Appendix 1: Body function/structure categories

Table A1: Coding examples for body function/structure categories

Body function/structure coding category	Examples of types of harm alleged/claimed
1. Mental functions/structures of the nervous system	Psychological harm—for example, nervous shock Subdural haematoma Cerebral palsy
2. Sensory functions/the eye, ear and related structures	Vestibular impairment Injury to the structure of the eye or ear
3. Voice and speech functions/structures involved in voice and speech	Dental injuries Injuries to the structure of the nose or mouth
4. Functions/structures of the cardiovascular, haematological, immunological and respiratory systems	Injury to the spleen or lungs Generalised infection Deep vein thrombosis Vascular or artery damage Conditions affecting major body systems—such as cancer that has progressed and no longer affects a single body part or system
5. Functions and structures of the digestive, metabolic and endocrine systems	Hepatitis Injury to the gall bladder, bowel or liver Generalised abdominal pain Appendicitis
6. Genitourinary and reproductive functions and structures	Injury to the breast Injury to male or female reproductive organs Injury to the kidney
7. Neuromusculoskeletal and movement-related functions and structures	Loss of function due to inappropriate casting of joint
8. Functions and structures of the skin and related structures	Burns
9. Death	'Death' is recorded where the incident was a contributory cause of the death of the claim subject
10. No body functions/structures affected	Failed sterilisation, where there is no consequent harm to body functions or structures

Appendix 2: Policy, administrative and legal features in each jurisdiction

New South Wales

The New South Wales Treasury Managed Fund (TMF) covers all employees of public health organisations (PHOs), as defined in the state's *Health Services Act 1997*. This includes area health services, most statutory health corporations, and affiliated health organisations in respect of recognised establishments.

In some circumstances TMF cover is available to visiting medical officers (VMOs) and honorary medical officers (HMOs) under a separate contract of liability cover. Since 1 January 2002 the government has offered VMOs and HMOs cover by the TMF when treating public patients in public hospitals, subject to certain conditions, including a condition that doctors sign up for comprehensive risk reduction programs. The majority of VMOs have elected to participate. At the same time the government accepted financial responsibility for unreported incidents of medical defence organisations where the incidents involved public patients in public hospitals and the treating doctor had a VMO or HMO appointment.

Medical indemnity for private patients in rural public hospitals is the responsibility of the VMO or staff specialist (SS). Since 1 July 2003, however, VMOs and SSs Levels 2 to 5 who have rights of private practice and working in rural areas and selected hospitals in the Hunter and Illawarra have been able to obtain public sector medical indemnity for private patients they treat in public hospitals, subject to various conditions.

Similarly, medical indemnity for private paediatric patients in public hospitals is the responsibility of the VMOs or SSs. However, since 1 January 2004, VMOs and SSs Levels 2 to 5 (having rights of private practice) have been able to access public sector medical indemnity for private paediatric patients they treat in public hospitals in New South Wales. (Note that private paediatric patient indemnity for VMOs and SSs in the rural sector, including specified hospitals in the Hunter and Illawarra, has been available in their indemnity package since 1 July 2003.)

Since 1 January 2002 NSW Health has been providing clinical academics with interim cover (in specified areas of activity) through TMF, subject to the universities paying an per-claim excess of up to $250,000 (subject to annual consumer price index movements) capped at around $1 million a year. The period for which this interim cover was provided was extended to 30 June 2005.

For the 2005 student intake only, public indemnity was made available to students studying for a Bachelor of Midwifery at University of Technology Sydney and on practicum in public hospitals—but only during the actual birthing process and only whilst under strict PHO supervision.

The TMF fund manager manages all aspects of the claim, including arranging for such legal advice and representation as may be necessary. Incidents involving employees of PHOs are

notified to TMF through PHO risk managers. VMOs and HMOs are required by their contracts of liability coverage to notify their PHOs of all incidents; the PHO then notifies the department, which notifies TMF.

When notified of an incident, TMF sets a reserve if it believes the incident is likely to become a claim and, if necessary, arranges to have a solicitor on the record; investigates the incident; provides instructions to the solicitor; and conducts interviews. TMF remains involved in the settlement of the claim through the courts or the settlement process.

New South Wales has introduced various law reforms that affect medical indemnity claims. Relevant reforms implemented in the *Health Care Liability Act 2001* are as follows:

- raising to 5% the discount rate for future economic loss damages
- capping damages for loss of earnings and for non-economic loss (general damages for pain and suffering)
- abolishing exemplary and punitive damages
- enabling structured settlements.

The *Civil Liability Act 2002* generally applies the tort law changes enacted in the *Health Care Liability Act 2001* to civil actions for damages. It also:

- introduced threshold and capping for gratuitous care
- capped lawyers' costs when the amount recovered on the claim was to be less than $100,000, unless there was a cost agreement
- amended the *Legal Professional Act 1987* (NSW) to introduce a stipulation that solicitors and barristers are not to act on a claim or defence unless they reasonably believe the claim or defence has reasonable prospects of success; cost orders may be awarded against barristers or solicitors who fail to do so.

Relevant reforms implemented in the *Civil Liability (Personal Responsibility) Amendment Act 2002* are as follows:

- creating a peer acceptance test for professional negligence
- amending the limitation period within which an action must be brought to a date three years after the date of 'discoverability' or 12 years from the time the event occurred, whichever is earlier (the 12-year period can be extended at the discretion of a court)
- limiting the claims for pure mental harm or nervous shock
- protecting 'Good Samaritans' and volunteers from civil liability claims
- providing that apologies made are not relevant to the determination of liability in connection with the matter.

The following other reforms were introduced by legislation amending the *Civil Liability Amendment Act 2002*:

- limiting the damages payable to a person if the person's losses resulted from conduct that would have constituted a serious criminal offence if the person had not been suffering from a mental illness at the time of the conduct

- precluding the recovery of damages for the costs of rearing or maintaining a child, or for lost earnings while rearing or maintaining a child, in proceedings where there is a civil liability for the birth of a child
- restricting damages that can be recovered by a person from personal injury resulting from the negligence of a protected defendant suffered while the person was an offender in custody
- providing protection from civil liability in respect of food donations
- providing for the satisfaction of personal injury damages claims by victims of crime from certain damages awarded to offenders.

Victoria

In Victoria, medical indemnity claims for incidents that occur in public health care agencies are insured by the Victorian Managed Insurance Authority (VMIA), a statutory authority created under the *Victorian Managed Insurance Authority Act (1996)*. The insurance covers the health care agency, employed doctors and other health professionals, and independent contractors (VMOs). Employed doctors with limited private-practice rights who enter into fee-sharing arrangements with a public hospital can be covered for treatment of their private patients in the hospital. These are generally senior specialist practitioners.

Rural procedural general practitioners can elect to participate in a Department of Human Services scheme whereby they can purchase medical indemnity cover for their private-practice work undertaken in certain rural and remote public hospitals and bush-nursing hospitals. There were 320 practitioners insured under this scheme in 2004–05. A significant proportion of these doctors are covered for obstetrics.

Any medical student appointed to a public health service or public hospital by a tertiary education institution for the purposes of accreditation is covered for their clinical duties.

When a public health care agency service notifies VMIA of an incident, VMIA sets a financial reserve if it considers the incident is likely to materialise into a claim. This is classified as an 'open' claim and the files are reviewed at least twice in a 12-month period. If a minimum reserve is placed, the amount will at least cover legal defence costs. A claim reserve may be placed before a letter of demand or writ has been received.

In 2002 Victoria introduced initial changes to legislation designed to deal with concerns and problems in relation to the affordability and availability of public liability and medical indemnity cover. These changes included:

- a cap on general damages for personal injury awards and a cap on compensation for loss of earnings awards
- initial changes to reduce the limitation period in which injured people can bring legal proceedings from six years to three years for legally competent adults
- a change in the rate used to calculate lump-sum payments for future economic loss and care costs; this measure is expected to provide significant savings on payouts for large claims
- protection of volunteers and 'Good Samaritans' from the risk of being sued

- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability.

In 2003 the Victorian Government introduced additional reforms with the passing of the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act* and the *Wrongs and Other Acts (Law of Negligence) Act*. These changes, applied to personal injury claims (including medical negligence), cover:

- thresholds on general damages
- major reform to limit the time in which proceedings can be brought
- regulation of damages awarded for gratuitous and attendant care.

Of significance to the MINC are the changes made to the limitation of actions so that, where a child is in the custody of their parents, ordinarily it will be presumed that the parent will protect the child's interests by bringing proceedings, where appropriate. The limitation period for minors has been changed to six years from the date of discoverability, which means that legal proceedings in relation to minors will generally have to be brought earlier than was previously the case. Some special protections do, however, apply.

The changes also provide that legal proceedings seeking damages for personal injury cannot be brought after 12 years from the date of the incident that is alleged to have caused the injury. There is judicial discretion to extend the limitation period where it is in the interests of justice to do so.

Queensland

Insurance cover for medical indemnity claims made against Queensland Health is provided through the Queensland Government TMF, called the Queensland Government Insurance Fund. The Fund was established on 1 July 2001 and its coverage extends to Crown employees and others who, at the time of the event or incident, are entitled to obtain indemnity in accordance with government policy.

From 4 November 2002 Queensland Health restated its indemnity arrangements in a new indemnity policy for medical practitioners, IRM 3.8–4. It confirmed the existing policy that Queensland Health indemnifies all medical practitioners engaged by Queensland Health to undertake the public treatment of public patients and medical practitioners treating private patients in limited specified circumstances. Indemnity under the policy is offered to doctors under an insurance-like model, with exclusions (proven criminal conduct and wilful neglect).

IRM3.8–4 does not apply to doctors who are independent contractors providing services to Queensland Health, doctors engaged by agencies other than Queensland Health, or contracted VMOs (who must look to the indemnity clauses in their contract of engagement). Other staff engaged by Queensland Health, such as nursing and allied health staff, are covered by a separate indemnity policy, IRM 3.8–3. Queensland Health does not indemnify medical students.

Queensland Health MINC jurisdictional data come primarily from medical indemnity claims information provided to Queensland Health by the litigation panel firms engaged to provide medico-legal litigation services to the department. Therefore, in the main, the pool of MINC

jurisdictional data from Queensland Health covers matters that have been briefed to a panel firm.

By and large, these matters are court proceedings and notices of claim under s.9 of the *Personal Injuries Proceedings Act 2002* (PIPA) but they can include complaints under the *Health Rights Commission Act 1991* and other demands falling within the scope of the collection.

Queensland Health matters are 'potential claims' within the MINC only where they have been referred to a panel firm and the firm has placed a reserve against the matter. The following do not come within the scope of the MINC, except in cases where a panel firm has placed a reserve against the matter: an initial notice under s.9A of PIPA (a preliminary notice that a claim may eventuate); adverse events; and coronial inquests.

Each claim is evaluated on its own merits and on known facts as they become available, and a reserve is placed where appropriate. Accordingly, a reserve may (and often does) change during the course of a medical indemnity claim and as expert and factual evidence on questions of liability and quantum is obtained and assessed.

In response to community concerns about increases in liability insurance premiums, the Queensland Government passed legislation in June 2002 that affected the way in which compensation claims for damages for personal injuries in a medical context are dealt with before court proceedings are initiated. The legislation also sought to regulate the extent of compensation recoverable in, and various legal matters generally associated with, court proceedings for personal injury. Changes made under PIPA include:

- a positive duty on claimants to bring a claim under PIPA within nine months of the incident (or the appearance of symptoms) or one month of consulting a lawyer
- no legal costs payable for claims under $30,000 and a maximum of $2,500 costs for claims between $30,000 and $50,000
- mandatory exchange of information (including medical reports) to facilitate early settlement and avoid costly litigation
- mandatory offers of settlement and settlement conferences
- capping of claims for economic loss
- exclusion of exemplary, punitive or aggravated damages awards
- provisions for a court to make a consent order for a structured settlement
- recognition and protection for 'expressions of regret'
- exclusion of juries from hearing personal injury trials.

PIPA began operating on 18 June 2002. On 29 August 2002 it was amended to apply retrospectively to injuries, except where a claim had already been lodged with a court or a written offer of settlement had been made before the amendments came into force.

On 9 April 2003 further tort reform initiatives took effect with the passing of the *Civil Liability Act 2003*. These included:

- the majority of Justice Ipp's recommendations introduced
- a new way to assess general damages for pain and suffering in personal injury actions where the incident occurred after 1 December 2002

- capped awards for general damages, at $250,000
- general damages to be assessed on the basis of an injury scale value. Injuries are assessed on a scale of 1 to 100, where 0 is an injury not severe enough to justify an award of general damages and 100 is an injury of the gravest conceivable kind. Monetary values are allocated to each point—for example, 5 = $5,000, 50 = $93,800, 100 = $250,000. The regulation under the *Civil Liability Act 2003* sets out a scale of injuries, with a guide to an appropriate injury scale value for particular injuries. There are limited medico-legal examples in the injury scale value. The *Civil Liability Regulation 2003* commenced on 7 October 2003
- introduction of thresholds for claims for loss of consortium and gratuitous care
- codification of the proactive and reactive duties of doctors to warn of risks
- codification of the standard of care for professionals to protect against liability for acts performed in accordance with a respected body of professional opinion
- amendments to PIPA, including changes to claim notification procedures. One such change relates to claims involving medical negligence in the treatment of a child: the parent or guardian of the child must provide the initial notice and then Part 1 of the notice of claim on behalf of the child within defined time-frames. A Part 1 notice of claim must be given before the earlier of six years after the parent(s)/guardian knew that the personal injury occurred or 18 months after the parent(s)/guardian first consults a lawyer about the possibility of seeking damages. A respondent has the right to seek a court order that the claim not proceed if the Part 1 notice is given out of time.

Western Australia

Public sector hospitals and health services in Western Australia are insured through the RiskCover Division of the Insurance Commission of Western Australia. Since 1 July 1997 RiskCover has acted on behalf of the Department of Treasury and Finance to manage the self-insurance fund covering liability claims arising from the operations of the state's agencies.

All public hospitals and health services are charged an annual 'contribution' to RiskCover to cover the cost of managing and settling claims, including Medical Treatment Liability (MTL) claims. Claims that pre-date RiskCover are managed by the State Solicitor's Office with the Department of Treasury and Finance generally funding settlement costs on a case-by-case basis.

When a MTL claim naming a hospital is lodged, RiskCover liaises with the relevant claims manager and the Department of Health's Legal and Legislative Services. RiskCover manages the case management and financial aspects of each claim through its appointed legal representatives. The department and the relevant hospital receive regular reports on progress until each matter is settled.

Since 1 July 2003 the Department of Health, through RiskCover, has contractually indemnified all non-salaried medical practitioners treating public patients in public hospitals for MTL claims. The cost of the indemnity is met by the relevant hospital(s). In return, the practitioners are required to support and participate in further safety and quality management programs.

In mid-2004 the scope of the indemnity was extended. It now provides:

- effectively unlimited cover
- IBNR cover dating to the time when the doctor's medical defence organisation changed from 'claims incurred' to 'claims made' cover
- full death, disability and retirement cover
- indemnity for participating in authorised clinical governance activities—including clinical audit, reporting and investigation of adverse events—and participating in quality improvement committees
- indemnity for medical services provided to private and other 'non-public' patients treated in hospitals administered by the WA Country Health Service.

From 1 July 2004 salaried medical officers have been offered the same contractual indemnity for MTL claims arising from their treatment of public patients and also, where the doctor has assigned his or her billing rights to the hospital, their private patients.

The state government has introduced a range of tort law reforms, including:

- the *Civil Liability Act 2002*, which introduced restrictions on awards of damages and legal advertising, and enabled structured settlements
- the *Volunteers (Protection from Liability) Act 2002*, which protects certain volunteers from incurring civil liability when doing community work on a voluntary basis
- the *Insurance Commission of Western Australia Amendment Act 2002*, which allows for the establishment of a Community Insurance Fund
- the *Civil Liability Amendment Act 2002*, which contributes to containing insurance problems and also assists in changing social and legal attitudes towards the assumption of and liability for risk
- the *Civil Liability Amendment Act 2003*, which expanded on the *Civil Liability Act 2002* by clarifying, and in some cases modifying, certain common law rules of negligence in relation to foreseeability, standard of care, causation and remoteness of damage, and contributory negligence. Of particular relevance to medical practitioners, the Act also introduced protection for 'Good Samaritans' and in relation to apologies. Most of the amendments give effect to key recommendations of the 'Ipp Report'
- the *Civil Liability Amendment Act 2004* which further amended the *Civil Liability Act 2002* in two respects—introducing a new evidentiary test in relation to the standard of care required of health professionals and making further provision with respect to proportionate liability. The Act provides a new test for medical negligence that will preclude a finding of negligence against a health professional if their conduct was found to be compatible with the views of a responsible body of their peers.

South Australia

Public sector insurance arrangements cover the following groups: employees of public hospitals; VMOs providing services to public patients; staff specialists for services to private patients under approved rights of private practice; health professional students; short–term visiting

medical practitioners and medical students; rural fee-for-service doctors who have opted to be covered under government arrangements; and clinical academics providing services to public patients.

The main steps in the claims management process are as follows:

- initial notification of incident
- assessment of notification by claims manager
- if necessary, claim file opened and reserve raised
- if necessary, panel solicitor appointed
- investigation of claim
- decision about approach to liability and quantum
- reserve monitored throughout the claim and adjusted if necessary
- settlement conference—either informal or compulsory conference convened by the court.

The main parties involved in the claim process are the plaintiff and their solicitors, the Department of Health's panel solicitors (the defendant's solicitors), the health unit from which the claim emanated, the Department of Health's Insurance Services Unit, Minter Ellison, lawyers (Department of Health—appointed claims manager), and the South Australian Government Captive Insurance Corporation (SAICORP), which is responsible for claims in excess of the department's deductible.

In gathering information about claims or potential claims, the claims manager liaises in the first instance with the clinical risk manager or other appointed staff member of the relevant health unit. Where a panel solicitor is appointed, he or she liaises directly with the clinical risk manager or appointed hospital staff member to coordinate the investigation of the claim and interviews with staff.

A claim file is opened at the discretion of the claims manager when he or she considers the incident is likely to result in a claim. A reserve is placed against all open claim files. The reserve is calculated by multiplying the following components:

- the dollar estimate of the worst–case scenario (including plaintiff's legal costs)—based on advice from the panel solicitor
- the probability of the claim proceeding—expressed as a percentage
- the probability of success of the claim—expressed as a percentage.

The estimated defence costs are then added to the amount derived.

Independent expert medical opinion on the matter is usually obtained once interviews with medical staff are completed.

If a matter that has had a reserve placed against it remains inactive—that is, does not materialise into a claim—the claim file is usually closed on expiration of the statutory time limitation within which proceedings would have had to have been initiated. Occasionally files are reopened when a plaintiff seeks an extension of time.

Structured claim settlements are not common in South Australia.

A range of tort law reforms have been introduced in the state:

- the *Wrongs (Liability and Damages for Personal Injury) Act 2002*. The Act sets limits to the damages that can be claimed for bodily injury. It applies a points scale to injury claims and limits claims for loss of capacity to earn a living. It also protects 'Good Samaritans' from legal liability if they make an error when trying to assist someone in an emergency, and it makes clear that there is no legal liability implied when one person apologises to another for an accident
- the *Statutes Amendment (Structured Settlements) Act 2002*, which allows people to have their compensation paid in instalments rather than as a lump sum if they wish
- the *Law Reform (Ipp Recommendations) Act 2004*. This Act makes changes to the law of negligence so that people are not liable to pay damages if the way in which the injury occurred was unforeseeable or a reasonable person would not have taken action to reduce the injury risk. It also prevents claims for failure to warn the injured person about a risk that should have been obvious to them. Further the Act makes it harder for people to claim compensation if they have let the legal time limit go by and requires parents to give early notice of an injury claim by a child, so that insurers can take this into account. Among other things, the Act also provides doctors and other professionals with a defence if they acted in accordance with what is widely accepted in Australia to be proper professional practice.

Tasmania

The Tasmanian Government provides indemnity in relation to any services provided by a medical practitioner in a public hospital or other health facility operated by the state, with the exception of medical services provided in the course of private practice in premises that the practitioner or another person occupies pursuant to a lease or other right of exclusive occupation granted by the state.

Insurance coverage for medical indemnity matters is provided through the Tasmanian Risk Management Fund. The Department of Health and Human Services makes an annual contribution to the fund and, under the coverage provided by the fund, the Department is required to meet the first $50,000 in respect of any claim.

The claims management process is as follows:

- Initial notification of a claim is lodged. This can result from
  - receipt of a letter of demand or writ
  - or notification by the responsible Departmental division when it has been determined that the nature of the incident and the potential impact on the department are sufficiently material to warrant notification.
- Claim notification forms are completed by the relevant medico-legal officer at each of Tasmania's three major public hospitals and duly designated officers in other departmental divisions, including district hospitals, aged care facilities, mental health and disability services, and oral health services. The claim notification forms include all data required under the MINC, as well as additional data required for internal management of the claim.
- A copy of the claim notification form is forwarded to the Departmental officer responsible for maintaining the database in respect of medical indemnity matters. The Office of the

Director of Public Prosecutions, which undertakes all litigation matters on behalf of the State of Tasmania, is advised of the (potential) claim. A claim file is opened and a reserve is placed on the matter by the Director of Public Prosecutions.

- The claim is managed by the relevant medico-legal officer and a representative from the Office of the Director of Public Prosecutions. Claim files are reviewed quarterly.

Tasmania has implemented a number of tort law reforms, largely through amendments to the *Civil Liability Act 2002*. Most of the reforms flow from recommendations of the 'Ipp report' of the law of negligence. Key reforms relevant to medical negligence claims include:

- clarification of aspects of the duty of care owed by medical practitioners to patients
- a statement that an apology—for example, by a medical practitioner to a patient—does not constitute an admission of fault or liability
- provision for a court to make an order approving of, or in the terms of, a structured settlement
- changes to the manner in which damages relating to loss of earning capacity, economic loss, and non-economic loss are assessed
- restriction of the circumstances in which a plaintiff may seek to recover damages for pure mental harm
- awarding of payments for gratuitous services (subject to certain conditions and effective from 15 December 2005). No damages were previously payable for such services
- a reduction of the discount rate used in determining a lump-sum payout, from 7 to 5 per cent, effective from 15 December 2005
- changes to the limitation period where an action for damages for negligence now cannot be brought after the sooner of three years from the date of discoverability or 12 years from the date of the cause of action (effective from 1 January 2005) (see s.5A of the *Limitation Act 1974*). Previously, the limitation period was three years from the date of the cause of action, with an extension of a further three years at the discretion of the court.

Australian Capital Territory

All ACT government employees providing clinical services are indemnified under general staff cover for professional officers. Staff specialists are also indemnified for rights of private practice providing they do not bill their private patients directly.

In January 2002 the ACT introduced the Medical Negligence Indemnity Scheme to provide indemnity to VMOs providing public health services to public patients in public health facilities. The term 'public' is crucial in this description because the scheme is specifically limited to that type of service. A recent change to sessional and fee-for-service contracts with VMOs has seen the scheme now rolled into the VMO service agreements.

In 2003 the ACT also agreed to indemnify medical and nursing students who were placed in the ACT health system as part of their training.

The overall manager of claims and provider of public medical indemnity cover in the ACT is ACT Health; the cover is underwritten by the ACT Insurance Authority, which obtains the necessary re-insurance covers internationally. ACT limits its deductible to $50,000, the balance of any one claim then being covered by the insurance authority.

Key providers of medical insurance data are the two public hospitals, Mental Health ACT and Community Health, which monitor and report adverse incidents and/or potential claims. Claims and circumstances that come to the attention of the responsible entity are to be reported immediately to the ACT Insurance Authority under obligations ACT Health has to that insurance provider. To ensure that all claims and circumstances are notified to the insurer in accordance with policy conditions, claims and circumstances must be reported to ACT Health and the ACT Insurance Authority as soon as possible (and during the Period of Insurance).

If at any time the responsible entity is served with court proceedings or becomes aware of a serious incident, the matter is to be notified immediately to the Government Solicitor's Office, which will ensure that a defence is filed within the specified timeframe, as required.

Legal reforms are under-way with the *Civil Law (Wrongs) Amendment Act* having been passed by the Legislative Assembly in 2003. Elements of the Act relevant to personal injury claims (including medical negligence) are:

- changes to reduce the limitation period in which injured people can bring legal proceedings, from six years to three years from the date of the incident for legally competent adults, and, in relation to children, other reforms to limit the time in which proceedings can be brought
- provisions for a single expert witness to give evidence
- clarification of the interpretation of the concepts of 'standard of care', 'causation' and 'assumption of risk' in negligence proceedings, by defining the concepts in the Act
- restriction of liability for mental harm to a recognised psychiatric illness
- a limit on damages for non-economic loss and economic loss
- direction as to the apportionment of liability and contributory negligence
- ensuring that saying 'sorry' or waiving payment of a fee for service does not represent an admission of liability
- early notification—procedural reforms designed to make early settlements more likely and to improve the efficiency of court proceedings.

Among other reforms are the following:

- introduction of a 'reasonable prospects' test for cases brought before the court
- imposing obligations on the parties to claims to exchange relevant documents—for example, about the cause of the accident, the extent of injuries
- establishing the principles to apply in deciding whether a public or other authority has a duty of care or has breached a duty of care
- providing for court–ordered mediation in addition to neutral evaluation
- requiring that a claimant notify all respondents of an intention to sue nine months after the date of the accident or after the date symptoms first appear if they are not immediately

apparent or one month after consulting a lawyer. If these notices are not given, the claimant can proceed only with the leave of the court and at the risk of cost penalties

- requiring that, for adult claimants, this notice be given within three years
- requiring that for child claimants, this notice be given within six years (there will be significant financial disincentives to delaying the giving of the notice on behalf of child claimants; that is, no medical, legal or gratuitous care costs will be awarded for the period up to the date the notice is given)
- requiring that, once notice is given, the prospective defendant have carriage of the progress of the claim (in the case of children, a prospective defendant can oblige a plaintiff to file suit on six months' notice).

Northern Territory

Current public sector medical indemnity insurance arrangements in the Northern Territory cover VMOs and specialist medical officers providing medical services to any public patient. Recent amendments extend cover to instances where care is provided to a public patient in a private hospital—for example, where the territory 'buys' beds from a private hospital or where care is provided outside the hospital setting. VMOs and specialist medical officers are still, however, required to cover any liability that may arise from services provided outside such agreements.

Once notification of an incident that might result in a claim is received, a possible legal action file is established and referred to a legal practitioner in a private law firm or to a departmental lawyer. Upon receipt of a writ, a legal action file is established and the matter is outsourced to a private law firm.

When a possible legal action is identified as the result of a complaint or inquiry, the Legal Support Branch of the Department of Health and Community Services will usually refer the complainant to the Health and Community Services Complaints Commission in an effort to pre-empt litigation.

The main players in a medical negligence suit are the plaintiff and their representative lawyers, the defendant (that is, the Northern Territory, the Department of Health and Community Services, and the hospital and/or staff involved), and outsourced defence lawyers engaged by the department.

In investigating a claim, statements are generally obtained from the relevant clinical or medical staff involved, along with medical records. Expert medical advice is normally sought in the initial stages of the claim in order to ascertain potential liability and to assist with preparation of a defence.

When calculating a reserve, factors taken into account can include:

- the liability or otherwise of the Northern Territory
- the gravity of the loss, injury and/or damage to the claimant
- legal advice on quantum.

If a file has been opened on the basis of a potential legal action and no claim or proceedings result, the file remains inactive. Once a litigation file is opened, it is closed only if the department is notified of discontinuance or the matter is settled.

The statute of limitations legislation prescribes that personal injury legal proceedings be initiated within three years of the occurrence of an adverse event.

At present no compulsory dispute resolution processes exist as a prerequisite to litigation. An aggrieved person may, however, lodge a complaint through the Health and Community Services Complaints Commission in the first instance to have the matter investigated, conciliated or resolved before the commencement of litigation.

The Northern Territory *Personal Injuries (Civil Claims) Act 2003* contains some provisions in relation to claims for personal injury, but those relating to commencement of proceedings (ss.7–10) and resolution conferences (s.11) have not yet commenced. Therefore the *Limitation Act* continues to apply in that any action in tort must be brought within three years of the date of the cause of action.

The *Personal Injuries (Liabilities and Damages) Act 2003* makes the following provision:

- A court must not award aggravated damages or exemplary damages in respect of a personal injury.
- A court may award damages for gratuitous services only if the services are provided
  - for six hours or more a week
  - or for six months or more.

The maximum amount of damages a court may award for non-pecuniary loss is $350,000 at commencement of the Act (May 2003) and as declared by the minister on or before 1 October in each year after the year in which the Act commences.

The award of damages for non-pecuniary loss is determined according to the degree of permanent impairment of the whole person and the relevant percentage of the maximum amount to be awarded.

Structured claim settlements are not common in the Northern Territory. As a general rule, an all-encompassing settlement figure is reached without detailed itemisation of categories of loss and is settled in one lump sum rather than by periodic payments.

Appendix 3: Detailed tables

Table A3-1: Clinical service context: number of claims for which each clinical service context recorded, 1 July 2004 to 30 June 2005, Australia

Clinical service context	Number	Per cent of claims
Accident and emergency	940	14.6
Cardiology	135	2.1
Dentistry	137	2.1
Cosmetic procedures	25	0.4
Ear, nose and throat	89	1.4
General medicine	295	4.6
General practice	130	2.0
General surgery	721	11.2
Gynaecology	508	7.9
Hospital outpatient department	78	1.2
Neurology	117	1.8
Obstetrics	1,141	17.7
Oncology	60	0.9
Orthopaedics	450	7.0
Paediatrics	190	2.9
Perinatology	47	0.7
Plastic surgery	44	0.7
Psychiatry	277	4.3
Radiology	68	1.1
Urology	100	1.5
Other	703	10.9
Not known	198	3.1
Total	**6,453**	**100.0**

Table A3-2: Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July 2004 to 30 June 2005, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Anaesthetics—general	205	3.3
Anaesthetics—intensive care	10	0.2
Cardiology	80	1.3
Cardio-thoracic surgery	41	0.7
Chiropractics	—	—
Clinical genetics	11	0.2
Clinical haematology	74	1.2
Clinical pharmacology	—	—
Colorectal surgery	25	0.4
Cosmetic surgery	3	0.0
Dentistry—oral surgery	87	1.4
Dentistry—procedural	40	0.6
Dermatology	9	0.1
Diagnostic radiology	124	2.0
Ear, nose and throat	80	1.3
Emergency medicine	610	9.7
Endocrinology	9	0.1
Endoscopy	7	0.1
Facio-maxillary surgery	10	0.2
Gastroenterology	46	0.7
General and internal medicine	150	2.4
General practice—non procedural	123	2.0
General practice—procedural	85	1.4
General surgery	489	7.8
Geriatrics	4	0.1
Gynaecology only	356	5.7
Infectious diseases	20	0.3
Intensive care	63	1.0
Medical oncology	27	0.4
Midwifery	165	2.6
Neurology	33	0.5
Neurosurgery	94	1.5
Neonatology	82	1.3
Nuclear medicine	5	0.1
Nursing—general	361	5.8
Nursing—nurse practitioner	2	0.0
Nutrition/dietician	—	—
Obstetrics and gynaecology	271	4.3

(continued)

Table A3-2 (continued): Specialties of clinicians closely involved in incident: frequency of coding categories recorded for claims, 1 July 2004 to 30 June 2005, Australia

Specialty of clinician	Number	Per cent of all recorded speciality categories
Obstetrics only	715	11.4
Occupational medicine	1	0.0
Ophthalmology	57	0.9
Orthopaedic surgery	400	6.4
Osteopathy	1	0.0
Paediatric medicine	93	1.5
Paediatric surgery	51	0.8
Paramedical and ambulance staff	20	0.3
Pathology	100	1.6
Pharmacy	8	0.1
Physiotherapy	25	0.4
Plastic surgery	72	1.2
Podiatry	9	0.1
Psychiatry	225	3.6
Psychology	2	0.0
Public health/preventive medicine	7	0.1
Rehabilitation medicine	8	0.1
Renal medicine	13	0.2
Respiratory medicine	13	0.2
Rheumatology	7	0.1
Spinal surgery	4	0.1
Sports medicine	—	—
Therapeutic radiology	13	0.2
Thoracic medicine	5	0.1
Urology	90	1.4
Vascular surgery	50	0.8
Other allied health	43	0.7
Other hospital-based medical practitioner[(a)]	234	3.7
N/A[(b)]	52	0.8
Not known	136	2.2
Total[(c)]	**6,257**	**100.0**

(a) 'Other hospital-based medical practitioner' includes junior doctors, resident doctors, house officers and other clinicians who do not have a specialty.

(b) 'Not applicable' for this data item indicates that no clinical staff were involved in the incident—for example, where the claim relates to actions of hospital administrative staff.

(c) Total number of specialty categories recorded. Since up to four specialty codes can be recorded for a single claim, the total may be greater than the total number of claims in all jurisdictions excluding NSW.

Note: NSW data are not included because data on clinical specialty are not available.

Table A3-3: Specialty of clinicians closely involved in incident: percentage of claims with one, two, three and four specialty codes recorded, 1 July 2004 to 30 June 2005, Australia

	One specialty only	Two specialties	Three specialties	Four specialties	Total
Per cent of claims	86.9	10.7	2.0	0.4	100.0

Note: NSW data are not included because data on clinical specialty are not available; therefore only percentages are shown.

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