all physicians (approx 7 per 100 in 1987) and just over 6 claims per 100 internal medicine practitioners (approx 5 per 100 in 1987): American Medical Association cited by *Medical Malpractice*, id at 14.

26 Ibid. See also Jacobson, P D, "Medical Malpractice and the Tort System" (1989) v262 no 23 *J of the AMA* 3320 at 3321.

27 US Gen Accounting Office, above n23 at 18. See also Danzon, P, *Medical Malpractice, Theory, Evidence and Public Policy* (1985) at 24 inferring from the statistics a 60% failure rate for claims made.

28 The decision to abandon in nearly all cases was based on solicitor's advice, Harris, D, McLean, H, Genn, H, Lloyd-Bostok, S, Fenn, P, Corfield, P and Brittan, Y, *Compensation and Support for Illness and Injury* (1984) at 114. Other reasons given for abandoning claims include the following: victim's own fault in causing the accident, 18%; fear of legal expenses, 16%; denial of liability by the potential defendant, 15%; problems over solicitors'

Pearson Committee by Medical Defence societies in United Kingdom showed that 60 per cent of claims made in 1973 were abandoned, 34 per cent were settled out of court with only 5 per cent going to trial; twenty out of twenty-five cases going to trial were won by the defendant. This was in contrast to an 86 per cent success rate with respect to other personal injury claims.[29] In South Australia there is some evidence that in medical malpractice cases some 30-40 per cent of claims made do not succeed either because they are withdrawn or successfully contested.[30] No statistics are available for other states although in New South Wales professional indemnity insurers and the Government Insurance Office think the figure more likely to be about 20 per cent.[31] There is no local evidence as to the extent of negligently inflicted injury by medical providers. Incident reports will not necessarily provide a useful guide; an incident may not result in any real damage. There are also risks of both under and over reporting, that is, incidents may be reported which do not involve negligent conduct and incidents involving negligence not reported.[32]

If the 40 per cent failure rate of medical malpractice claims in South Australia holds true in all states, this means a considerable number of persons who *claim* to be injured as a result of the negligent provision of medical services will go uncompensated. But this 40 per cent failure rate will not represent all those injured. Many persons sustaining injury may never contemplate making a claim.

2. *Uncompensated Injuries*

(a) Malpractice claims — barriers to success

The common law compensates only a very small proportion of those sustaining injury. The first major hurdle is presented by the common law requirements of proof of fault and a causal relationship between that fault and the injury sustained. The difficulties of proof in malpractice claims are

handling of claims, 8%; delay in the claims process, 6%; the bother involved in claiming, 6%; injuries not serious enough, 5%; no one at fault, 4%; no loss of income 3%.

29 *Pearson Report: Royal Commission on Civil Liability and Compensation for Personal Injury* (Cmnd 7054, 1978), par1326.

30 Legal Services Commission of South Australia, *Submission to Patients' Rights Task Force* (1988) at 20; South Australian Task Force Report, above n1 at 14. The American experience suggests that with growing specialization and selectivity of cases, there has been a substantial improvement in the number of cases won for plaintiffs, Jacobson, above n26 at 3325-26.

31 Actual statistics are not available, Personal Communication, McGee, P M, GIO (NSW), 12 November 1990; McIvor, A, FAI Insurance, 12 November 1990.

32 In Victoria in 1986 there were reported to be 100,000 (sic) odd incident reports of which 300 by November 1990 had resulted in successful actions, Insurance Council of Australia, *Response on Behalf of the Australian Insurance Industry to the Task Force on Patients Rights Report on No-Fault Compensation for Medical Misadventure*, November 1989, at 5. The Victorian incident report rate per 100 members is almost double that in New South Wales. Medical Defence Assocn of Victoria, *Annual Report* 1987, 1988 at 6, 11 respectively; NSW *Medical Defence Union, Annual Report* 1988 at 5; 1989 at 7. US evidence suggests that this higher reporting rate is desirable. In the United States, Insurers opened a file in response to an incident report in only 7% of cases. In 30% of cases a file was opened because of notification of claim by the plaintiff's lawyers; in 38% in response to service of suit papers and in 18% of cases on complaint by the patient or patient's friend or relative, US General Accounting Office, above n23 at 36.

formidable. The plaintiff must show that the injury sustained results from negligence on the part of the medical provider rather than from the underlying medical condition which required initial treatment or the unavoidable risks attached to the procedure or treatment.[33] A further problem is the apparent difficulty in persuading expert medical witnesses to give evidence on the plaintiff's behalf.[34]

The potential litigant is also at a severe informational disadvantage. There may be real difficulty in finding out what actually occurred.[35] In some states the problem may be alleviated by the provision of medical complaints units[36] who can inspect medical files[37] or the existence of Freedom of Information legislation which allows access to files of public hospitals.[38] It is also ameliorated in some states by procedures which allow a litigant to issue a summons requiring a person to attend before the Supreme Court to be examined to establish the identity of a prospective defendant and allow discovery of documents in that person's possession to determine whether the applicant has any right to obtain damages.[39] The South Australian Taskforce Report on No-Fault Liability recommended that the rights of patients to have access to their medical records should be secured by legislation.[40]

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33 In the CMA study (referred to below (c) Patient injuries — How many) elderly patients were more likely than younger patients to sustain injuries resulting from normal risks attached to the treatment or procedure, see Danzon, n27 at 23. It was estimated that 83% of injuries resulted from adverse outcomes consistent with the normal risks of medical treatment, Danzon, id at 21.

34 *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 at 562 per Reynolds JA; Report of the Task Force on Patients' Rights, above n1 at 8; O'Bryan, P, in his article "Medical Negligence Claims" (1988) 62 *Law Instit J* (Vic) 931 claims that interstate academics are "frequently the best and only avenue" for proving obstetric claims.

35 In South Australia the Legal Services Commission of South Australia, responsible for legal aid cases reported that "almost without exception" some litigation has been necessary in order to secure sufficient information to determine whether a claim exists, *Submission to Patients' Rights Task Force* (1988) at 1.

36 Health Services Commissioner (Vic), Health Advice and Complaints Office (SA), Dept of Health, Complaints Unit (NSW), Health Complaints Unit (Qld). In Queensland it is proposed that the Unit deal only with complaints arising from the public health system. The Complaints Unit in NSW has an arrangement with public hospitals' insurers and the GIO, for access to files even if the complaint under investigation involves negligence. See also Health Commission of NSW (1982), *Confidentiality of Health Records in Hospitals and Community Health Centres* circular 82/369, Sydney, giving patients rights of access to medical records. See also *Health Services (Conciliation and Review) Act* 1986, Vic, ss16(1), 27.

37 In NSW, a private practitioner can be asked to disclose medical records; if this is refused a complaint can be lodged with the Medical Board. This is rarely necessary, Personal Communication, Donnelly, S, Policy Officer, NSW Complaints Unit, Dept of Health, 13 November 1990. As to private hospitals, see *Private Hospitals and Day Procedure Centres Act* 1988 (NSW) ss47, 48.

38 See for example, *The Freedom of Information Act* 1982 (Vic), ss13, 33(4).

39 See *Rules of the Supreme Court* (Vic), Order 32 and discussion Dunn, I, "Actions against Health Care Providers — Three Victorian Reforms" 2nd International Conference on Law and Medicine, London, July 1989; Note the more limited rules in NSW, *Supreme Court Rules* 1970 (NSW) Pt 3, Qld (*Rules of the Supreme Court* Order 35 r28) and SA (*Supreme Court Rules* Order 31). Note also "Discovery in Medical Negligence Actions and the View of the Court or Appeal" (1987) *Qld L Soc J* 405-406 and the possible equitable jurisdiction to order discovery, see *Norwich Pharmacal Co v Customs and Excise Commissioners* [1964] AC 133 discussed in Cairns, B C, *The Law of Discovery in Australia* (1984) at 166-169.

40 Report of the Task Force on Patients' Rights, above n1 at 85; see also Aust Law Reform Comm *Privacy* Vol 2, LRC 22, pars1236, 1339-1342 and support by the Law Council of Australia, "Law Council of Aust Supports Reform in Medical Compensation Arrangements

(b) Social, psychological and financial factors inhibiting claims

Even if common law requirements can be met there are even greater financial, social and psychological barriers which dissuade injured patients from making any legal claim. Although there is no Australian empirical evidence, the English study carried out by the Oxford Centre for Socio-Legal Studies published in 1984 suggests a reluctance to make claims by the young, elderly and women particularly in areas other than work and motor vehicle accidents. Although the study did not deal with, or separate out, medical accidents, it suggests alarming biases in claims made for compensation under the common law regime.

The Oxford study found that the age groups under 16 and over 65 accounted for one-third of all victims but only 11 per cent of successful claimants.[41] Young and elderly victims rarely made a claim for damages[42] but were disproportionately represented in non-work, non-vehicle injuries[43] which constituted the largest number of accidents. In this category of accidents no claim was made by 96 per cent of accident victims and only one in 50 of them obtained any damages.[44] A similar bias has been found in medical malpractice claims in the United States where the paid claim rate for negligently caused injury ranges from one in 55 for persons over 65 to one in 18 for persons aged 20 to 44.[45]

The Oxford study's findings were that about 75 per cent of all accident victims never considered making a claim at all and of the 25 per cent who gave any thought to the question of compensation, only half actually sought legal advice about a claim. Only 12 per cent of all accident victims actually recovered damages.[46]

The Oxford study examined whether there were factors other than youth and age which were significant in determining whether a claim would be made. The existence of some residual disability and extended absence from work were related in a minor way to whether damages were recovered but fewer than one-fifth of all accident victims who sustained serious long-term effects recovered any damages.[47] With respect to the elderly, serious residual disability did not increase the likelihood that damages would be obtained.[48]

Working status of the injured person increased the likelihood that damages would be obtained.[49] The importance of being in employment as a predictor of obtaining damages lies not only in loss of income but also in other factors which lead to a claim being made, such as access to networks of advice and

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But No-Fault Scheme is Opposed" (1989) 24 *Law News* 6.

41 Harris, et al, above n28 at 52.

42 Ibid.

43 Id at 53, Table 2.4.

44 Id at 51.

45 Californian Medical Association Study, National Association of Insurance Commissioners (NAIC). *Survey of Closed Medical Malpractice Claims 1975-1978* (1980) discussed in Danzon, above n30 at 24.

46 Harris, et al, above n28 at 46.

47 Id at 57.

48 Id at 58.

49 Id at 56. For example, housewives constituted 14% of accident victims in the survey but only 5% of those who obtained compensation, id at 56.

information.[50] Access to free information and advice about compensation and legal rights immediately after an accident occurred were more likely to be available in road and work accidents than in other accident situations.[51]

As with all statistical information obtained on survey of different populations, it will be uncertain whether such biases will be found in medical malpractice claims in particular and whether such biases exist in the Australian population. The information may be important, however, in any assessment of whether the common law fault based system should be abandoned in favour of a no-fault medical misadventure scheme such as is currently being debated in Australia. It is also important in highlighting the importance of readily available and free advice and information about legal rights.[52] Thus it may be opined that if there is ready access to free advice and information concerning medical malpractice claims, a larger incidence of claims could be expected. This informational gap might be filled, at least in part, by the existence of complaints units in a number of states providing information on how to make a complaint against a medical service provider.[53] In Victoria,[54] the conciliation process offered by the Health Services Commissioner can result in recommendations for payment of compensation (see below, Part C(2) Reforming the Common Law, The Victorian Experiment). Like unions with respect to work accident claims,[55] complaints units such as the Victorian Health Services Commissioner[56] could to some extent "take on the claim" obviating the need for the injured to obtain a solicitor, to understand the legal aspects of the claim, and very importantly remove the risk of large legal costs if the claim is unsuccessful. A further effect may well be to increase claims consciousness among the injured population.[57] Such units may well remove informational and cost barriers to claims, but at present the Victorian Health Service Commissioner is the only complaints body who can recommend payment of compensation.

The Oxford study examined whether failure to claim in accidents other than work or road accidents could be attributed to difficulty of proof of fault where, for example, there may be lack of available (and willing) witnesses.

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50 Id at 58, 65-67.

51 Id at 67. For example, even in respect of claims which do not depend upon proof of fault, such as claims under the Criminal Injuries Compensation Scheme, failure of half of the victims to make a claim (10 out of 20) was attributed to ignorance of the existence of the Scheme or confusion about the grounds for a claim or the procedure for making an application, id at 209.

52 This applies equally in no-fault systems such as workers compensation claims, see Shaw, S, "Workers' Compensation, Who Benefits from the System?" (1977) 2 *Legal Services Bull* 363.

53 There is not unexpected resistance by the medical profession to widespread dissemination of information on how to make a complaint on the basis that this will encourage claims, personal communication, Donnelly, S, Complaints Unit, NSW, 13 November 1990.

54 At the time of writing it is proposed that the NSW Complaints Unit be given conciliation powers similar to those utilised by the Victorian Health Complaints Commissioner under the *Health Services (Conciliation and Review) Act* 1987 (Vic), NSW Dept of Health, Complaints Unit, *Annual Report* 1989, at 2.

55 Harris, et al, above n28 at 69.

56 The NSW Complaints Unit gives no advice about the potential for a malpractice claim, personal communication, Donnelly, S, Complaints Unit, Dept of Health, NSW, 13 November 1990.

57 This has apparently been the case with manual workers in Britain suffering accidents; the evidence suggested that they were more inclined to initiate a claim for damages than non-manual workers, Harris, et al, above n28 at 63.

This, of course, would be particularly pertinent to medical malpractice claims. The evidence suggested that the failure to claim did not relate to problems of proof but rather to the failure to even consider whether a claim should be made or to seek legal advice.[58]

Attribution of fault to another for the accident was only a poor predictor of whether a claim would be made. Only 17 per cent of victims of accidents other than road or work related accidents who blamed another entirely for the accident consulted a lawyer.[59] A sample of all accident victims who entirely blamed another for the accident showed that men (71 per cent) were more likely than women (68 per cent) to consider the question of compensation. Women (38 per cent) were considerably less likely than men (54 per cent) to seek legal advice. If legal advice was sought women were more likely than men to obtain damages (94 per cent as against 88 per cent).[60] The young and elderly rarely obtained damages even in cases where another was entirely blamed for the accident.[61] For those accident victims who considered the question of compensation but had not sought legal advice or pursued it, the major reasons given for not going further were trouble and inconvenience in making a claim,[62] legal costs and assumed difficulties in providing evidence of liability.[63] Women were more likely to explain failure to claim on possible difficulties in obtaining evidence of fault.[64]

The biases inhibiting claims by the young, elderly and women may not be the only biases inhibiting claims. It is also possible that other biases not examined in the Oxford study may be relevant in determining whether a claim will be made, for example, migrants claims may be under-represented.[65] It is also possible that these biases found in the Oxford study might not be found to apply to medical claims. There is, however, US evidence that suggests that the probability of a person over 65 filing a medical malpractice claim, given a potentially actionable injury, is roughly one-fourth of that of persons under age 65.[66] A major reason for this it is suggested is the lower compensable damages that would be received by the elderly.[67] There is also substantial evidence from the United States that large numbers of injured patients never make a compensation claim. The evidence analysed by Patricia Danzon

58 Id at 61.

59 This contrasts with a much higher claim rate for road (58%) and work (65%) accidents where the victim blamed another, id at 70.

60 Harris, et al, above n28 at 70. This contrasts with the finding of the 1984 GAO study of closed claims which showed that males had a slightly higher percentage of paid claims than females, 45% as against 42%, US General Accounting Office, above n23 at 29.

61 Harris, et al, id at 70.

62 Ibid. Table 2.12 at 72 gives the following statistics for failure to make a claim in relation to accidents other than work or road accidents, trouble or bother: 31%; problems in providing evidence: 23%; fear of legal costs: 6%.

63 Id at 72.

64 Id at 72, Table 2.12.

65 See Shaw, S, "Workers' Compensation: Who Benefits from the System?" (1977) 2 *Legal Services Bull* 363. This reluctance to claim is supported by other evidence where victims and consumers were unwilling to complain, the evidence is reviewed in Abel, R L, "The Real Tort Crisis — Too Few Claims" (1989) 48 *Ohio St LJ* 419 at 450-451.

66 Danzon, above n27 at 74. For the most recent evidence see US General Accounting Office, above n23 at 23-28.

67 Danzon, above n28 at 74. For the most recent evidence on malpractice claims, see US General Accounting Office, above n23 at 27-31.

suggests that in the period 1975-1978 only one out of 10 persons negligently injured actually make a claim and only one in twenty-five obtain compensation.[68] Even in respect of major permanent disabilities, at most one in seven negligently injured patients file a claim.[69] In the most recent US study reported in March 1990, eight times as many patients suffered an injury from negligence as filed a malpractice claim and sixteen times as many patients suffered an injury from negligence as received compensation from the tort liability system.[70]

If this reluctance or failure to claim compensation is reflected in medical malpractice claims in Australia it will be necessary to make some assessment of how far these biases will continue to operate under a no-fault scheme for medical misadventure. If the disincentives to suit are removed by a no-fault scheme a very substantial increase in claims should be expected. The process of suing a defendant can be seen as a number of hurdles the first of which is whether the accident victims even considers whether a compensation claim might be available. Secondly, whether the accident victim then goes ahead and seeks legal advice. Thirdly, whether a legal claim is commenced and finally whether it leads to compensation. As noted previously, even if the potential litigant commences legal proceedings substantial numbers of claims are abandoned.

No-fault schemes do not depend upon proof of fault as a pre-requisite to compensation. Any serious consideration of a no-fault scheme must entail an assessment of the numbers of injuries, as distinct from the number of claims, resulting from provision of medical services.

(c) Patient injuries — How many?

There is little statistical information concerning patient injuries as distinct from malpractice claims in Australia; there is some evidence relating to anaesthetic deaths.[71] In contrast, a lot of data is available from the United States. Studies in the United States suggest that in that jurisdiction the rate of iatrogenic injury may be high and the medical malpractice claim rate only a fraction of injuries sustained. A Medical Insurance Feasibility Study carried out by the Californian Medical Association in 1974 studied 20,864 hospital records and found evidence of an iatrogenic rate of approximately one out of every 20 admissions; 17 per cent of these would probably result in a jury finding of negligence.[72] A majority of *claims*, both paid and unpaid, could be categorized as claims involving temporary disabilities.[73] Some 80 per cent of

68 Danzon, above n27 at 24.

69 Id at 25.

70 Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, a *Report to the State of New York, Harvard Medical Practice Study*, Harvard College, March 1990 p6.

71 *Report on Anaesthetic Related Mortality in Australia* 1985-1987 (NHMRC August 1990) at 8, 24 found on limited data not covering all states that there were at least 153 anaesthetic related deaths from 1985-1987. More than one quarter of the deaths were said to relate to inadequate pre-operative assessment and management. The statistics are conservative because of data constraints.

72 Danzon, above n27 at 20.

73 60% of all *claims* and 56% of *paid claims* could be categorized as claims involving temporary disabilities, id at 22.

all *injuries* were similarly classified.[74] This contrasts with injury rates under 10 per cent for minor permanent injuries, major permanent disability and fatal injuries.[75] The risk of injury increased with age. Patients over 65 sustained an injury rate three times that of patients under 20.[76] Injuries attributable to negligence were highest in cases of serious permanent disability.[77] A much higher iatrogenic rate has been reported in a later US study[78] which reviewed records of 815 consecutive admissions to a university teaching hospital in 1979 and found that 290 (36 per cent) showed evidence of at least one iatrogenic illness. Of these, 76 records (9 per cent of all admissions) showed signs of "major complications" and 15 (2 per cent of all admissions) experienced iatrogenic complications which were "believed to have contributed to...death". Fifty-three per cent had at least one problem related to drug exposure.[79]

These statistics are not necessarily indicative of all hospital situations. A university hospital may have disproportionately high numbers of high risk patients and carry out substantially greater numbers of high risk procedures. Compare for example a 1972 United States study[80] finding an iatrogenic rate of 7-8 per cent of admissions after examining approximately 800 medical records in two hospitals which were regarded as largely representative of American hospitals. The records were drawn from adult medicine, surgery and gynaecology cases. It was estimated that 29 per cent of injuries resulted

74 Ibid.

75 Id at 20-25. See below n250 detailing the severity of injuries. Danzon notes that the estimates are likely to be very conservative. Where there is a high proportion of elderly patients more fatal injuries are likely, see Pocincki, L S, Dogger, S J, Schwartz, B P, "The Incidence of Iatrogenic Injuries" in *US Dept of Health, Education and Welfare Secretary's Commission on Medical Malpractice, Report of the Commission*, App pp56, 57.

76 Danzon, above n27 at 21. Patients under 20 sustained injury at the rate of 22% whilst patients over 65 had an injury rate of 68%. These rates can only be suggestive of the nature of the problem. Compare the earlier 1972 US study which found an injury rate of 11% in patients 65 and above. The study also points out that on the available evidence there it was not clear whether age or service is the principal factor associated with injury, Pocincki, et al, above n75 at 61, 63. In the more recent *Harvard Medical Practice Study* (above n70) it was found, after correcting for case complexity, that persons over 65 had double the rate of injury of persons within the 16-44 age group.

77 It was estimated that whilst only 8% of minor temporary disabilities were due to negligence, 83% of serious permanent disabilities could be attributed to negligence, Danzon, above n27 at 20-25.

78 Steel, K, Gertman, P, Crescenzi, C, Anderson, J, "Iatrogenic Illness in General Medical Service at a University Hospital" 304 *N Engl J Med* 638-642. The *Harvard Medical Practice Study* (above n70 at 3-4) examined a sample of persons injured in hospitals in New York state. It found that 57% of "adverse results" were of a minor temporary nature, in 14% of patients death was related to an adverse event, 9% had a disability which lasted longer than six months. The balance had moderate or permanent impairment.

79 Age, drug exposure and length of stay were positively associated with a complication, Steel, et al, id at 640. In the field of general surgery a 1981 US study of general surgical patients admitted to the Peter Bent Brigham Hospital found 36 cases of avoidable surgical misadventure among 5612 surgical admissions. In 23 of the cases the surgical mishap occurred prior to transfer Surgical misadventure resulted in a 55% mortality rate.Complications peculiar to orthopaedics, thoracic and cardiac surgery, urology, neurosurgery, otology and opthalmology were excluded. Only cases of clear error were included, Couch, N P, Tilney, N L, Rayner, A A and Moore, F D, "The High Cost of Low-Frequency Events — The Anatomy and Economics of Surgical Mishaps" (1981) 304 *N Eng J of Med* 634 at 636.

80 Pocincki, et al, above n75 at 50.

from negligence.[81] In all these studies the found rate of injury must be regarded as conservative; not all injuries will appear on hospital records particularly where there has been failure to follow up after discharge.[82] The Californian study was based on 1974 data but in the light of the most recently reported study in March 1990 it provides reasonable evidence of the rate of adverse injury. The Harvard Medical Practice Study[83] studied a sample of hospitalizations in New York State in 1984 and found an injury rate of 37 per cent for that year, 1 per cent of all hospital discharges (27.6 per cent of injuries) were regarded as being due to negligence. The rate of such injury found in the US studies of hospital admissions are unlikely to be reflected in non-hospital situations in Australia. This is borne out by evidence that in Victoria in 1986 approximately 75 per cent of successful claims were against hospitals.[84] It cannot be assumed that the same injury rate or statistical relationships will exist in our own jurisdiction. But the point is that we need to find out in order to assess the impact of a no-fault scheme. The point was taken by Simanowitz[85] in relation to a British proposal to establish a no-fault compensation scheme for medical misadventure:

> It is quite extraordinary that two responsible bodies should be proposing a complex and expensive solution to a problem when they do not have the faintest idea what the size and nature of the problem is. Nobody knows how many medical accidents occur in Britain each year, what their distribution is, or what the nature of the accidents are. The DHSS refuses to keep statistics of medical accidents separately from ordinary accidents...Even the doctor's defence organisations, the Medical Defence Union, ...who do at least have statistics of doctors who consult them when they believe that they may have been involved in an accident, refuse to publish even that only partly helpful figure.[86]

In summary first, there is inadequate publicly available statistical information in Australia on the number and severity of paid medical malpractice claims. In addition there is, at best, only the very roughest of estimates of the number of claims that are made that do not result in the payment of compensation. Secondly, malpractice claims are probably only a fraction of negligently caused patient injuries as there are, in addition to special legal problems generated by medical malpractice claims, numerous financial, social and psychological factors inhibiting claims. The evidence presented above suggests as few as one out of every twenty five negligently sustained medical injuries result in payment of some compensation. Thirdly, evidence from the United States on patient injuries sustained in hospitals

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81 Id at 55.

82 In the 1972 US study reviewers identified only slightly more than half the control records where there had either been an incident report by the hospital or a claim made against the hospital resulting in release of the record, Pocincki, et al, id at 57, 58. See also Danzon, above n27 at 24 commenting on the 1974 CMA study. The CMA study excluded certain types of injury as nonindicated treatments with no adverse outcome, unauthorized treatments, injuries resulting in emotional damage only or where disability did not prolong hospitalization and probably would not cause continuing disability following discharge, Danzon, above n27 at 20.

83 Above n70 at 3.

84 Insurance Council of Australia, above n19 at 5.

85 Simanowitz, above n3 at 120-121.

86 Many Medical Defence Associations and Unions in Australia do provide useful information on reporting of incidents and claims made, see above.

suggests that negligently caused injuries are less than one third of all patient injuries sustained. There is therefore a potentially huge pool of injured patients who may qualify for compensation under any no-fault scheme but who at present are not compensated through the torts system. But does this mean that the common law basis of liability ought to be abandoned?

Part B
What's Wrong With the Common Law?

1. Introduction — The Compensation Objective

The common criticisms of common law fault based liability in relation to medical malpractice claims include the following. It is not efficient in minimising waste and cost[87] nor does it compensate either fairly or promptly.[88] The uncertainties created by a lump sum, once and for all assessment of injuries[89] frequently under-compensate severely injured plaintiffs[90] and the nuisance value of trivial injuries may result in over-compensation for small claims

87 *Compensation and Rehabilitation in Australia*, Report of the National Committee of Inquiry (July 1974, Chairman Woodhouse J) Vol 1 pars151-162, known as the *Woodhouse Report*, NSW Law Reform Commission, *Accident Compensation Final Report* Vol 1, *A Transport Accident Scheme for New South Wales* (October 1984, LRC 43/1) pars 3.89-3.94. In South Australia it has been estimated that 40% of premiums go to legal expenses although few claims go to trial, Report of the Task Force on Patients' Rights, above n1 at 10. The US data is reviewed in Zuckerman, S, Koller, C F and Bovbjerg, R R, "Information on Malpractice: A Review of Empirical Research on Major Policy Issues" (1986) 49 *Law and Contemp Probs* 85 at 100 with estimates as low as 18% return to plaintiffs and as high as 40-50% return. Insurers costs in defending and investigating claims (whether paid or not) in the United States based on 1984 data ranged from a median of $2,390 to an average of $10,985, US Gen Accounting Office, above n23 at 18. Legal costs are likely to be higher in malpractice claims because of difficulties in proving causal issues and costs of obtaining expert evidence. Administrative costs of the New Zealand no-fault scheme are 7% (NZ Law Reform Commission, *The Accident Compensation Scheme Report* No 3 par18, Wellington 1987) and under the Swedish Scheme constitute 14% of premiums, Oldertz, C, "Security Insurance, Patient Insurance, and Pharmaceutical Insurance in Sweden" (1986) 34 *Am J of Comp Law* 635 at 655.

88 See *Woodhouse Report* above n87, Vol 1 pars111-116; NSW Law Reform Commission, above n87 at pars3.78-3.83. Klar objects that this is not true of the bulk of claims which are settled very quickly, Klar, L N, "New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective" (1983) 33 *UToronto LJ* 80 at 94. In the United States medical indemnity insurance claims closed in 1984 took an average of 16 months from the time of injury to the time of claim and an average of 25 months from time of claim to final disposition; large claims (payments over $1 million) took 65 months on average from time of claim to final disposition, US Gen Accounting Office, above n23 at 18. Note the speedy resolution of claims under the *Health Services (Conciliation and Review) Act* 1987 (Vic) below, Part C(2) Reforming the Common Law, The Victorian Experiment.

89 "There is really only one certainty: the future will prove the award to be either too high or too low", *Lim Poh Choo v Camden and Islington Area Health Authority* [1980] AC 174, 183 per Lord Scarman. Alternatives to once and for all assessment and lump sum awards have not generally been utilised in common law claims in Australia, see Fleming, J G, *The Law of Torts* (7th edn, 1987) at 204-205. There is apparently little use of structured settlements, see Goldring and Young, Aust Law Reform Commission, *Product Liability* RP 5, ALRC February 1989 at 30. For a recent innovation see *Workers Compensation Benefits Amendment Act* 1989 (NSW) inserting s151Q relating to employees injuries claims.

90 NSW Law Reform Commission, above n87 at pars3.50-3.60.

although the latter is less likely in medical malpractice claims.[91] Lump sum awards and delay in compensation have negative effects on rehabilitation.[92] Uncertainties, particularly in relation to proof of fault in medical malpractice claims, in the United States have had the effect that plaintiffs either drop their claims or settle before trial at a substantial discount.[93] The high rate of withdrawal of claims has already been referred to.[94] Although awards for pain and suffering may be substantial in rare cases of quadriplegia or serious brain damage, critics have not argued that current damages awards in this jurisdiction are unreasonably high.[95]

2. *Deterrence, Accident Reduction and Accountability*

Fault-based liability is attacked not only on the ground that it fails to achieve its primary aim of fair compensation for injured plaintiffs but also on the ground that it fails to achieve any deterrence objective. Even if torts liability in the light of liability insurance[96] is a relatively weak tool to achieve deterrence it should not be assumed that damages and costs of torts proceedings are the only relevant matters to determining deterrence.[97] Even if there is no direct loss because of malpractice liability insurance coverage there are social costs resulting from loss of reputation and the potential for economic loss resulting from loss of patients.[98] At the individual level, injury to

91 Danzon, above n27 at 42. High litigation costs and practitioner resistance to settling small claims accounts for the difference, Keeton, R E, "Compensation for Medical Accidents" (1973) 121 *UPa LR* 590 at 595 and see below n99.

92 *Woodhouse Report* Vol 1 pars138-144, NSW Transport Accident Scheme Report (above n87) pars3.71-3.77.

93 See Danzon, above n27 at 50-51, US General Accounting Office, above n23 at 47. Note also O'Connell, J, "A 'Neo No-Fault' Contract in Lieu of Tort: Postaccident Guarantees of Postaccident Settlement Offers" (1985) 73 *Calif LR* 898 at 901-903. There is no local evidence on medical malpractice cases but some evidence of discount in motor accident cases where fault is in issue, NSW *Transport Accident Scheme Report* (above n87) Vol 1 par326.

94 See nn27-31 above.

95 Report of the Task Force on Patients' Rights, above n1 at 18. The figures for motor vehicle accidents in the period 1983-1985 in South Australia indicate that pain and suffering accounted for an average of 44-56% of the cost of claims as against 27% for loss of earning capacity, State Government Insurance Commission (SA), *Compulsory Third Party Insurance Fund Enquiry* December 1985 at 57.

96 Where there is limited or no insurance, the risk of liability might possibly operate as a deterrent. As to the Australian insurance position, see n9. Experience rating in malpractice insurance has not in the past been used in the United States in order to achieve deterrence (Schwartz, W A, Komesar, N K, "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice" (1978) 298 *N Eng J Med* 1282-1289; Danzon, above n27 at 94-95), but is now said to be generally used by physician owned insurance companies, Kladiva, S, "The Clash over Medical Malpractice" (1988) 1 *GAOJ*, (Quarterly sponsored by the US General Accounting Office) 48 at 53. Experience rating is also not utilised by Australian medical defence societies although there may be a discretion as to whether to indemnify a member, see n9. In the public sector, in New South Wales, the Government Insurance Office which provides cover for public hospitals though the Treasury Managed Fund provides economic incentives to reduce accidents by such measures as a $200 excess applying to each claim.

97 For a general discussion of the relationship between medical malpractice and quality of care, see Brook, R H, Brutoco, R L and Williams, K N, "The Relationship between Medical Malpractice and Quality of Care" 1975 *Duke LJ* 1197.

98 See the survey by Peters et al concerning the anticipated effects of malpractice suits on reputation and case load by medical and legal practitioners who had not been sued as

reputation[99] and embarrassment[100] may operate as deterrents. Although it must be accepted that the system is less than ideal in providing deterrence[101] there is evidence that individual medical providers do respond to increasing malpractice premiums and the threat of malpractice suits by introducing measures to reduce the future risk of claims.[102] One US study found that practice changes resulting from increasing malpractice premiums undertaken by at least one-third of respondents were: maintaining more detailed patient records, prescribing additional tests, referring more cases, and spending more time with patients. The study concluded that there appeared to be a positive relationship between the probability of a claim and the probability of undertaking one of these actions.[103] In a survey of doctors and lawyers in Detroit and Columbus, 58 per cent of respondents indicated that the fear of being sued for malpractice prompted them to engage in procedures and practices beyond those required by the standards of their profession.[104] There was a greater proportion of practitioners who had already been sued for malpractice who responded positively to this question.[105] A recent study, however, has found that physicians in Florida with adverse claims experience were less likely than other physicians to quit practice or move interstate; physicians with adverse claims experience in the period 1975-1980 were more likely to have worse claims experience from incidents arising between 1981-1983.[106]

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against the perceptions of those who had been sued, Peters, J D, Nord, S K, Woodson, R, "An Empirical Analysis of the Medical and Legal Professions' Experiences and Perceptions of Medical and Legal Malpractice" 19 *U Michigan JL Ref* 601 at 618-619.

99 It is suggested that deterrence may be marginally more effective in medical malpractice claims as medical practitioners have a reputation to protect, Luntz H, *Commentary on SA No-Fault Task Force Report* (unpublished) at 2. But this likely to be true of most professionals, see Peters, et al, id at 618-620. Professionals who have been sued for malpractice are reported to be more likely to believe that a suit causes no damage to reputation or caseload than professionals who have not been sued leading to the inference that the actual effects of a malpractice suit are not as great as the perceived effects, Peters, et al, id at 618-620.

100 The effects of adverse publicity are, however, more likely to be felt by the least reprehensible as cases involving clear cut negligence are likely to be settled prior to trial, *Royal Commission on Civil Liability and Compensation for Personal Injury* (Cmnd 7054, 1978) (the *Pearson Report*) Vol 1 par13434; see also Medical Defence Association of South Australia, *Submission to the SA Health Commission Taskforce on No-Fault Compensation for Medical Misadventure* at 4. Note, however, that the Medical Defence Association of Victoria reported to its members that the Association successfully fought to verdict cases which could have been settled for very small amounts, and which a commercial insurer would undoubtedly have settled to achieve the best net financial result and added that the Association can and does consider the reputation and the wishes of the individual member, Medical Defence Association of Victoria, *Defence Update*, March 1989 at 3.

101 The deterrence signal is blunted by such factors as liability insurance and the numbers of negligent injuries which do not result in a claim, see Part A(2) Uncompensated Injuries, and Schwartz and Komesar, above n96 at 47 and above n9.

102 For a contrary view regarding the effectiveness of the common law to act as a deterrent, see Sugarman, S D, "Doing Away with Tort Law" (1985) 73 *Calif LR* 555 at 559-590.

103 Zuckerman, Koller and Bovbjerg, above n87 at 108. See also Reynolds, R A , Rizzo J A and Gonzalez, M L, "The Cost of Medical Professional Liability" (1987) 257 *J AMA* 2776. See also below, PartB(4) Defensive Medicine. Contrast Wiley, J, "The Impact of Judicial Decisions on Professional Conduct: An Empirical Study" (1981) 55 S *Calif LR* 345 doubting the effectiveness of appellate decisions in changing the standard of practice.

104 Peters, et al, above n98 at 616.

105 Ibid. Contrast the evidence given to the *Harvard Medical Practice Study*, above n70 at 9-57 to 9-61.

106 Sloan, F A, Mergenhagen, P M, Burfield, B, Bovbjerg, R R and Hassen, M, "Medical

But as pointed out this does not necessarily correlate with diminished quality of care as a higher number of claims may relate to taking on more complex cases.[107] The evidence is therefore equivocal on this issue. In the case of hospitals Harvard Medical Practice Study concluded after a study of New York hospitals that there is at best "weak evidence of no deterrence".[108]

Insurers also play an increasingly important role in promoting accident reduction. Australian professional indemnity insurers which predominantly provide cover for private hospitals may, in addition to imposing excess clauses, refuse to renew policies or impose conditions for renewal. These may include adoption of specific risk management procedures and in some cases require the employment of risk management consultants.[109]

Putting the deterrence issue in perspective there are two issues, first the question whether the costs of the common law system are outweighed by its perceived deterrent effects and secondly, whether such deterrence can be more efficiently achieved by other methods. In the United States it has been estimated that on 1974 costs if one in 10 incidents of negligence leads to a claim and one in 25 receives compensation, only a 4 per cent reduction in the rate of negligent injury would be required to justify the additional costs of the torts system.[110] The difficulty is that it is impossible to measure the extent to which the risk of tort liability does operate as an effective deterrent. It is also arguable that deterrence can be built into non-tort based systems[111] or provided by other regulatory mechanisms[112] (see below). We can only speculate how far this role might be adequately or more efficiently fulfilled by other regulatory means.

The common law role in providing deterrence is also in question if it results in a reluctance to adopt precautions following injury; this can provide evidence that the risk could have been reduced or avoided.[113] The problem

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Malpractice Experience of Physicians, Predictable or Haphazard?" (1989) v262 no23 *J of the AMA* 3291 at 3297. Contrast the finding in New York State that injuries are not caused by a handful of accident-prone doctors, *Harvard Medical Practice Study*, above n70 at 1-8.

107 Sloan, et al, id at 3296-3297.

108 *Harvard Medical Practice Study*, above n70 at 10-45 to 10-48.

109 Personal Communication, McIvor, A, FAI Insurance, 13 November 1990.

110 Danzon, above n27 at 226. This assessment is based on 1974 costs and is calculated on the basis that 80cents of every health insurance premium dollar is delivered to the patient as compared to 40cents of every malpractice insurance premium dollar. This does not take into account other costs of the tort system such as defensive medicine, court time, psychic costs of litigation to patients and providers.

111 See Trebilcock, M J, "Incentive Issues in the Design of No-Fault Compensation Systems" (1989) 39 *UToronto LJ* 19.

112 In the United States there is support for the view that accident reduction is best attacked by procedures outside the common law, in particular, disciplinary proceedings against physicians who do not provide adequate care and development of risk management programs at an institututional level; in the United States 80% of malpractice claims closed in 1984 were against hospitals, US General Accounting Office, *Report to Congressional Requesters, Medical Malpractice, A Framework for Action* (May 1987) (GAO/HRD-97-73) 12.

113 See generally Trindade, F A, Cane, P, *The Law of Torts in Australia* (1985) pp333-334. The threat of negligence and defamation actions are said to constitute a significant barrier to participation and documentation of patient care review activities, Health Dept Victoria, *Quality Assurance in Health Care in Victoria* (June 1987) at 31. See also *Enquiry into Hospital Services in South Australia*, Adel 1983, Chairman Sidney Sax at 98. Protection is now given to these proceedings, see *Health Services Act* 1988, (Vic) s139 giving protection

has been exacerbated by insurance obligations which preclude admission of liability by the insured and consequently inhibit the giving of information or admission of errors or mistakes.[114] The South Australian taskforce reporting on No-Fault Compensation recommended that insurance policies be amended to make it clear that provision of factual information about an error does not constitute an admission of liability so as to affect insurance and that complaint bodies ought to be able to investigate complaints fully and report that mistakes have occurred to a complainant, without necessarily admitting or alleging negligence.[115]

3. *Quality of Care Standards*

Tort liability is also said to be an ineffective method of establishing quality of care standards when these standards are set on a case by case basis by a tribunal of fact. It is further argued that the application of the customary practice standard does not properly address the cost/benefit equation:

> Malpractice law does not purport independently to assess the reasonableness of risky behaviour in order to determine the optimal levels of risk avoidance and risk acceptance, but instead enforces a standard of care derived almost entirely from the customary practice of providers themselves. In drawing its standard of care from the usages of the medical services market, the law may inadvertently perpetuate or exacerbate the deficiencies of that market in assessing the appropriate level of expend- itures on risk reduction.[116]

Thus it is possible that unnecessary tests and procedures utilised for the purpose of protection against malpractice suits may become the standard, that practices known to be less efficacious than other available techniques will nevertheless be followed because it has been customary to do so and further that under the technological imperative costly procedures will be undertaken despite limited possible benefits.[117] Although the position cannot be regarded as being finally settled, the Australian courts have not accepted that the *Bolam*[118] test adopted by the House of Lords in *Sidaway v Bethlehem Royal Hospital Governors*[119] should automatically set the appropriate standard of care.[120] According to the *Bolam* test there is no breach of duty if the defend-

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to proceedings of peer review and evidence given before the Commissioner. See also *Health Services (Conciliation and Review) Act* 1987, (Vic) ss31, 32, *Evidence Act* 1958 (Vic) s21A; *Health Administration (Quality Assurance Committees) Amendment Act* 1989 (NSW).

114 Report of the Task Force on Patients' Rights, above n1 at 25. In New South Wales, the Government Insurance Office who insures public hospitals has an arrangement with the Complaints Unit so that all hospital files can be accessed by the unit.

115 Id at 85. See also Siggins, I, *The Health Services (Conciliation and Review) Act* 1987 (Vic) (1988) 62 *Law Inst J* (Vic) 932, 933 where conciliation proceedings are undertaken with advice and consent of the insurers.

116 Bovbjerg, R, "The Medical Malpractice Standard of Care: HMOs and Customary Practice" (1975) *Duke LJ* 1375 at 1377.

117 Id at 1389-1390. Moreover, evidence as to the professional standard may not reflect the actual position unless supported by empirical evidence, see Wiley, J, "The Impact of Judicial Decisions on Professional Conduct: An Empirical Study" (1981) 55 *S Calif LR* 345.

118 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587.

119 [1985] AC 871.

120 *Albrighton v Royal Prince Alfred Hospital* above n37; *F v R* (1983) 33 SASR 189, 192, 194 per King CJ *Golski v Kirk* (1987) Aust Torts Reports 80-095, (1987) 14 FCR 143, 155-157,

ant acts in accordance with a practice accepted at the time as proper by a reasonable body of medical opinion even though other practitioners adopt a different practice.[121] In *F v R* King CJ in the Supreme Court of South Australia said:

> The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.[122]

4. *Defensive Medicine*

Commentators also frequently point to the anti-social consequences of tort liability on medical practice. It is argued that tort liability produces defensive medicine which in turn greatly increases health costs. The American Medical Association survey found that 40 per cent of physicians ordered additional tests and 27 per cent ordered additional procedures in response to the fear of malpractice claims. The study concluded that this added 5 per cent to the total US health care bill.[123] These statistics have been doubted on two grounds.[124] First, it seems that factors such as disruption and embarrassment rather than economic factors account for the fear of litigation. Malpractice premiums for individual physicians in the United States in the past (and generally in Australia) were not determined with reference to individual claims experience[125] so that there were few in the way of direct economic consequences which resulted from being sued for medical malpractice.[126] It has been pointed out that fear of litigation appears to be less significant than the method of payment adopted;[127] a fee for service system gives practitioners a financial incentive to order additional tests and procedures.[128] Moreover,

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Petrunic and Anor v Barnes (1988) Aust Torts Reports 80-147, *Ellis v Wallsend & District Hospital* 1989 Aust Torts Reports 80-259, and on appeal 1989 Aust Torts Reports 80-289.

121 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 587.

122 (1983) 33 SASR 189 at 194.

123 AMA, *Special Task Force on Professional Liability and Insurance Professional Liability in the 80s* Vols 1, 2, 3, (1984) (unavailable to the author but cited in Quam, L, Fenn, P, Dingwall, R, "Medical Malpractice in Perspective — The American Experience" (1987) 294 *Br Med J* 1529, 1531). See also Peters, et al, above n98 at 616; Reynolds, et al, above n103.

124 Quam, et al, ibid.

125 Schwartz and Komesar, above n96 at 1282-1289; Danzon, above n27 at 94-95.

126 See n96 and related text.

127 In other countries such as West Germany, in a fee for service system, increases in the volume of tests and procedures have not been accompanied by a similar rise in malpractice litigation, Quam, et al, above n123 at 1531.

128 *Duke Law Journal* Defensive Medical Project reported in 1971 that although physicians may over-utilise diagnostic tests and procedures in particular cases, it was tentatively concluded that the practice was not extensive and probably not a contributing factor to the rising costs of medicine care. The available data indicated that the weakness of costs constraints was one of the more important factors, Duke Law Journal Project, "The Medical Malpractice Threat: A Study of Defensive Medicine" 1971 *Duke LJ* 939 at 964, 965. See also Freeborn, D L, Baer, D, Greenlick, M R, Bailey, J W, "Determinants of Medical Care Utilization: Physicians use of Laboratory Services" (1972) 62 *Am J of Public Health* 846-853. The position would appear to be the same in Australia under a fee for service system. There are, however, mechanisms directed to prevent over-servicing, see Moore, A P, Tarr, A A, "Regulatory Mechanisms in Respect of Entrepreneurial Medicine" (1988) 16 *Aust Bus LR* 4.

dramatic increases in health costs have occurred in countries where malpractice suits are virtually unknown.[129] There are also very substantial difficulties in determining whether tests or procedures are unnecessary. Evidence shows considerable disagreement between practitioners as to what is required in an individual case. What is regarded as excessive by one practitioner may be regarded as good medical practice by another.[130] Zuckerman, Koller and Bovbjerg, reviewing empirical research dealing with the issue of defensive medicine, concluded that it is a significant cost factor which is impossible to measure precisely. They conclude that "the implication that physician spending could be reduced by 25 per cent without a real reduction in the quality of care seems implausible and, almost certainly, not a position supported by the AMA [American Medical Association]".[131] It has also been argued that the legal environment only partially explains the practice of defensive medicine; other factors relevant were medical technology, changes in public expectations about appropriate medical care, and requirements of peer and other reviews.[132]

5. *Availability of Medical Services*

A further serious consequence suggested is that high risk essential medical services, particularly obstetrical services, may be unavailable or withdrawn. There is evidence in the United States and Britain in support of this claim. The evidence, however, comes from the medical profession and not from consumers and for that reason has to be treated with some caution.[133] There is also some local empirical evidence to suggest that withdrawal from the medical profession may be due to factors other than the rising cost of malpractice premiums and fear of malpractice suits. In 1983 a survey of Australian medical practitioners reported that 24 per cent of all general practitioners and 21 per cent of all specialists said they had seriously considered leaving medicine in recent years. More than 90 per cent of general practitioners and 77 per cent of specialists blamed falling public image for theirdissatisfaction.[134] Other reasons given were: shrinking clinical freedom (602 per cent); method of payment under the medicare system (43.9 per cent);

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129 Japan in 1971 had the lowest level of per capita health expenditure, but in the period 1971-1985 had the highest growth rate for health expenditure of 13% per annum, Aust Inst of Health, *Australian Health Expenditure* 1970-1971 to 1984-1985 at 17 citing OECD, *Measuring Health Care* (1985). Sweden which introduced its Patient Insurance scheme in 1975 had, for the period 1971-1985 an average annual rate of growth for health expenditure of 10.1%, *Australian Health Expenditure* (above) at 17. At the time of introduction of its Patient Insurance Scheme approximately 10 medical malpractice cases per year resulted in compensation, Oldertz, above n87 at 637.

130 Nathan Hershey, "The Defensive Practice of Medicine" (1972) 50 *Milbank Mem Fund Quarterly* 69; *Duke Law Journal* Defensive Medicine Project, above n128 at 964. A study of services provided by physicians under the Kaiser-Portland Health Plan in the United States suggested that the following factors may be significant in determining usage of laboratory tests: emphasis on preventative medicine, whether the physician has a leadership role, cost to the patient, age, medical school attended, length of service within the institution, Freeborn, et al, above n128.

131 Zuckerman, et al, above n87 at 107-109.

132 *Harvard Medical Practice Study*, above n70 at 10.

133 The evidence is reviewed by Zuckerman, et al, above n87 at 109-110. See also Peters, et al, above n98 at 616.

134 *Medical Practice* (Aust) January 1983 at 22.

colleagues' unethical behaviour (42.9 per cent); inadequate remuneration (30.2 per cent); ruining family life (25.5 per cent); can't do enough for patients (18.4 per cent); excessive working hours (22.4 per cent); other (26.5 per cent). There was no reference at all to medical malpractice liability. At the time of survey malpractice claims in Australia were negligible.

6. *Doctor-Patient Relationship*

Proponents of reform point to the negative effects of common law liability on the doctor-patient relationship; the threat of malpractice suits destroys the trust and confidence between doctor and patient.[135] This claim is difficult to measure and it is suggested that it will be virtually impossible to show that the deteriorating relationship is due to the threat of malpractice suits rather than general breakdown in traditional relationships and institutions,[136] growing consumer knowledge and independence in medical matters,[137] the medical profession being seen as a money-making business with too many patients and too little individual attention. On the other side of the coin, groups representing injured patients, argue that medical practitioners portray themselves as the victims at the expense of injured patients.[138]

The evidence from New Zealand and Sweden, two no-fault systems, is of interest. Although malpractice suits in New Zealand are rare and available only where a claim cannot be brought under the Accident Compensation scheme,[139] it is reported that there is continuing fear of the litigation process in the minds of practitioners.[140] In contrast, it is reported that under the no-fault Swedish Patient Insurance Scheme, (discussed below) where claims outside the scheme are not restricted but rare, the doctor becomes the "lawyer of the injured patient. He argues his case and always tries, at least in most cases — to give an objective view of what happened";[141] the doctors defend the patients not themselves.[142] There is a risk, however, that any system requiring accountability will inhibit an honest statement of events leading to injury. The question is whether accountability is at too high a cost in terms of

135 A medical practitioner's response to a serious medical accident may be to cease care of the patient altogether. One view is that this approach is generated by defence organisations and is the very reverse of what ought to occur, see Simanowitz, above n3 at 126-128.

136 Brook, et al, above n97 at 1221. See also Peters, et al, above n98 at 620.

137 A survey of Australian medical practitioners in 1983 reported that 93% say their relationships with their patients were better or unchanged over the last five years despite growing disenchantment by many about their profession; malpractice claims within that period were negligible, "But It's All Rosy with Your Patients" (March 1983) *Medical Practice (Aust)* 23. This survey may provide the basis for comparison with current attitudes now that there have been substantial increases in malpractice claims and consequent heightened awareness of malpractice suits in Australia.

138 Simanowitz, above n4 at 145 et seq.

139 A common law claim for damages is precluded where there is a compensable injury arising out of "personal injury by accident", *Accident Compensation Act* 1982 (NZ), s27.

140 Vennell, M, comment in Mann, R D and Havard, J, *No-Fault Compensation in Medicine* (The proceedings of a joint meeting of The Royal Society of Medicine and The British Medical Association, 12-13 January 1989) at 69.

141 Oldertz, C, comment in Mann and Havard, above n140 at 69. But even insurers complain that they are sometimes being fed a tale; no-one likes to admit making a mistake, McIvor, A, FAI Insurance 13 Nov 1990. And see comment below nn196-199.

142 Brahams, D, comment in Mann and Havard, above n140 at 107-8.

the doctor-patient relationship. A more aggressive application of disciplinary measures may see some change.

7. *Issues of Equity*

A further objection to the common law fault-based system is that it is inequitable in its application both from the point of view of the defendant and from the point of view of the injured patient. From the defendant's perspective liability appears to be random in its effect as negligence rarely results in a paid claim.[143] There is also a perception that the least reprehen ible medical practitioners are more likely to receive adverse publicity from malpractice suits.[144] In the United States it has been said that the likelihood of a physician being sued more than once is related "as much to chance as to . . . being a poor physician".[145] The point, however, is contentious as there is increasing evidence that physicians who are sued more than once represent a higher risk than other physicians.[146] In Florida it was found that physicians with poor claims histories were more likely to have complaints made against them with the State licensing board and that physicians with adverse claims experience in the 1975-1980 period were more likely to have a worse claims experience from incidents arising during 1981-1983.[147] But a higher claim rate might indicate that a few practitioners take on the more complex and difficult cases where error is more likely.[148]

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143 In the United States data from a 1974 Californian study suggested that conservatively about one out of 126 hospital admissions resulted in an injury due to medical negligence but only one in 10 led to a claim and only one in 25 received some compensation, Danzon, above n30 at 18-29. See also Meyers, A R, "'Lumping It' The Hidden Denominator of the Medical Malpractice Crisis" (1987) 77 *Am J of Public Health* 1544 and nn68-70 and related text.

144 Medical Defence Association of South Australia, *Submission to South Australian Taskforce on No-Fault Liability for Medical Misadventure* at 4: "It is usually the highly conscientious who face Court proceedings — the grossly negligent do not since their cases are settled". See also *Royal Commission on Civil Liability and Compensation for Personal Injury* (Cmnd) 7054, 1978) (The *Pearson Report*) Vol 1 par1343.

145 Brook, et al, above n97 at 1207. In a 10 year survey in Maryland it was found that 276 (9%) physicians insured under the Med-Chi program were sued once, 46 (1.4%) physicians were sued more than once for a total of 105 times, but no conclusions could be drawn upon whether physicians involved in more than one incident were a problem because of lack of data on factors such as number of patients seen and the specifics of each claim, Evans, C P C, Hemelt, M D, Olsson, J E, "A Survey of Professional Liability Incidence in Maryland" *Report of the Secretary's Commission on Medical Malpractice* (US DHEW (OS) 73-89) Appendix 623, 630. In the GAO report on closed claims for 1984 it was found that just on 42% of physicians had previous claims against them, see US General Accounting Office, above n23 at 56. Physicians with prestigious qualifications had no better and in some instances had worse claims experience than other physicians, Sloan, et al, above n106 at 3295.

146 See an account of a four year study of 8000 physicians in the Los Angeles area that 46 physicians (0.6%) accounted for 10% of all claims and 30% of all payments made by the insurance plan, Ferber, S, Sheridan, B, "Six Cherished Malpractice Myths put to Rest" (1975) 52 *Med Econ* 150-156 cited in Schwartz and Komesar, above n96 at 1287. As the report is not available to the author it is not clear whether there was control as to specialty. A Florida study found that in relation to the medical specialty group of physicians, 85% of payments were made for 3% of physicians; in the obstetrics-anaesthesiology group, more than 85% of payments were incurred by 6% of physicians, and for surgical specialties, three-fourths of the total payment was made on behalf of 7.8% of physicians, Sloan, et al, above n106 at 3293.

147 Sloan, et al, above n106 at 3296.

From an injured patient's viewpoint the common law is inequitable in its application as it compensates only those who can prove fault leaving injured with equivalent needs without remedy. This argument is reflected in the Woodhouse Report recommending a general compensation scheme for accident and sickness:

> It is wrong that injured persons should be treated by society in different ways, depending upon the fortuitous cause of the injury and it is equally wrong to leave other incapacitated groups of people indefinitely aside because the diagnosis of their problem is sickness or disease. Once the principle of community responsibility is applied to alleviate the plight of the injured, as it must, then the same community assistance cannot as a matter of social equity be withheld from the sick.[149]

Part C
Reforming the Common Law

1. Introduction

Supporters of the common law system for compensation point not only to its potential for deterrence but also argue for retention of common law actions against health providers on the ground that the notion of fault reflects community values that compensation should only be available where fault can be proven.[150] This argument is questionable in the light of the Oxford study, referred to above, which suggests only a weak link between attribution of fault and the belief that compensation should be paid.[151] In New Zealand, there is clear community support for the no-fault accident scheme and no claim for a return to a fault based system.[152]

The common law is also seen as satisfying an important social need; the need for the victim to gain retribution. Once again the Oxford study, referred to above, suggests the reverse.[153] Respondents to that survey gave many reasons for not pursuing a claim for compensation when blame was attributed to another. Some respondents felt that making a claim might disrupt social relationships and in some instances would be a vindictive thing to do thus having the opposite effect to that claimed. Moreover it was doubtful whether pursuing a legal claim vindicated the victim's anger.[154] In the case of an existing doctor-patient relationship, fear of disrupting that relationship may well inhibit a claim.

If common law claims for medical malpractice are retained there is no doubt that some of the unsatisfactory elements of torts claims relating to its compensation objective can be overcome with the provision for access to patient records, structured settlements, periodic payment and ongoing assess-

148 Id at 3297.
149 *Woodhouse Report* above n87, Vol 1 at 246. The recommendations of the report were never implemented.
150 Law Council of Australia, above n40 at 9.
151 Harris, et al, above n28, ch 4.
152 Law Commission, New Zealand, *Personal Injury: Prevention and Recovery*, Report No 4, (1988) par78 at 15.
153 Harris, et al, above n28 at 155.
154 Ibid.

ment.[155] These, whilst providing a fairer measure of harm, are likely to add substantially to administrative costs.

In relation to the common law's capacity to achieve accident reduction by deterring negligent conduct, it is uncertain how far that objective can be achieved under the present system of liability insurance.[156] In the United States, and to a more limited extent in Australia,[157] there is increasing evidence that insurance companies can, and do, penalise practitioners with high claims records. A range of remedies have been utilised by insurance companies; insurance can be terminated, made conditional, subject to excess clauses or surcharges and restrictions imposed on medical practice. Physician-owned companies have been particularly effective in this area.[158] Individual experience rating is commonly employed by such companies.[159] It is difficult to make any judgments about the effectiveness of these measures in achieving accident reduction. Even if it is possible to measure these effects, the issue will be whether the cost of common law claims is offset by deterrence achieved by insurers. Although there is some evidence of a positive individual response to malpractice claims,[160] the issue is whether the very high costs of common law actions are offset by these accident reduction measures. If only a small proportion of those injured sue and recover compensation[161] the malpractice insurance bill will not reflect the extent of a defendant's negligence. It may continue to be worthwhile to practice despite increased costs.[162] At an institutional level, statutory immunity for all patient care, review processes anddocumentation[163] may assist accident reduction by encouraging open and uninhibited discussion and review of practices and procedures.

Some of the common law deficiencies relating to delay and costs have been addressed in Victoria by the establishment of a Health Services Commissioner under the *Health Services (Conciliation and Review) Act* 1987 (Vic).

2. *The Victorian Experiment*

Under the *Health Services (Conciliation and Review) Act* 1987 (Vic) the Health Services Commissioner is given power to deal with health complaints and refer complaints for conciliation.[164] This provides a speedy[165] and inex-

155 As to other procedural reforms which may assist, see McIntosh, D A, "A Prescription for Medical Negligence" 131 at 139 and Mildred, M, "The View of the Plaintiff's Lawyer" 123 at 124-126 both contained in Mann and Havard, above n143.

156 See above nn96-109 and related text.

157 See n109 above.

158 Schwartz, W and Mendelson, D, "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence" (1989) v262 no10 *J of the Americ Med Assoc* 1342.

159 Kladiva, above n96 at 53.

160 See above nn103, 104 and related text.

161 See nn68-70 above and related text.

162 In a recent Florida study physicians with adverse claims experience were less likely than other physicians to make subsequent major changes in their practice such as quitting or moving to another state, Sloan, et al, above n106 at 3297.

163 This has been done in Victoria, *Health Services Act* 1988 (Vic), s139; see also *Health Services (Conciliation & Review) Act* 1987, ss31, 32, *Evidence Act* 1958 (Vic), s21A. See also *Health Administration (Quality Assurance Committees) Amendment Act* 1989 (NSW).

164 *Health Services (Conciliation and Review Act* 1987 (Vic) s20. Under the Act conciliation involves informal discussions between the health service provider and the complainant, s20(5). Neither party can be represented unless in the Commissioner's opinion the process will not work effectively without that representation, s18. Apparently the Commissioner

pensive remedy[166] in a non-adversarial environment. Conciliators in the exercise of their powers have recommended payment of compensation[167] but only where a common law claim would be available.[168] Conciliation proceedings are totally confidential.[169] Evidence of anything said or admitted during the conciliation process is not admissible in proceedings before a court or tribunal[170] and cannot be the subject of a Freedom of Information application.[171] This promotes a full and frank discussion between the parties. Difficulties and costs of obtaining expert medical assessment of the claim are overcome by the Health Services Commissioner providing a medical assessment to both parties.

The conciliation process will overcome a number of deficiencies of the common law but by no means all of them. Under the Victorian system conciliators with no formal legal training may be involved in the assessment of whether a common law claim exists. The complainant may be advised to drop any claim for compensation where the conciliator is of the opinion that no legal claim would exist. Since there is a general rule that complainants cannot be legally represented the complainant is severely disadvantaged.[172] Medical assessments of the claim are obtained by the Health Services Commissioner. This may result in adoption of the medical professional standard in preference to community standards.[173] A further risk is that many small and trivial claims or claims where there is considerable difficulty and cost in obtaining medical evidence will be directed to the Health Services Commissioner by the Legal Profession.[174] Whilst the speedy resolution of claims is a clear advantage there may be some cases where time is required to determine what the complainant's long term disabilities will be. Under the *Health Services (Conciliation and Review) Act* 1987 (Vic) s19(3) the Commissioner must reject a complaint about an incident which occurred more

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normally grants the right of representation to the provider of the medical service which would put the complainant at a considerable disadvantage, Dunn, I, "Actions against Health Care Providers — Three Victorian Reforms", Law and Medicine Conference, London, July 1989. The system is generally supported by medical defence unions and the legal profession. Conciliation proceedings stop if either party commences legal proceedings relating to the issue, s23(1)(a).

165 There are strict time limits for dealing with complaints under the Act, see *Health Services (Conciliation and Review Act* 1987 (Vic). A statutory complaint cannot be more than one year old (s19(3). Within 28 days of receiving the complaint the Commission must decide to accept, reject or refer the complaint, s19(8). Note also other time limits under s22.

166 Conciliators may suggest that the parties consult legal practitioners so that an agreement can be reached as to quantum of damages. Payment of legal costs involved are the subject of agreement between the parties.

167 Where the conciliator is of the view that a claim exists, the complainant may be advised to seek advice from a legal practitioner as to the quantum of compensation that should be sought. The amount of compensation is generally left up to the parties to sort out. Quite often substantial sums are involved, Dunn, above n164.

168 Health Services Commissioner, (Personal Communication 18 August 1989 Jackson, K, Conciliator).

169 Health Services (Conciliation and Review) Act 1987 (Vic) ss20(14), (15), 32.

170 *Health Services (Conciliation and Review) Act* 1987 (Vic) s20(14).

171 *Health Services (Conciliation and Review) Act* 1987 (Vic) s32.

172 *Health Services (Conciliation and Review) Act* 1987 (Vic) s18 criticised by the Law Council of Australia above n40. See also n164. This would not prevent the complainant bringing a common law claim but evidence in the conciliation proceedings cannot be used in other proceedings, *Health Services (Conciliation and Review) Act* 1987 (Vic) s20(14).

173 See nn118-122 and associated text.

174 Dunn, above n164 at 9.

than 12 months before the complaint is made if in the Commissioner's opinion the person who made the complaint has not shown good reason for the delay. This does not appear to be directed at a case where there is doubt as to long term disabilities. The system will therefore continue the difficulties involved in a once and for all assessment of damages. To the extent that the embarrassment factor provides some element of deterrence[175] this may well be lost in the conciliation process which remains confidential. Disciplinary proceedings by Medical Boards and Tribunals may act as a deterrent; this is examined below.

The conciliation process does not, however, address the more fundamental issue of whether the common law fault requirement is a fair basis for distinguishing between compensable and non-compensable claims. From the evidence outlined earlier there are substantial numbers of injured patients who do not receive any compensation.

In Australia the plight of injured patients who cannot prove fault or who decide not to claim is not nearly as drastic as in the United States. Social security benefits and a national system of health insurance provide a safety net for the injured, although critics point to the subsistence levels of support provided by the social security system and the long waiting periods for some procedures in public hospitals.[176] Can a case be made for giving preferential treatment to those injured through the provision of medical services?

3. *Medical Misadventure — The Claim for Preferential Treatment*

Assuming that the benefits of a common law system of compensation are outweighed by the detriments, is there any good reason for differentiating between victims of medical accidents as distinct from victims of other misfortunes? There is force in the argument that once tort liability is abandoned as the basis for compensation there is no rational justification for special treatment for a particular group of victims.[177] This should not, however, be the ultimate argument for doing nothing if it is accepted that common law liability should be abandoned as a basis for compensation. There is a risk, however, that politically powerful lobby groups will press for special treatment.

Many of the reasons suggested for preferential treatment for victims of medical malpractice are related to the alleged anti-social effects of torts liability on medical practice, that is, defensive medicine, unavailability of medical services, distrust in the doctor-patient relationship. The extent to

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175 See nn99-100.

176 It is reported, however, that Australia has the highest rate of hospitalisation in the world; in 1989, 218 out of every 1000 Australians will have been treated in a public or private hospital, Blewett, Dr N, Federal Minister for Community Services and Health, "Why Medicare is not on the critical list" *The Age*, Melbourne, 30 October 1989. The Australian rate which exceeds that of the United States and Canada, is 21% as against a United Kingdom rate of 12.6%: Federal Minister for Health, Howe, Mr, *Courier Mail*, Brisbane, 13 September 1990 at 14.

177 Stapleton, J, *Disease and the Compensation Debate* (1986) at 115. The argument is made also by the Law Council of Australia, above n40 at 9. Apart from Workers Compensation, preferential treatment providing limited compensation is extended to victims of crimes, (see for example *Criminal Injuries Compensation Act* 1967 (NSW)) and for victims of medically acquired HIV infection resulting from the transfusion of infected blood or blood products between 1 January 1979 and 1 May 1985 or the transplantation of infected human tissue during that period by the federally funded Mark Fitzpatrick Trust Fund.

which these adverse effects resulting from exposure to malpractice claims cannot be measured with any certainty.[178] Further, the assumption that the medical profession is exclusively affected by such adverse effects is unwarranted.[179] A further argument is that:

> The patient has no choice whether he will be a patient or not. He is practically always a layman encountering an expert and will have to rely on the expert's judgment...he is under...practical coercion which Esser mentions as a reason for providing a person with protection superior to that afforded by general principles.[180]

But the victim of illness or disease similarly has no choice. It is also difficult to justify preference on the basis of need. The Oxford study found that illness victims may have the greatest need, for they suffered the longest hospital stays and the greatest residual disability.[181] The New Zealand Law Commission, chaired by Sir Owen Woodhouse, has recommended that the New Zealand scheme (discussed below) be extended to illness and disability. Cost, however, provides the critical barrier to the extension of the scheme. The Law Commission recommended that sickness incapacities be brought within the scheme by several stages; first by providing health services on an equal basis; secondly, by accepting congenital incapacities supported by the social welfare system or which become manifest by a defined age; thirdly, taking in higher level disabilities; fourthly, accepting less serious disabilities.[182] It is doubtful whether this would be possible without either unacceptable increases in funding costs or unacceptable reductions in benefits.

If the injured patient is to be singled out for preferential treatment what form should this reform take?

Part D
No-Fault Compensation for Medical Misadventure

1. Introduction

Following the 1983 *Sax Report*,[183] there has been increased interest in alternatives to fault based liability for medical malpractice. This coincides with substantial increases in malpractice subscriptions in the private health sector, increases in claims frequency and severity and also with growing governmental and consumer awareness of patients' rights. In 1988 the South Australian Task Force on Patients Rights was requested by the Australian Health Ministers' Conference to develop a model for a national or uniform state no-fault liability scheme for medical misadventure. The Taskforce's

178 See nn123-141.

179 See for example, Schwartz, V E and Mahshigian, L, "National Childhood Vaccine Injury Act of 1986: An Ad Hoc Remedy or a Window for the Future", (1987) 48 *Ohio St LJ* 387.

180 Hellner, J, "Compensation for Personal Injury: The Swedish Alternative" (1986) 34 *Am J of Comp Law* 613 at 629.

181 Harris, et al, above n28 at 241 Tables 9.1, 9.2. In the 1988 Canberra, ACT survey, 5% of all men and women reported chronic illness or disability. Men in the 55-64 year age group had the highest rate of chronic illness or disability at 15%. Among women, the highest rate was for the 65 years and over group with 12% of respondents reporting chronic illness or disability, Commonwealth of Australia, *Canberra Health Survey*, Report 1 (1988) at 26.

182 Law Commission, New Zealand, above n152 at par7 at xiii.

183 *Sax Report*, above n7.

Report brought down in March 1989 acknowledged the deficiencies of common law proceedings in medical misadventure cases and concluded that, subject to cost analysis, a no-fault scheme had the potential for considerable benefits.[184]

Implicit in any criticism of the common law fault-based system for compensation is that any satisfactory compensation system should meet certain objectives. What goals should any system of compensation achieve? Can some or all of these be feasibly attained? Keeton suggests eight principles for judging the effectiveness and fairness of a compensation system. The system should:[185]

1. be equitable as between those who receive its benefits, those who bear its costs, among the different beneficiaries and among the different cost bearers;
2. contribute to the protection, enhancement and appropriate allocation of human and economic resources;
3. compensate promptly;
4. be reliable and predictable;
5. distribute losses;
6. be efficient in minimising waste and cost;
7. avoid inducements and, if feasible, provide deterrence;
8. minimise risk of exaggeration, fraud and opportunity for profit from such conduct.

How far these principles ought to be built into a compensation system is ultimately concerned with "value judgments about what kind of society we want to live in, and what principles and priorities we want reflected in our lives".[186] Advocates of no-fault liability regard the issue of equity between injured patients as critical to any system of compensation. But as will be seen even if fault is abandoned as a basis for determining compensability, there are still very difficult problems in defining the basis of compensation and problems in maintaining equity between injured patients.

As the South Australian Taskforce acknowledged, the most significant barrier to any new scheme will be the question of cost. Unlike no-fault motor vehicle accident schemes, the financial benefits of the abolition of common law liability[187] will not, on present liability contribution rates, produce sufficient funds to provide any reasonable level of cover to all victims of medical misadventure.[188] The efficiencies and savings generated by a no-fault system will be outweighed by the sheer numbers of uncompensated victims of medical misadventure (see above) and the potential for substantial administrative costs even under a no-fault system determining whether medical intervention rather than the underlying condition has caused the complainant's injury.[189]

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184 Report of the Task Force on Patients' Rights, above n1 at 3.

185 Keeton, R E, "Compensation for Medical Accidents" (1973) 121 *UPa LR* 590 at 603.

186 Lloyd Bostock, S, "Common Sense Morality and Accident Compensation" [1980] *Ins LJ* 331 at 345.

187 The New Zealand scheme has administrative costs of 6%, Accident Compensation Corporation, *Report* for the year ended 31 March 1989, at 21.

188 Keeton, above n185 at 593.

No system could ever hope to offer all who suffered adverse consequences some significant level of compensation. In the 1974 Californian Medical Association study 83 per cent of injuries resulting from medical treatment were classified as adverse outcomes consistent with the normal risk of medical treatment in contrast to 17 per cent which could be classified as negligent injuries.[190] As we have already noted, at least in the United States, only a very small proportion of patients negligently injured actually make a claim and an even smaller proportion actually obtain compensation.[191] If all victims of injury resulting from the provision of medical services were to claim there would be a potentially huge pool of claimants; no system could hope to compensate all of these. As will be seen from the following discussion, existing no-fault insurance or no-fault legislative schemes, as in Sweden and New Zealand respectively, do not compensate all patients injured as a result of medical intervention. The first difficulty is in proving a causal relationship between the injury sustained and the provision of medical services.

2. *The Causal Problems of No-Fault Compensation Schemes*

An initial problem for any no-fault scheme is determining whether medical intervention has caused the patient's injury.[192] Under the New Zealand no-fault accident compensation scheme the injury must be caused by medical or surgical misadventure rather than the pre-existing medical condition;[193] the exclusion of disease similarly requires proof that the adverse consequence resulted from medical misadventure rather than the natural onset of the disease.[194] A current member of the Board of the Accident Compensation Corporation writes that in "most cases" where a claim based on "medical misadventure" is brought, difficult issues, very often involving causal issues, will arise.[195] Causation is said to pose no great difficulties under the Swedish no-fault insurance scheme[196] because the fear of malpractice suits has generally been removed[197] and consequently medical service providers are

189 Gellhorn disputes the claim saying that there is no evidence in New Zealand that causal problems have generated substantial costs, Gellhorn, W, "Medical Malpractice Litigation (US) — Medical Mishap Compensation (NZ)" (1988) 73 *Cornell LR* 170 at 193. New Zealand statistics do not separate out medical claims from all other claims so it is not possible to come to a conclusion on this issue. See below nn195 at 196.

190 Danzon, above n27 at 20. See also the *Harvard Medical Practice Study*, above n108 which found that 27.6% of adverse results involved negligence.

191 Danzon, above n27 at 24.

192 Keeton argues that this factor would be an influence towards a social security type system, Keeton, above n185 at 594.

193 *Accident Compensation Act* 1982 (NZ), s2.

194 The difficulties involved are discussed in Ison, T G, *Accident Compensation A Commentary on the New Zealand Scheme* (1980) at 23-29.

195 Vennell, M A, "Medical Injury Compensation under the New Zealand Accident Compensation Scheme: An Assessment Compared with the Swedish Medical Compensation Scheme" 2nd International Conference on Health Law and Ethics, London 17 July 1989 at 20.

196 Oldertz, C, comment in Mann and Harvard, above n140 at 67.

197 In Sweden, common law claims were not abolished with the introduction of no-fault insurance. In 1989 it was reported that in about 10 cases legal proceedings had been brought since the inception of the scheme, see Oldertz, C, "Compensation for Personal Injuries — The Swedish Patient and Pharma Insurance" in Mann and Harvard, above n140 at 31. Claims were made outside the scheme on the basis that the no-fault insurance does not

encouraged to be more honest and open about the circumstances surrounding the injury. But it might be objected that if the practitioner sees no risk of disciplinary or other proceedings, it is possible that this may result in a practitioner interpreting the circumstances favourably for the patient, after all the practitioner has nothing to lose.[198] Increasing emphasis on discipline and accountability to achieve accident reduction may change this benevolent attitude. There is also the risk that injury may simply be accepted as a consequence of the initial disease or medical condition when expert advice, if tested, may yield different results.[199]

One attempt to overcome causal difficulties in the context of a proposed insurance based scheme has been to provide an advance listing of events which attract compensation the designated compensable event system.[200] The events attracting compensation would be readily identifiable and compensation paid without the necessity of proving fault. But not all adverse effects of medical treatment would qualify as compensable events. In order to provide incentives for better treatment the scheme envisages that events would only be added if medical opinion accepted that the event was usually avoidable by good quality medical care.[201] The list was compiled by reviewing the most common surgical complications and considering them in the light of a series of questions:

1. To what extent is the incidence of this complication related to the technical skill, judgment, or attentiveness of the surgeon?
2. Is this complication a clinically distinct entity? Can its existence be readily substantiated?
3. How early in the post-operative period is this complication detectable?
4. How costly are the sequelae of this complication?
5. Would an incentive to minimize the occurrence of this complication bias the choice of treatment in unfortunate ways?[202]

For example, the proposed list of compensable events include the following: General (1) Foreign bodies acquired intra-operatively (2) Burns acquired intra-operatively.[203]

The principal criticisms of this proposal relate to problems of definition.[204] Only a small fraction of events could be sufficiently defined under any such system. Under the proposed system designated compensable events are by definition those which involve obvious error. But these claims present little

provide sufficient compensation even though it is assessed on a tort basis of compensation, Rosenthal, M M, *Dealing with Medical Malpractice — The British and Swedish Experience* at 257. Loss, subject to threshold and ceiling limits, are assessed in accordance with the rules governing tort claims generally, see Mann and Harvard, above n140, App2, Patient Insurance #5, at 217.

198 There is some evidence this was occurring in New Zealand, *Report of the Accident Compensation Corporation*, 31 March 1990 at 22.

199 Simanowitz, above n4 at 149-151.

200 Havinghurst, C C, "Medical Adversity Insurance: Has its time come?" 1975 *Duke LJ* 1233-1280

201 Id at 1254. Other qualifications on inclusion may also be necessary to prevent distortion, id at 1255.

202 Id at 1256 n71.

203 Id at 1257.

204 See Danzon, above n27 at 217-219.

difficulty under a common law system where they can be dealt with efficiently, at low cost and are usually settled out of court. The great bulk of cases involving high litigation costs are likely to be cases where there is a serious contest as to whether negligence exists. The designated compensable event system does not address these cases.[205]

Under no-fault compensation schemes for medical misadventure a much more serious difficulty is in defining the circumstances when compensation will be payable.

3. *Defining the Compensable Event*

In New Zealand[206] the compensable event, "personal injury by accident", is defined to include:[207] "(a)(ii) Medical, surgical, dental or first aid misadventure", and to exclude: "(b)(ii): Damage to the body or mind caused exclusively by disease, infection, or the ageing process".

The term "misadventure" coupled with the requirement of an "accident", if read restrictively, can severely limit the range of potential claimants.[208] Medical misadventure has been interpreted by the New Zealand courts to include a mischance or accident, unexpected and undersigned, relating to medical treatment and arising out of a lawful act.[209] The scheme does not compensate for unsuccessful treatment if the results are within the normal range of medical or surgical failure:

> All treatment, whether medical or surgical has a chance of being unsuccessful. There is an expected failure rate in all these matters and such failure may be because no matter how correct the treatment, nature does not always respond in the desired way. It would be quite beyond the intention or wording of the Accident Compensation Act that cover should be granted on the basis of personal injury by accident because medical treatment was not 100 per cent effective. Certainty cannot be underwritten.[210]

A more generous interpretation of the compensable event admits a claim where, from the point of view of the patient, things "turned out badly".[211] An

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205 Id at 217-219.

206 See generally, Palmer, G, *Compensation for Incapacity, A Study of Law and Social Change in New Zealand and Australia* (OUP); Ison, T G, *Accident Compensation A Commentary on the New Zealand Scheme* (1980); Klar, L, "New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective" (1983) 33 *Univ Toronto LJ* 80; Brown, C, "Deterrence in Tort and No-Fault: The New Zealand Experience" (1985) 73 *Calif LR* 976; Vennell, M A, "Medical Injury Compensation under the New Zealand Accident Compensation Scheme: An Assessment Compared with the Swedish Medical Compensation Scheme" (Paper presented to the 2nd International Conference on Health Law and Ethics, London July 17, 1989); Vennell, M A, "Medical Misfortune in a No-fault Society" in Mann and Harvard, above n140 at 33.

207 *Accident Compensation Act* 1982, (NZ) s2.

208 See discussion in Palmer, above n206 at 256-258.

209 Notes on "Personal Injury by Accident" [1981] NZACR 242 at 243 approving dicta of Blair J in Appeal by Collier SM, (1976) NZAR 130, *Accident Compensation Commission v Auckland Hospital Board* and *M* [1980] 2 NZLR 748. The problem of informed consent and failure to treat or appropriately diagnose have presented continuing difficulties in this context, see Vennell, "Medical Misfortune in a No-fault Society" above n206 at 45-49.

210 *Accident Compensation Commission v Auckland Hospital Board* [1980] 2 NZLR 748 at 751.

211 Vennell, M A, above n209 at 43-44 discussing *McDonald v Accident Compensation Corporation* (1985) 5 NZAR 276.

adverse consequence from a known risk which could have been avoided will qualify as misadventure.[212] Where the adverse consequence is statistically rare, its occurrence will also qualify.[213] It should be noted, however, that in 1980 the percentage of claims declined under the New Zealand system was said to be less than 4 per cent and in a number of those declined the reasons for rejection were such matters as the accident occurring before enactment.[214] This rejection rate is very low in contrast with the 42 per cent rejection rate in Sweden.[215] It is possible that the New Zealand rejection rate does not accurately show the number of claims excluded by the scheme; potential claimants may have decided not to lodge a claim following advice that the claim is not compensable. Additionally since medical practitioners perform a gate-keeping function, a claim might not have eventuated because of lack of advice, information or dissuasion at that stage.[216] The reverse is, however, apparently true; injuries which would not have satisfied the statutory definition had been certified as constituting injury by accident.[217] The Corporation in its Annual Report for the year ended 31 March 1990 commented that the definition of personal injury by accident in the minds of the health care providers had become "very much expanded".[218]

Three common criticisms of the New Zealand scheme are first, that the scheme embodies an unjustifiable "accident" preference.[219] Secondly, where there is identifiable negligence this will almost invariably qualify as misadventure as for example, where defective equipment is used[220] or there is a failure to use proper procedures.[221] Patients who suffer adverse consequences within the anticipated range of results will not be compensated

212 Vennell, id at 44.

213 Ibid, discussing *Viggars v Accident Compensation Corporation* (1986) 6 NZAR 235, 1% risk of stroke during carotid arteriogram classified as misadventure.

214 Sandford, K L, "Personal Injury by Accident" [1980] *NZ LJ* 29 at 30.

215 See *below* n231.

216 A claim for accidental injury must be supported by a medical certificate that "personal injury by accident" has been suffered, this may expose the practitioner responsible for the injury to disciplinary proceedings, but as pointed out by Gellhorn a liberal interpretation of accidental injury allows recovery of no-fault compensation and bars a common law claim, see Gellhorn, above n189 at 192. Apparently, in Sweden more physicians and nurses themselves submit reports, Rosenthal above n197 at 256. Where claims are lodged directly with the insurer medical professionals are less vulnerable than in a system where claims are lodged with a body who both receives complaints, initiates disciplinary proceedings and recommends compensation, see NSW Dept of Health, Complaints Unit, *Annual Report* 1989.

217 The Accident Compensation Corporation up until recently was entitled to rely on a certificate that treatment was for personal injury by accident. Regulations coming into effect 1 December 1989 places the responsibility on the Accident Compensation Corporation to monitor the legitimacy of each claim, *Report of the Accident Compensation Corporation* 31 March 1990 at 22.

218 Ibid.

219 See discussion by Ison, above n196 at 21-22. The New Zealand Law Commission has recommended that compensation be extended to the sick and disabled, Law Commission *Personal Injury: Prevention and Recovery*, (1988) Report No 4, Wellington par7 at xiii.

220 See Vennell "Medical Misfortune in a No-Fault Society" above n205 at 43 discussing *Accident Compensation Commission v Auckland Hospital Board and M* [1980] 2 NZLR 748 failed tubal ligation when defective forceps used; *Re Muir* [1981] NZACR 828 (hepatitis resulting from unsterile instrument) cited id at 62 n80.

221 But there are rare cases which have been held not to come within the definition and which have subsequently succeeded at common law, see *E's Claim* 1980 Sept ACC Rep 59 (omission to treat) cited and discussed by Vennell, above n203 at 47-48.

unless it is possible to point to something akin to negligence in carrying out the treatment. This re-introduces the negligence preference. A third criticism is that there is no sound reason for refusing compensation where an adverse consequence is within the anticipated range of results. Recognising this, the New Zealand Law Commission has recommended that compensation be extended to injury occurring as part of the normal and expected risks associated with medical treatment:[222]

> Medical mishap should not be excluded simply because in advance there was some recognised risk of the therapy any more than the risks of using the highway could sensibly disqualify victims of road accidents.[223]

The New Zealand Law Commission has recommended the redefinition of the compensable event to overcome these criticisms. Under the proposed legislation, "a misadventure in connection with medical, surgical, dental or first aid treatment, care or attention of a person is also personal injury"; personal injury is defined with reference to a detailed specification of injury causes taken from the World Health Organisation's (WHO) International Classification of Diseases.[224] But as one commentator points out the use of such words as "accidental" and "excessive" reintroduce uncertainty; moreover the Classification does not address questions of lack of informed consent or failure to disclose information.[225] The majority of injury causes listed such as foreign objects left in body, failure of sterile precautions would give rise to cases of prima facie negligence. The list extends to "abnormal reaction of patient, or of later complication caused by surgical operation and other surgical procedures, without mention of misadventure at the time of operation".[226] Several problems are raised by this definition: first, what is "abnormal"; secondly, proof of causal connection between the operation or procedure and the later complication and thirdly, the relevance of the reference in the item of the phrase "without mention of misadventure at the time of the operation". Does this mean that if the patient is alerted to possible misadventure, the complication no longer qualifies as a relevant cause of injury? This would be a very curious result. Exceptions under the WHO's classifications include the following: E873: accidental overdose of drug, medicinal or biological substance, E878-879: abnormal effect caused by anaesthetic management properly carried out. Putting aside the difficulties resulting from the use of such terms as "accidental", "abnormal" under a no-fault system injuries resulting from these procedures should not be excluded simply because no-fault was involved.

Under the Swedish scheme compensability is not cast in terms of medical misadventure. The Swedish Patient Insurance Scheme together with a Pharmaceutical Insurance Scheme[227] were introduced in 1975. The Patient

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222 Law Commission, New Zealand, *Personal Injury: Prevention and Recovery*, Report No 4, Wellington pars8, 27, 165-166.

223 Ibid.

224 Ibid, par8 at xii-xiii. This follows recommendations of the Australian *Woodhouse Report* above n87, Vol 1 at 246. The recommendations of the report were never implemented.

225 Vennell, above n195 at 16.

226 E878, contained in Law Commission, New Zealand, *Personal Injury: Prevention and Recovery*, Report No 4, Wellington at 178.

227 For descriptions of the scheme see Hellner, above n180; Oldertz, above n87; Mann and Harvard, above n140, App2 at 216. A useful summary is provided by the SA Task Force Report, above n1 at 42-46.

Insurance Scheme involves voluntary insurance by health care providers and provides no-fault top up compensation over and above a generous social security system.[228] Whilst an insurance based system has the advantage of flexibility[229] and is less susceptible to political influence[230] it suffers from many of the same deficiencies as the New Zealand legislatively based system. In addition to the difficulties in proving that the injury resulted from medical intervention,[231] compensation for injuries will be available in circumstances which to a substantial degree parallel negligence tests of avoidability.[232]

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228 Under the Swedish social security system a worker is paid 90% of lost income during sickness or disability, id at 45.

229 Hellner, above n180 at 625. Flexibility also carries some risks as the insurer is also the assessor of claims with no representation of patient interests, id at 626.

230 Calabresi, G, "Policy Goals of the 'Swedish Alternative'" (1986) 34 *Am J of Comp Law* 657 at 662. These agreements are not directly regulated by the State although the State may be in a position to influence the scheme, Hellner, above n180 at 626. Note the experience in New Zealand when levies for motor cycle riders were to be raised to reflect the rate of injury for cyclists, see Trebilcock, above n111 at 19, 34.

231 For the first six months of 1988, 25,349 injuries were not compensated. Reasons for refusal were: not caused by treatment (4,420), not possible to avoid (3,376), barred by the statute of limitations (2,364), costs to be paid by other insurance (2,115), injured not maintained the claim (1,490), a consequence of the basic disease (1,293), not caused by incorrect diagnoses (986), not on the sick list for the minimum stipulated time (897), occurred before the scheme (846), accidents caused by the medical care (sic) (714), consequence of an intentional risk taking (571), caused by pharamaceuticals (301), loss less than the deductible amount (129), claimant was not a patient(63): in Mann and Harvard, above n140, Appendix 6, Table 19 at 253.

232 Details of the scheme can be found in Mann and Harvard, above n140, Appendix 2 at 216. The indemnity provisions as of 1 April 1988 provide:

#1 Indemnity for a treatment injury shall be paid to a patient who is injured in direct connection with health and medical care, or to the survivors of such a patient, in accordance with the following conditions.

#2 A treatment injury shall be understood to be an injury or disease of a physical nature which:

2.1 has occurred as a direct consequence of an examination, treatment or any other similar procedure, on the condition that it does not constitute an unavoidable complication of a measure which was justified from a medical viewpoint;

2.2 has occurred as a direct consequence of a diagnostic measure, unless the complication reasonably must be accepted as a consequence of such a risk-taking because it was motivated by the nature and severity of the injury or disease to be treated and the general health status of the patient;

2.3 has occurred or has been impossible to prevent as a consequence of the fact that examination results obtained by means of technical equipment were incorrect or symptoms of illness actually observed in connection with the diagnosis were not interpreted in a manner which corresponds with generally accepted medical practice;

2.4 has been caused by an infection due to an infectious matter that was probably transmitted to the patient by means of health and medical care measures, but not if the infection is a consequence of:

- an operation or other measure in the intestines, oral cavity, respiratory system or other area which, from a bacteriological viewpoint, is deemed unclean;
- an operation in tissue which had considerably reduced vitality or other similar characteristics;
- a treatment which causes an increased risk of infection such as prolonged catheterisation, drainage, external fixation, traction, transplantation surgery, etc;

2.5 has been caused by an accident:

- as a consequence of a sudden external event which has a connection with an examination, treatment or any other measure that has been undertaken by the medical personnel;
- that occurred during the conveyance of the patient;
- that occurred in connection with a fire or other kind of damage to the health care facilities

Like the New Zealand scheme, not all adverse injuries resulting from medical intervention are compensable; unavoidable risks of medically indicated treatment are not recoverable.[233] Under the Swedish scheme approximately 42 per cent of claims are rejected.[234] Calabresi, in discussing the Swedish system, describes the choice of who receives extra compensation as "haphazard and unprincipled" which will inevitably lead to expensive border-line cases requiring case by case determination.[235] It is also of interest that problems of definition and proof of causal relationship exist under the UK *Vaccine Damage Payments Act*. It was reported that only 13 per cent of initial determinations resulted in payment; of the rejected claims half were appealed and 72 per cent of those appeals were upheld.[236]

4. *Deterrence, Accident Reduction and Accountability*

No-fault schemes can be tailored to achieve a number of goals. Aside from the primary goal of compensation, funding arrangements can be used to provide economic incentives to accident reduction. This potential benefit has not been utilised by the New Zealand scheme. In New Zealand there is no direct contribution to the scheme by health care providers[237] and consequently no attempt to allocate costs to the risk creating enterprise nor to provide economic incentives to avoid accidents either at the organisational or individual level. In Sweden the Patient Insurance Scheme provides top up compensation over and above a generous social insurance system. As most

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or equipment, or as a result of a defect in the medical equipment.

#3 However, a treatment injury shall not be understood to mean an injury or disease which:

3.1 is a consequence of a necessary risk-taking, from a medical point of view, for diagnosis or treatment of an injury or disease, which if untreated, is life threatening or entails a risk of severe disability;

3.2 to a preponderant extent, other than those cases mentioned in 2.3, has its origin in or is caused by a disease or comparable condition in the patient;

3.3 has been caused by a drug to which the drug regulations apply and which in view of the directions for use of the drug could not be avoided.

233 See the previous footnote.

234 Under the Swedish system in the period 1 January 1975 to 1 July 1986 it was estimated that approximately 44,647 cases leading to medical complications were reported, of which about 18,054 did not receive compensation. Of the remaining total of 26,593 injuries, 22,252 received compensation but no decision had been made in 4,341 cases because of incomplete investigation. It was estimated that the total number of indemnifiable injuries which occurred during 1986 would be approximately 4,000. This contrasts with an average of 10 cases per year receiving compensation prior to introduction of the patient insurance scheme, Oldertz, above n87 at 637, 655. A higher percentage than the earlier reported 62% of the injuries are now being compensated, Rosenthal, above n197 at 256. In 1988 it was stated that the frequency of reports continued to rise although the rate of rise had begun to slow down, ibid. Under the similar but not identical Finnish legislatively based scheme some 62% of claims were rejected in the first full year of operation, Mann and Harvard, above n140, Appendix 10 at 272. For details of the scheme, see Brahams, D, "No-Fault Compensation in Finland with an Overview of the Scandinavian Approach to Compensation of Medical and Drug Injuries" in Mann and Harvard, above n140.

235 Calabresi, above n230 at 663.

236 Lee, R G, "Liability for Vaccine Damage in Great Britain" Proceedings VIIth World Congress on Medical Law, Ghent, 1985, 3, 162-8 cited Palmer, R N, "Faults in No-Fault Compensation Schemes" in Mann and Harvard, above n140 at 163. See also Wall, Dr J A, comment, id at 116 regarding the problems of the Florida Birth Related Neurological Injury Compensation Plan.

237 Vennell, M A, above n195 at 18.

compensation is paid through social insurance (rather than under the Patient Insurance Scheme) without direct contribution by health care providers there is limited deterrence.[238]

This is not to deny that a no-fault scheme may set up independent mechanisms to achieve accident reduction. The New Zealand Accident Compensation Corporation was intended to have an important role in accident prevention, but it has not been an effective force in this regard.[239] Nor, with respect to the Swedish scheme, is there hard evidence that accident prevention has been enhanced.[240]

Neither scheme itself provides for accountability by medical service providers. Accountability may be as important a value as compensation to the victims of medical misadventure.[241] Other mechanisms directed to deterrence, accident reduction and accountability will be referred to later.[242]

Part E
The South Australian Task Force's Approach to No-Fault

1. *Introduction*

The South Australian Task Force on No-Fault Liability was of the view common law liability for medical misadventure should be abolished and subject to cost factors there was much to commend the establishment of a statutory based no-fault scheme administered by a government appointed statutory board.[243]

2. *The Compensable Event*

The Task Force recognised the difficulties of maintaining equity between injured patients if patients were denied compensation for injury or loss simply because of a known risk of adverse consequences. Limits on compensation payable would be preferable to introducing illogical limitations on compensability.[244] The Task Force were of the view, however, that deterioration through sickness or disease should be excluded as well as inevitable consequences of treatment, for example, hair loss through chemotherapy.[245] The Committee did not find it necessary to define the ambit for compensation in terms of misadventure.[246] The Task Force recommended that if a new scheme were introduced compensation should be payable for "any injury or loss arising out of or caused by health treatment or care".[247] Phraseology such as

238 Calabresi, G, above n230 at 663-664. In Sweden premiums correspond to compensation paid out and are assessed according to category, Oldertz, C, above n87 at 655.
239 Law Commission, New Zealand (1988) *Personal Injury: Prevention and Recovery* Report No 4 par5 at xi.
240 Ham, C, "Should A No-Fault Compensation Scheme Be Introduced & What Would It Cost" in Mann and Harvard, above n140 at 99, 103-104.
241 Simanowitz, above n4 at 145.
242 See Part E(4) The South Australian Task Force's Approach to No-Fault, Deterrence, Accident Reduction, Accountability, below.
243 Report of the Task Force on Patients' Rights, above n1 at 63-64, 70.
244 Id at 61.
245 Id at 60.
246 Ibid.

this may generate expensive and continuing litigation as to the scope of coverage; difficulties in proving the relevant causal relationship are likely to remain.[248]

3. *The Compensation Goal*

Under the suggested scheme the expressed goal is to attempt to restore an injured person to her or his pre-accident position having regard to the need to:

- provide rehabilitation as a paramount objective;
- ensure that the compensation provided does not exceed the limits of resources in the health care area;
- give priority to the long term requirements of people sustaining serious and permanent disability and incapacity.[249]

Can these objectives be attained? The majority of injuries sustained by patients in the course of medical treatment are minor. In the 1974 Californian study[250] of all iatrogenic injuries approximately 36 per cent of such injuries were classified as resulting in a minor temporary disability, that is a disability not exceeding 30 days and not requiring surgery.[251] In the 1984 GAO study of closed negligence claims 15.7 per cent related to emotional or insignificant injury with a further 30 per cent involving minor temporary disability.[252] In the Harvard Medical Practice Study, a sample of persons injured in 1984 in New York State hospitals showed that 57 per cent of adverse results were of a minor temporary nature.[253] Administrative costs of dealing with minor claims are very substantial and the Taskforce in suggesting threshold limits excludes minor claims on the basis that resources ought to be directed to those with greatest need. Recommended threshold limits would exclude minor injuries or loss such as a few days' absence from work, or minimal medical expenses.[254]

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247 Ibid.

248 Keeton, above n185 at 614-615; O'Connell, J and Partlett, D, "An America's Cup for Tort Reform? Australia and America Compared" (1988) 21 *J of Law Reform* 443 at 483.

249 Report of the Task Force on Patient's Rights, above n1 at 68.

250 In the Californian study, the following classifications of severity of injury were adopted, under each heading the number of injuries per 1,000 admissions and the percentage of injuries within that severity index is added in brackets: 1 — Minor Temporary Disability: not exceeding 30 days and not requiring surgery (16.3 per 1,000, 35.8%); 2 — Minor Temporary Disability: not exceeding 30 days but requiring surgery (11.94, 25.7%); 3 — Major Temporary Disability: lasting more than 30 days but no longer than 2 years (8.62, 18.6%); 4 — Minor Permanent Disability: most functionally nondisabling disabilities (3.02, 6.5%); 5 — Major permanent Partial Disability: substantial damage, but not sufficient to cause complete loss of ability to perform most ordinary functions (1.06, 2.3%); 6 — Major Permanent Total Disability: substantial damage, usually sufficient to alter patient's life-style into a dependent position (0.38, 0.9%); 7 — Grave Permanent Total Disability: complete dependence or a short term fatal prognosis (0.34, 0.6%); 8 — Death (4.51, 9.7%). Details are contained in Danzon, above n27 at 21. The figures must be treated with some caution because of the size of the sample (970 injuries), ibid.

251 *California Medical Association: Medical Insurance Feasibility Study* (1977). The study is discussed by Danzon, above n27 at 20-25. Danzon notes that the estimates are likely to be very conservative. Where there is a high proportion of elderly patients more fatal injuries are likely, see Pocincki, et al, above n75, Appendix at 56-57.

252 US General Accounting Office, above n23 at 24.

253 14% of patients deaths were related to an adverse event, 9% had a disability which lasted longer than six months. The balance had moderate or permanent impairment, *Harvard Medical Practice Study* above n70 at 8.

Under the Taskforce proposal, economic losses would be compensated at a rate of 80-85 per cent of earnings on a periodic basis and hospital and other medical costs met as they arose.[255] As in most no-fault accident plans, loss of earnings is discounted to provide incentive to return to gainful employment. Pain and suffering and loss of enjoyment of life would not be compensable except for permanent disability.[256] Using the Californian study figures as a guide, excluding patients who died as a result of medical treatment, approximately 80 per cent of potential claimants under a no-fault scheme would be barred from making a claim for pain and suffering.[257] This will have the effect of excluding a very substantial number of claims by the unemployed particularly the elderly, the majority of whom are women. They are the largest health consumers[258] and therefore the most likely to sustain injury through medical treatment.

The scheme proposed by the South Australian Taskforce directs benefits to those most in need. The costs of offering a broadly based scheme will be, at least partially, offset by eliminating small claims. This threshold requirement is extremely important in maintaining cost effectiveness and preventing abuse of any scheme.[259] The views of the Taskforce attack many of the criticisms directed to tort-based compensation. Two fundamental objections remain. First the fundamental issue of equity: why should victims of medical misadventure be given preference over other victims? If the costs of the proposed scheme can be contained within the existing expenditure by Government on social security benefits and medical health providers through liability insurance, then the benefits of such a scheme might outweigh the discrimination against those afflicted with illness and disease. It is difficult to see how the new scheme could be funded within the existing financial constraints even with economies resulting from imposing threshold limits and limiting recovery of non-economic losses to the permanently injured or disabled. A second objection is the loss of individual deterrence and incentives to accident prevention.

4. *Deterrence, Accident Reduction and Accountability*

Another negative feature of the proposed scheme is that individual deterrence may be lessened through the removal of the embarrassment factor,[260]

254 Report of the Task Force on Patients' Rights, above n1 at 69.

255 Ibid.

256 Ibid.

257 See above n250. See also the GAO report which indicates that by limiting recovery of pain and suffering to those with permanent disability this would exclude 56.8% of negligence claims, US General Accounting Office, above n23 at 24.

258 In the year 1988-1989 women in-patients had an average per capita user rate of medical services of 10.4 as against 6.7 for men, Dept of Community Services and Health, *Annual Report 1988-1989*, Medicare: Summary of Selected Key Statistics for Services Processed 1984-5 to 1988-89, table 56 at 32. In a given period within the 12 months prior to interview, persons 65 and over comprised 20% of hospital admissions, Aust Bureau of Statistics, *Australian Health Survey* (1983) chart 1 at 18.

259 See for example, the alleged abuses under the New Zealand scheme where there was a a 92% increase in lost time work absences, mostly short term, by workers in the meat freezing industry in the two years following the adoption of the scheme, compared with the previous two years, Ison, above n194 at 73-75.

260 See nn96-100 and related text. The Task Force said that it could find no evidence that in New Zealand the removal of the threat of being sued led to lower professional standards by

although it is suggested adequate deterrence exists through financial responsibility for the scheme by health care providers and the maintenance and strengthening of quality assurance and disciplinary proceedings.[261] There are already in place a number of mechanisms which may assist in accident reduction. First, self-regulatory mechanisms such as medical audit and peer review are available. Secondly, disciplinary tribunals as Medical Boards may have a role to play in accident prevention. It is in this context that Complaints Units have assumed importance in referring complaints to disciplinary tribunals and in New South Wales assuming a prosecutorial role in disciplinary matters.

The first of these mechanisms in the context of quality assurance programs is becoming of increasing importance, particularly in the public health sector.[262] How far these mechanisms provide an effective force in injury reduction is unknown. In 1983 the *Sax Report*, reporting on quality assurance in South Australia said:

> Mechanisms set up with quality assurance as their explicit purpose may also serve other functions. For example, establishing a programme of regular audits or review sessions may create an appearance of self-regulation and so serve to stave off pressures for structural reform. There are well documented examples from the USA where the patient care review function became very much subordinate to the primary purpose of creating an appearance of self-regulation. There are grounds for concern that the same influence in Australia could so distort review mechanisms that they serve as obstacles to accountability rather than facilitating it.[263]

Medical audit and peer review systems have the capacity to be effective methods of accident reduction but only if the findings and decisions of these groups can be satisfactorily implemented within the institution. Empirical evidence in Australia is not available on this issue.

Medical Boards and Tribunals have historically been concerned more with "personal conduct derogatory to the reputation of the profession" than questionable clinic practice.[264] The problem lay largely[265] with the restricted statutory jurisdiction of tribunals to deal with professional misconduct. Mere negligence, which was not the subject of professional reprobation, did not qualify as "professional misconduct" for the purposes of these regulatory

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medical health providers, above n1 at 68. But it should be noted that this information was derived from hospital and health department administrators and the New Zealand Medical Association rather than consumers, id at 77. Cf the results of a survey in the United States which elicited responses from medical practitioners and lawyers about their own perceived deviations from standards of care and those of their colleagues, Peters, et al, above n98 at 609.

261 Report of the Task Force on Patients' Rights, above n1 at 80.

262 See Health Dept Vic, *Quality Assurance in Health Care in Victoria* (June 1987), Health Dept Vic, *Quality Assurance in Hospitals* (March 1989); *Health Administration (Quality Assurance Committees) Amendment Act* 1989, NSW and critical assessment of the South Australian position by the *Sax Report (Enquiry into Hospital Services in South Australia)*, (1983) at 35-38, 75-82. See also Report of the Task Force on Patients' Rights (SA, November 1987) at 17-18.

263 *Sax Report*, above n7 at 35-38, 75-82.

264 Rosenthal, above n197 at 226.

265 The South Australian Medical Board explained its reluctance to take up actual complaints of unprofessional or incompetent practice on the basis that most cases end up on appeal in the Supreme Court which is time consuming and costly, Report of the Task Force on Patients' Rights, above n1 at 79.

statutes.[266] In Victoria, the Health Service Commissioner in the first 15 months referred 11 complaints to the Medical Board. The Health Service Commissioner, however, commented that such referrals to the various disciplinary boards were not satisfactory because:

> [T]he existing registration Acts are anything but consistent, the powers of the boards are ill-defined, and the sanctions available to them are inappropriate to most consumer complaints. This Act *(Health Services (Conciliation and Review) Act* 1987, Vic) assumes that the boards form part of a health complaints system, but their own Acts do not justify that assumption. Early completion of the current review of registration boards is essential to the complaint structure established by this Act.[267]

In New South Wales and Queensland the definition of professional misconduct has been extended to cover negligent conduct[268] but there is still nevertheless some uncertainty about how far negligence can qualify as professional misconduct.[269] The structure of New South Wales Medical disciplinary tribunals provides flexibility and powers which could fulfil both a deterrent and an educative function in dealing with negligent conduct.[270] Conduct not warranting suspension or deregistration of a registered medical practitioner may be referred to the Professional Standards Committee of the Medical Board[271] which can investigate individual complaints of negligence or deviation from professional standards. If the complaint is proved the Committee has a wide range of remedies. The Committee can fine, reprimand, require counselling, impose conditions on registration, require completion of specified educational courses, require report to persons specified and order that the person seek and take advice in relation to the management of her or his medical practice.[272] It should be pointed out, however, that isolated acts of negligence not demonstrating a general lack of adequate knowledge, experience, skill, judgment or care would not constitute professional misconduct. These boards can only constitute an effective force in accident reduction if medical practitioners, the public and health and related authorities report instances of substandard medical care. Reluctance of medical practitioners to report colleagues is understandable but not conducive to maintaining quality of care.

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266 See *Qidwai v Brown* [1984] 1 NSWLR 100; *Pillai v Messiter* (No 2) (1989) 16 NSWLR 197.

267 Health Services Commissioner, Victoria, *First Annual Report* (1989) at 11.

268 The *Medical Practitioners Act* 1938 (NSW) s27(1) provides that "professional misconduct" includes (a) any conduct that demonstrates a lack of adequate knowledge, experience, skill, judgment or care, by the practitioner in the practice of medicine. See also *Medical Act* 1939 (Qld), s35(xii).

269 The New South Wales Medical Board has recommended (recommendation 26) "That, in considering complaints of professional misconduct, Professional Standards Committees and the Medical Tribunal be empowered to arrive at a lesser finding of 'unsatisfactory professional conduct' in cases where the practitioner's conduct, while not satisfactory, has not been such as to incur the strong reprobation of his peers of good standing and competence": see NSW Medical Board, "Proposals for the Introduction of A New Medical Practice Act" *A Discussion Paper* March 1990 at 26-27 and Annexure G.

270 *Medical Practitioners Act* 1938, (NSW) s27(1).

271 *Medical Practitioners Act* 1938, s32B.

272 *Medical Practitioners Act* 1938, s32I and see NSW Health Dept, Complaints Unit, *Annual Report* 1989 at 29.

In recent years the establishment of Health Complaints Units have provided an important avenue for referral of complaints to the relevant Medical Boards and Tribunals in Victoria and New South Wales. In New South Wales the Complaints Unit was established "to examine alleged instances of malpractice, negligence or abuse and recommend a Departmental response".[273] Its essential role was seen as a prosecutorial body[274] although only very few complaints lead to prosecution.[275] In 1989 the Complaints Unit appeared before the Medical Tribunal in ten complaints lodged by the Unit and one matter referred by the Medical Board.[276] The Complaints Unit within the New South Wales Department of Health provides an integrated approach to dealing with complaints. The addition of a power to conciliate complaints[277] is proposed. Unlike the Victorian Health Services Commissioner, it is not envisaged that the Unit will have power to recommend payment of compensation. The Unit has a very important function in assessing and reviewing patient care. As a result of investigation by the Unit of Accident and Emergency Centres, new guidelines for their operation were proposed by the Unit and announced by the Minister for Health.[278] The Complaints Unit provides an important mechanism for accountability of medical service providers. Where complaints relate to Health Department staff the Unit advises the Human Resources Division of the Health Department of a complaint and, upon conclusion of any investigation, the outcome of that investigation. The Unit's co-operative relationship with other sections of the Department of Health is dependent upon continuing good will of the Department and the Minister concerned. The lack of statutory status and the position of the Unit within the Department of Health make it potentially vulnerable. The Unit's efficiency is also hampered by lack of co-operation by medical practitioners' legal advisers to enquiries from the Unit.[279] This, together with opposition by medical practitioners to the expansion of the Unit's powers,[280] make it uncertain whether an integrated approach to dealing with complaints will eventuate in New South Wales. As the Complaints Unit

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273 Health Dept, New South Wales, *Circular No 84/7*, 11 January 1984.

274 Authority to act as complainant before the Medical Tribunal is given by the *Medical Practitioners Act* 1938 (NSW), Sch4 cl8. Clause 8 provides that in any proceedings before a Committee or the Tribunal, the Secretary or an officer of the Dept of Health appointed by the Secretary may, with the consent of the complainant, act as the nominal complainant and when so acting is deemed for the purposes of the Act and proceedings to be the person who made the complaint. Where a complaint is lodged, the Crown Solicitors Office is briefed, NSW Dept of Health, Complaints Unit *Annual Report* 1989 at 7. The Director of the Complaints Unit has delegated responsibility for the investigation of complaints against medical practitioners, ibid and see *Medical Practitioners Act* 1938 (NSW) ss13, 32A.

275 Of the complaints received in 1987 only 25% (27) led to some form of prosecution, Phillips Fox (Solicitors and Attorneys), *Review of Complaints Unit for the Dept of Health* (Mant or Fox Report) January 1989 at 1.

276 NSW Dept of Health, Complaints Unit *Annual Report* 1989 at 28.

277 At the time of writing legislation has not been introduced to achieve this object. A preferred approach by the Medical Board of NSW is the establishment of an independent Health Ombudsman or a Health Care Commissioner similar to that established in Victoria to conciliate complaints, see NSW Medical Board, "Proposals for the Introduction of A New Medical Practice Act" *A Discussion Paper* March 1990 at 28.

278 NSW Dept of Health, Complaints Unit *Annual Report* 1989 at 15-16.

279 NSW Medical Board, "Proposals for the Introduction of A New Medical Practice Act" *A Discussion Paper* March 1990 at 29.

280 Id at 28-29 and Appendix H.

itself points out, where claims are lodged directly with the insurer medical professionals are less vulnerable than in a system where claims are lodged with a body who both receives complaints, initiates disciplinary proceedings and recommends compensation.[281] This vulnerability explains the medical profession's opposition to the extension of the Unit's powers.

Complaints Units independently constituted with statutorily defined jurisdiction and powers may be a very effective force in promoting deterrence and accident prevention. The potential to provide an integrated approach to health complaints could prove to be cheaper and more efficient than common law actions. Whether this could be so may depend upon the extent to which state governments are prepared to adequately staff and fund such bodies and the extent to which these bodies retain the confidence of both medical service providers and the public. The role of the Victorian Health Services Commissioner in dealing with compensation claims has been referred to above.

5. *Funding*

In examining funding for a no-fault scheme for medical injury the Taskforce accepted the proposition that the scheme should be self-funded within the health care arena.[282] It acknowledged that it was politically unacceptable that medical practitioners should be relieved of the costs of their own errors. The Task Force envisaged continuing financial responsibility by medical care providers so as to encourage risk management and quality assurance programs to maintain standards and therefore reduce costs and claims.[283] But it was also accepted that not all costs of the scheme should be borne by health care providers. It would be reasonable for the Government to bear the establishment costs of the scheme. It was argued that the Government should contribute a "small percentage" of on-going costs in recognition of those claims where serious adverse consequences have occurred but where there is no demonstrable negligence by the medical service provider: "contributions should be based on estimated percentages of liability, (or areas of causation to use a more appropriate term)".[284] Contributions by government from consolidated revenue would also be warranted on the ground that the scheme would result in savings to the government of sickness and other social security benefits. The allocation of financial responsibility between government and medical service providers would be a matter for negotiation. This is very likely to be the sticking point. If contributions are to be based on estimated percentages of liability and, like the United States it is found that only one out of 10 potentially compensable events are the subject of a legal claim, what will the allocation be based on? If deterrence is to operate more closely to the ideal, it should be all potentially compensable claims rather than the few claims which are actually made and succeed.[285] If it is the former very substantial increases in contributions by health care providers must be expected. The result is likely to be a political judgment rather than any real

281 NSW, Dept of Health, Complaints Unit, *Annual Report* 1989.
282 Id at 4.
283 Id at 72.
284 Id at 73.
285 In South Australia it has been estimated that some 30-40% of claims made fail, see above n30.

attempt to allocate at least the costs of fault to the medical profession. Where costs are allocated across providers (as recommended by the scheme) it will have the effect that by far the majority of those compensated will be compensated out of public funds either by way of direct Commonwealth contribution or as a levy on the public hospital system representing malpractice costs. The effect is that a few injured as a result of medical misadventure will receive compensation for no-fault adversity out of the public purse; the majority of injured persons will be left with social security entitlements highlighting an unprincipled preference in favour of injured patients.

The approach adopted by the Task Force on the funding issue would find some support in the principle that the enterprise should bear the costs it engenders. Although the Task Force does not accept that medical providers should bear all the costs caused by the enterprise, even limited acceptance may serve a number of policy objectives. First, it might be thought unfair that providers should be completely relieved of liability by the government assuming financial responsibility. Secondly, the continuing contribution by medical service providers may provide economic incentives to implement risk reduction measures. Thirdly, the attribution of accident costs to the enterprise, bring about a more efficient allocation of resources such that the true costs of the product or service are reflected in its price; dangerous activities are priced out of the market.[286] There is, however, no certainty that these goals can be attained by this funding mechanism. As already pointed out the evidence available is, at best, equivocal on the question whether economic deterrence is effective in reducing accidents. Allocative efficiency cannot operate effectively when only part of the costs (common law claims) are to be borne by the enterprise and when there is substantial evidence (referred to above) that common law claims are only a very small proportion of negligently caused medical injuries.

6. *Cost*

Putting administration costs aside, the costs of claims under such a scheme are a function of a number of different variables: first, the number and severity of claims, secondly, the definition of the compensable event, and thirdly, threshold and ceiling limits on compensation. There are almost insuperable difficulties in assessing cost without clear information on each of these fundamental elements.

The South Australian Task Force on No-Fault Liability suggested that the number of compensable claims in South Australia under the proposed no-fault scheme could increase from 350 per annum to 550 per annum or more.[287] The Law Council of Australia estimates that claims under a no-fault system might escalate by 500–1000 per cent.[288] If the US figures referred to above are any indication there may be even larger numbers of claims. In the United Kingdom it has been estimated that if a Swedish style system were introduced there would be a claim rate of 60 per 100,000 with an abandonment rate of 50 per cent.[289] The Swedish system does not does not give a good indication of

286 For a readable and short critique of the allocative efficiency argument, see Sugarman, S D, *Doing Away with Personal Injury Law* at 65-68.

287 SA Task Force Report, above n1 at 74.

288 Law Council of Australia, above n40 at 6.

claim rates under a no-fault scheme in Australia. In Sweden there is a generous social security system and no-fault compensation is a claim of last resort after other claims have been exhausted.[290] This coupled with a wider definition of compensable event proposed by the South Australian Taskforce (see above) and the differing threshold and ceiling requirements make any comparison with Sweden unhelpful.[291]

The Insurance Council of Australia has estimated the cost of a no-fault medical misadventure scheme with the same criteria for eligibility as in New Zealand:

Table 2

Estimated Cost of Claims for a National No-Fault Misadventure Scheme

Year	$M
1986	607.9
1987	711.3
1988	1,151.7
1990	1,523.1
1995	1,911.8

These estimates from 1986-1988 are based on estimates of average claim costs under the present system. Estimates for 1990 and 1995 are based in an assumed increase of paid claims of 15 per cent per annum.[292] The 15 per cent rate of increase is based on the averaged out increases in common law claims over an extended period.[293] At best this will provide only a limited guide to costs. Increases in population, claims consciousness and the removal or amelioration of financial and other constraints inhibiting claims will all clearly affect growth in claims. The estimated costs are calculated on the anticipated rate for common law claims plus an assessment of how many are "missing out". The latter are determined by references to the number of

289 Ham, C, Dingwall, R, Fenn, P, Harris, D, *Medical Negligence, Compensation and Accountability* Centre for Socio-Legal Studies, Oxford, Briefing Paper No 6 (1988) at 33.

290 The provisions are contained in Mann and Harvard, above n140, Appendix 2, #5.7 at 218.

291 Under the Swedish scheme a treatment injury will be indemnified only if, as a consequence of the injury, the injured person has been put on the sick list with at least 50% incapacity for work for more than 30 days or, has been hospitalized for more than 10 days, or has suffered a relatively serious permanent disability or died. Treatment costs and loss of income in excess of $300 are indemnified subject to an automatic 5% reduction in the base amount before compensation. There is a maximum limit of $A30,000 The administrative cost for the insurance is reckoned at 14% of premiums. Of moneys paid in compensation in 1986, 60% related to non-economic losses including pain and suffering, loss of income 15%, medical costs, 15%, costs in relation to death about 2%. The average payment for 1987 was approximately $A8,000, Oldertz, above n87, Oldertz "Compensation for personal injuries — the Swedish patient and pharma insurance" in Mann and Harvard, above 140 at 13, 16 and Appendix 4 at 217; Rosenthal, above n197 at 256-257; SA Task Force Report, above n1 at 44.

292 Contrast the assumption of a 15% increase with the fluctuating New Zealand figures for claims relating to the supplementary account, that is, claims unrelated to earners and motor vehicle accidents, increases in percentage of claims were of the following order: 1983, 19%; 1984, 12%; 1985, 3.6%; 1986, 29.6%; 1987, 10% (from *Accident Compensation Corporation Annual Report* 1987 at 12) and for the year ended 31 March 1990, 19.5% (from *Accident Compensation Corporation Annual Report* 1990 at 23).

293 Personal Communication, Brown, G, Heath, C, Underwriters 13 November 1990.

claims made that are withdrawn or lost.[294] This would seem not to be a sufficient estimation of the number of potential claimants under a no-fault system (see above Part A, Iatrogenic Injuries).

On a state by state basis an estimate of the cost of these claims for the period 1986-1988 are as follows:[295]

Table 3

Estimated Cost of Claims of a No-Fault Misadventure Scheme by State for the Period 1986-1988

State	%	1986 $M	1987 $M	1988 $M
Victoria	30	182.3	213.4	345.5
New South Wales	40	243.1	284.5	460.7
Queensland	11	66.9	78.2	126.7
South Australia	8	48.6	56.9	92.1
Western Australia	7	42.6	49.8	80.6
Tasmania	2	12.2	14.2	23.0
Northern Territory	2	12.2	14.2	23.0

As with assessment of costs based on the Swedish scheme, the projected costs of an Australian no-fault scheme based on the New Zealand scheme are unlikely to be helpful where risk definition, eligibility requirements[296] and ceilings on recovery are different. It also cannot be assumed that the existence of fraudulent claims can be easily discerned in a much larger population. A lower iatrogenic rate for those countries is also possible.[297] The volume of high risk procedures may be greater in countries with larger populations. Other factors which may be of importance include, the extent to which there is governmental control of health services[298] and community attitudes to claiming for injury sustained.

Conclusion

As pointed out in Part A, there is inadequate statistical information about the rate, type and victims of medically induced injury. This prevents any realistic assessment of a no-fault scheme. But this is not the only objection to the

294 Ibid.

295 *Response on Behalf of the Australian Insurance Industry to the Task Force on Patients' Rights Report on No-Fault Compensation for Medical Misadventure*, November 1989, at 12.

296 The South Australian Task Force preferred not to use the notion of "accident" for defining eligibility and saw no reason to restrict eligibility to adverse results outside the normal risks resulting from the procedures, see above.

297 For example a lower surgery rate may result in fewer injuries; in the United States 28.8% of claims to the largest US malpractice insurer related to surgery: Committee for Ways and Means, above n25 at 18. New Zealand has a significantly lower health expenditure per capita in comparison to Australia. In 1985 New Zealand's per capital expenditure was approximately $US396 per capita as against approximately $US737 per capita in Australia, $US1124 in Sweden, $US1776 in USA: Australian Inst of Health, *Australian Health Expenditure* 1970-1971 to 1984-1985 at 18.

298 In Sweden there are relatively few doctors in private practice, SA Task Force Report, above n1 at 42.

South Australian Task Force's proposals. The following steps should be taken before proceeding to introduce a no-fault scheme for injured patients. First, local evidence of the number of injuries caused by medical service providers should be obtained. Surveys such as the type carried out in the United States in the Harvard Medical Practice Study[299] or the Medical Feasibility Study carried out by the Californian Medical Association in 1974[300] would provide significant information in relation to hospitals of the rate and type of injury sustained together with data on injured patients. But even with these sophisticated data collection systems the statistics obscure real difficulties in determining whether the injury has been caused by the provision of medical services or is the result of the original condition requiring treatment.

The injury rate caused by medical service providers other than hospitals is much less significant but nevertheless important in assessing the viability of a no-fault scheme. The collection of statistics by Medical Defence Associations and Unions provides useful information about the extent of negligence claims against their members. But as pointed out in Part A, this probably constitutes a fraction of all injuries sustained both negligent and non-negligent. We need to know the full picture before proceeding to any no-fault scheme.

Secondly, in assessing the effectiveness of any no-fault system, it is important to determine whether the factors restricting potentially actionable claims under the present common law system, (see Part A(2) Uncompensated Injuries) will continue to operate in a no-fault system. This will be critical in determining the cost of any scheme and also important on the issue of maintaining equity between victims. A study of the type conducted by the Oxford Centre for Socio-Legal Studies[301] would enable an assessment to be made whether these factors are operative within our own jurisdiction. If it could be shown, as it was in the Oxford study, that there is a bias against claims by the young, elderly and women, then the causes of such bias should be addressed. In so far as they relate to lack of information and advice, this clearly would, as a matter of equity, require remedy.

Thirdly, the common law fault-based system has been criticised as failing to adequately fulfil such objectives as providing fair and adequate compensation, maintaining equity between injured victims with similar needs and providing deterrence and incentives to accident reduction. In the context of medical malpractice claims it has been seen as counter productive to the establishment of quality of care standards and positively anti-social in its impact on the doctor-patient relationship. It is also argued that the common law regime leads to the practise of defensive medicine and in some cases the withdrawal of high risk medical services. Even if all these effects could be demonstrated we still must ask whether reform necessarily requires abandonment of the common law system. Whilst it is clear that some of the defects of the common law system could be ameliorated, one objection seen as fundamental by critics remains unresolved. It is that the system by requiring proof of fault fails to achieve equity between persons with equivalent needs. If the common law is to be abandoned as a basis for compensation for victims of medical injuries by the establishment of a

299 See above n70.
300 See above n72.
301 See above n28.

no-fault system of liability for injured patients, we must decide whether this preferential treatment can be justified. If the basis is one of need the evidence presented suggests that the disabled and ill have equivalent or greater needs. Before such important reforms are introduced, there should be widespread community involvement on this central issue — whether this group of victims should have preference over others with equivalent needs, in particular, the disabled and ill social welfare recipients.

Fourthly, if a no-fault scheme is introduced for victims of medically induced injury, it must be determined whether this scheme would be effective in addressing the objections directed at the common law system. On examination of existing no-fault compensation systems in New Zealand and Sweden, it is evident that not all victims of medically induced injury are compensated. In these schemes there remains the difficulty of proving that the injury resulted from the provision of medical services. In addition the definition of compensable event provides unwarranted restrictions on recovery of compensation and fails to meet the objective of providing compensation for persons with equivalent needs. The deterrence, accident reduction and accountability goals are no less a problem under no-fault schemes and evidence is lacking that these goals have been, or could be, furthered under a no-fault scheme.

Fifthly, the difficulties encountered under the New Zealand and Swedish schemes are also pertinent when the South Australian Task Force's recommendations are examined. Whilst the expanded definition of the compensable event avoids many of the difficulties encountered under the New Zealand and Swedish schemes, the lack of firm proposals setting out threshold and ceilings on recovery make the task of assessing the cost of any such scheme an impossible one. The proposals themselves do not directly address issues of deterrence, accident reduction or accountability preferring to leave these aspects to outside regulatory bodies. In this respect existing institutions do provide a basis for accountability although regulatory bodies such as Medical Boards and Tribunals have, in the past, been circumscribed by statutory limits on jurisdiction. Whether the extended jurisdiction of such bodies will have an impact in this area has yet to be demonstrated. Although the supposed deterrent effects of common law liability have proved almost impossible to quantify, it is argued that before the introduction of any no-fault scheme, existing disciplinary and regulatory mechanisms be assessed to determine whether they are effective.

Finally, an informed estimate of the costs of a no-fault system is essential before any reforms are undertaken. At this point of time such costing is impossible. First because the precise parameters of the no-fault scheme recommended by the South Australian Task Force have not been settled and secondly, because there is no statistical base to allow the determination of the number and type of claims that could be anticipated under any proposed scheme. In short we must look before we leap!