

Managing medical indemnity: must we choose between quality assurance and risk management?

Paul Nisselle

To focus solely on reducing error may inadvertently reduce the quality of care

In this issue of the Journal, Wenck and Johnston (*page 117*) describe the response of a medical indemnity insurer to the potential for claims associated with the contraceptive implant Implanon (Organon).¹ The article stimulates reflection on whether the recent increased emphasis on risk management has been at the expense of quality assurance.

The “quality movement” began in Australia over 30 years ago. The 1970s and 1980s saw the development of hospital accreditation through the Australian Council of Hospital Standards (now the Australian Council of Health Care Standards [ACHS], www.achs.org.au) and drove the system of credentialling medical staff in hospitals and delineating their clinical privileges that has become the norm. Accreditation of general practices resulted largely from the Australian government’s decision in the late 1990s to tie various government general-practice payments to accreditation.

The “safety movement” developed more recently, catalysed in part in Australia by the 1995 report in this Journal of the Quality in Australian Health Care Study,² and internationally by the report of the Bristol Inquiry³ and the US Institute of Medicine’s article *To err is human*.⁴ However, the increased momentum of the safety movement brings with it the risk that “risk management” (avoiding error) will overshadow “quality assurance” (enhancing quality).

Further, Wenck and Johnston’s report raises the question of whether the *prudential* risk management outlined simply imposed financial disincentives to the continued use of Implanon, and increased funding for potential future claims. Or did it stimulate reduced error — *clinical* risk management?

Recently, concern at the escalating cost of public liability insurance in general, and medical indemnity insurance in particular, has stimulated:

- A wave of tort law reform across Australia. An early reform that directly affected medical accident compensation, and hence medical indemnity costs, was the New South Wales *Health Care Liability Act (2001)*.
- Reform of the medical indemnity industry. This culminated in Federal Parliament passing the *Medical Indemnity (Prudential Supervision and Products Standards) Act (2003)* and a number of subsequent bills.
- Over \$300 million in federal subsidies for medical indemnity insurance premiums (the “Premium Support Scheme”) and medical negligence claims (the “High Claims” and “Exceptional Claims” schemes).
- Over \$300 million in federal funding for the UMP (United Medical Protection) Support Scheme, which replaced the IBNRs (“Incurred but not reported” liabilities) Levy Scheme announced in 2002; the Commonwealth will now directly subsidise three-quarters of the IBNRs of doctors who were members of UMP at 30 June 2000.

Now that medical indemnity is not directly provided by the medical defence organisations (MDOs), but by the subsidiary

insurance companies they registered (“captive” insurers), the *quid pro quo* demanded by Government for the \$600 million “rescue” injection of subsidies was:

- that the parent MDO or its subsidiary medical indemnity insurer provide enhanced programs of *clinical* risk management for their clients *and*
- that those clients participate in the programs offered, *and*
- that the medical indemnity insurers practise much higher standards of *prudential* risk management than did their MDO parents in the past. (Prudential risk management refers to how insurers set premiums and manage their reserves and business risk to ensure they remain solvent and able to meet liabilities as and when they arise.)

In this process, the two meanings of the phrase “risk management” — the prudential risk management of the insurer, and the clinical/medicolegal risk-management services they offer those who are insured — became blurred. The article by Wenck and Johnston highlights the similarities and differences between these two forms of risk management.

Prudential risk management can have perverse effects on clinical practice. For example, from around 1990, the MDOs moved away from “mutual” subscriptions (all doctors paid the same) to “differential” subscriptions (higher-risk disciplines paid higher rates). One result was that general practitioner and specialist obstetricians who practised low-volume obstetrics found a powerful reason to cease midwifery: the extra cost of obstetric indemnity far exceeded the income they derived from obstetric work. There were other factors as well, but the number of doctors for whose obstetric services rebates were claimed through Medicare dropped by 29% between 1989 and 1995.⁵

The sudden spate of claims arising from the use of the implantable contraceptive Implanon saw the MDOs respond in different ways. Prudentially, they needed to ensure that Implanon claims were properly funded. Clinically, they wanted to reduce the number of such claims by encouraging safe use. Some MDOs chose to maintain the status quo — perhaps relying on media reports either to deter doctors from using Implanon or to ensure they reviewed their clinical techniques. Other MDOs, such as MDA National and UMP, moved coverage for matters arising from Implanon use into the more costly “procedural general practice” category of insurance.

The latter approach would predictably lead to most non-procedural GPs stopping use of Implanon in their clinical practice. Who would pay up to \$10 000 more per year for insurance to cover a procedure they might perform 20–30 times a year for a fee of less than \$30 per service?

A third approach was adopted by the Medical Defence Association of Victoria (MDAV) in July 2003,⁶ demonstrating that risk management by an MDO can be vigorous without perversely affecting clinical services. GPs who used Implanon were advised that they *might* be asked to pay an excess of \$5000 if they were

unable to demonstrate adequate training and technique should an Implanon claim be brought against them. There was no fixed economic deterrent to using Implanon, but there was an incentive to “risk manage” clinically to avoid the \$5000 excess.

After monitoring claims in the ensuing period, MDAV announced in May 2004 that the excess would no longer be applied.⁷ Similarly, United Medical Protection announced on 21 May 2004 that Implanon insertion would revert to being covered in the non-procedural general practice category of insurance, but with ongoing conditions. To quote from UMP’s media release:

It will be a condition of cover that members agree to adhere to risk management guidelines based upon the RACGP’s [Royal Australian College of General Practitioners] guidelines . . . Members using Implanon will be required to undergo a training session in patient selection and counseling and Implanon insertion and removal techniques arranged by the manufacturer Organon. In addition, members will need to perform the first six insertions under the supervision of a medical practitioner experienced in Implanon insertion.⁸

MDA National had earlier announced, on 25 February 2004, that, with effect from the insurance year commencing 1 July 2004, Implanon cover would be available again in the non-procedural category — subject to adherence to risk-management guidelines.⁹

Some MDOs now offer premium discounts to members who satisfy specified standards for risk management in their practices or attend risk-management educational seminars and similar activities. I recently reviewed well over a thousand of the applications for MDAV’s RISQ (Risk Identification for Sustaining Quality) program. Some applicants supported the program strongly, saying the application process stimulated a major review of their practice’s policies. Others thought the discount was not worth the time required to complete the application. In my opinion, this latter group missed the point. The premium discount is a relatively minor immediate incentive when compared with the ameliorative effect that effective risk management may have on claims frequency, and hence the potential impact on their future premiums.

Further, one member made another, poignant point:

I know this is a very worthwhile exercise, but it’s had the effect of making me view every patient as a potential plaintiff.

While his comment strikes an empathic chord, he also missed the point.

Medical practice requires quality assurance *and* risk management. It also requires organisational governance — management of personnel, financial efficiency, systems efficiency, and so on — as much as clinical governance. All the various components of practice governance need to be managed. Focusing on any one component to the detriment of the others leads to a mismanaged practice. It is not a choice between risk management or quality assurance, we need both — less error is part of better quality.

Saxe’s poem about the blind men and the elephant is apposite.¹⁰ Six blind men argue vigorously about the nature of the beast of which each is holding one part — the tusk, the trunk, an ear, a leg, and so on. The poem concludes:

*So oft in theologic wars,
The disputants, I ween,
Rail on in utter ignorance
Of what each other mean,
And prate about an Elephant
Not one of them has seen!*

The elephant is clinical governance (continuous quality improvement). It has many parts. All must be subject to equal focus.

Paul Nisselle

Health Law and Risk Management Consultant
Elwood, VIC
nisselp@ozemail.com.au

Competing interests: The author was the Australasian Secretary of the Medical Protection Society, 1989–1998, and the Chief Executive of the Medical Indemnity Protection Society (MIPS), 1998–2003. Since resigning from MIPS, he has been a consultant to a range of organisations, including the Medical Defence Association of Victoria.

- 1 Wenck BCA, Johnston PJ. Implanon and medical indemnity: a case study of risk management using the Australian Standard. *Med J Aust* 2004; 181: 117-119.
- 2 Wilson RM, Runciman WB, Gibberd RW, et al. The Quality in Australian Health Care Study. *Med J Aust* 1995; 163: 458-471.
- 3 Kennedy I. Learning from Bristol: the report of the Public Inquiry into Children’s Heart Surgery at the Bristol Royal Infirmary 1984–1995. Command Paper 5207. Available at: www.bristol-inquiry.org.uk (accessed May 2004).
- 4 Kohn LJ, Corrigan JM, Donaldson MS, eds. To err is human: building a safer health system. Washington DC: Institute of Medicine, National Academy Press, 1999.
- 5 Tito F. Compensation and professional indemnity in health care — final report. Review of professional indemnity arrangements for healthcare professionals (Australia). Canberra: AGPS, 1996.
- 6 Medical Defence Association of Victoria. Current news. Implanon update. Posted on 2 July, 2003. Available at: www.mdav.org/index_news.asp?art_id=245&menuid=020.010 (accessed May 2004).
- 7 Allison L. MDO removes \$5,000 excess for Implanon lawsuits. *Med Observer* 2004; 21 May: 3.
- 8 United Medical Protection Ltd. Media release 21 May 2004. UNITED/AMIL announce category change for Implanon. Available at: www.unit-edmp.com.au/0/0.13/home.htm (accessed 23 May 2004).
- 9 MDA National. News February 2004. Change of category for the insertion of Implanon. Available at: www.mdanational.com.au/news/newstemplate_2004_2_25_1.asp (accessed May 2004).
- 10 Saxe JG. The blind men and the elephant. Available at: www.wordfocus.com/word-act-blindmen.html (accessed May 2004). □

