

**Briefing Note: Final Report of the Professional Indemnity Review (PIR)**


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**Purpose of this Note:** To provide MCA members with some details and a few comments on key findings and issues raised by this important federal government review. Owing to the length of the PIR's report and complexity of some of the material this note should be viewed as a provisional aid to further discussion/study not as a final statement or view on the PIR's report. Also due the complexity of material this short note is **not** considered by MCA to be 'medical-consumer-friendly'. You need to read the PIR's report to get to grips with the detail, and understand all the terms used. (The PIR's report costs about \$25 from government bookshops.)

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**Background:**

The Federal Government set up this review in April 1991. It produced a 370 page interim report in February 1994 inviting submissions from all parties. MCA was most concerned by the content which seemed dominated by the views of medical professionals and said so at a face to face meeting in Sydney with Fiona Tito (Chair of the PIR). MCA submitted an 79 page report to the PIR in Sept. 1994 putting an alternate solution forward (see MCA Briefing Note BN/9-94/PIR). The PIR's final report dated November 1995 was made available to the public in March 1996.

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**PIR Final Report overview:**

The 400 page document makes 169 specific recommendations. It contains statements that MCA considers are very supportive of the consumer interest and in places goes some way in exposing the stream of myths and disinformation that the medical establishment produces about itself and the indemnity industry. The critical nature of indemnity issues is demonstrated by the scope of the report's recommendations that amount to a near revolution in the development and supply of medical services. A greater role for the consumer in design and supply is proposed, and large development efforts in many areas. Many of the recommendations relate to the flows of information involved in medical services and the application of scientific methods to management and supply.

The 10 chapters of the report cover; informed decision making; risks benefits and treatment options; information access; human and financial costs of adverse outcomes; priority areas for action, tort reform; partnership in health care; indemnity reform; and birthing services as a case study for reform.

Appended material includes:

Appendix B: Lists the 93 names of persons(16) or organisations(77) that made formal submissions to the Interim Report. (The submission mix being: providers 51; government 10; consumers 13; legal 6; not known 13)

Appendix C: Synopses of the 19 other reports the PIR has produced.

Appendix D: Guidelines are made in response to the PIR recommendations (PIRrec) on what to do if things go wrong. Presented in two sections; first from the patient' viewpoint (PIRrec35); second from the provider's viewpoints (PIRrec20), human emotions are modelled in dispute resolution terms and language The material thus tends to describe an ideal world where all parties are politically correct 'rational actors'. Thus consumer victims will find the material naive and even offensive in places perpetuating myths about patients set up by the medical industry and not see equity/justice issues addressed. The material does give a concise review of the structure of Australian medical complaints management landscape.

Appendix H: Is a prototype *best practice* standard on how complaints management should operate. Informed consumers will not find many of the generalised *best practice* outcomes provided by NSW arrangements under the HCC Act. (e.g. our members report that the following *best practice* elements are missing: promptness, efficiency, accessibility, adequate appeal mechanisms, rules for lawful decision-making, complainants treated with respect and advised of options and achievable outcome etc. This Act maintains a clear disadvantage for consumers, see MCA Note BN/2-94/HCC.) These draft *best practice* standards are clearly written assuming that complaints handling parameters are best set and defined by a structure based on a centralised complaints bureaucracy and not by virtue of the medical consumer having enforceable rights at law. They do not address NSW practicalities. (e.g. the way a NSW registration board is able to treat consumer complaints with utter contempt, see NSW Ombudsman's report of July 1995 into the Psychologists Registration Board)

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**Overview: PIR's Findings and Recommendations (PIRrec numbers noted)**

Providers/establishments should all have contractual uncapped indemnity cover on a claims incurred basis as a condition of practice/accreditation (128-137) and this cover should be fully funded with arrangements for incurred but not claimed events.(149)

Use motor accident law as a model for rehabilitation obligations for all personal injury cases (75) Compensation options should exist providing case-managed assistance rather than lump sum payment (88) The PIR does not support no-fault compensation at this time.(90) But suggests investigation of strict liability for certain specific outcomes flowing from QAHC's performance measures work. (110)

Transition to structured settlements in place of compensation lump sums plus related revision of the tax laws are needed. (105)

Reform of the tort system - monitor effects of contingency fee use - fund patients - ensure quality in plaintiff legal services , put in place systems to provide medical expert opinions for plaintiffs. (91-111)

Improve information flows from the court system and link this data to quality assurance programmes. (6,69,70)

Point of service complaints systems should be integrated with quality assurance systems.(113)

Victims advocacy systems should be set up modelled on UK experience (95) The prototype should be set up by the NSW HCCC. (126)

Explore how consumers can be told how doctors and hospitals rate relative to each other. (57)

Look at options at allow patients to hold their own records. (45)

Federal government to develop models for consumer-friendly information services similar to those existing in the UK and communication training for providers. (34,35,36)

The Taskforce on Quality in Australian Health Care (see MCA briefing note BN/6a-95/SEC) should give priority to study/solutions of treatment failure types that are killing the most people (1,21) and that consideration be given to creating of statutory duties over such danger 'black spots'.

MDO reporting standards to be to AASB 1023 and accountability for products offered by MDOs to be to the Trade Practices Commission or Insurance and Superannuation Commission (140-141)

Consumers should have more opportunity to have more input and feedback (54) into and better information out from the medical services industry. This to include data on new treatments, outcome variations and consumer involvement in relative treatment effectiveness R&D trials work. (12,10,15,16,17,18,30,32,46,55)

Consumers should know where they stand on rights via a National Charter. (112)

Birthing Services Recommendations (151-169) revolve around seeking to identify causes of cerebral palsy, collecting more data on all aspects to define practice patterns, and addressing the concerns of specialist obstetricians who claim to be leaving the profession because of risk of being sued. Records should be kept to audit any defensive practices, and such data should be made public. Midwife service premiums should be based on the claims risks of this group.

Clinical trials research should include subjects of both gender. (13)

NHMRC should consider results of US studies on treatment effectiveness. (15)

Clinical practice guidelines to be further developed as a tool for quality improvement (16) A means of detecting breaches of such guidelines should be considered. (20)

An increased focus on ethics and ethical safeguards. (7,25)

Work on investigating so called defensive medicine (71) and developments in risk management. (72)

Introduce scientific methods; performance measurement systems, and evidence-based medicine, to determine the usefulness existing/new treatments This effort to be linked to funding incentives so as to influence clinician practice patterns. (19,27,28,31,33,37,38,39)

Set up an Australian Institute of Health, Law, and Ethics. Provide more training for medical professionals in law. (7,8)

Counselling is needed for doctors who have claims made against them. (89)

Complaints Commissions should be set up in all States (114) and should be able to initiate disciplinary processes. (115)

Special attention should be focused on problems involving allegations of sexual abuse/ misconduct to define changes in education of providers. (120-125)

Standardised vicarious liability legislation is needed and enterprise liability cover availability and other aspects of indemnity cover impacting GP's and rural area providers should be considered by governments. (142-6)