



24 January 2003

Mr Greg Byrne
Director of Legal Policy
Department of Justice
Level 4, 55 St Andrews Place
MELBOURNE VIC 3000

Attention: Ms Marlo Baragwanath (marlo.baragwanath@justice.vic.gov.au)

Dear Mr Byrne,

PERSONAL INJURIES PROCEDURES BILL

The Victorian Branch of the Australian Dental Association (ADAVB) provides professional indemnity support to members under a referral agreement with Guild Insurance Limited, and so has a direct interest in the Personal Injuries Procedures Bill presented to Parliament before the election was called late last year.

We have checked with Ms Baragwanath of your office, who confirms that this same Bill will be presented once again for the new Parliament to consider.

The Branch is supportive of the legislative objectives for this Bill, and welcomes the Government's efforts to address the serious medical indemnity and public liability issues affecting the community at large. We have a number of comments and questions regarding the Bill as drafted however, and would ask that these be addressed before the Bill is presented to Parliament.

The ADAVB's interest

The Bill seems to have been written from a medical injury perspective, and allied health areas are not mentioned. Having spoken with Ms Baragwanath however, we understand that all types of personal injuries, including those resulting from treatment failure following dental, physiotherapy, optometric, chiropractic, and other non-medical procedures, are to be covered

We understand that the Bill does not preclude a person using alternative dispute resolution methods before they resort to the pre-litigation processes defined in the Bill, and that the legislation simply requires that before a personal injury matter is presented to a court or tribunal, a certificate of compliance must be provided. Information provided to the public about this legislation however, should draw attention to the alternative dispute resolution systems and mechanisms available, and encourage their use before the formal pre-litigation processes intended by the Bill are invoked.

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The Branch conducts a complaint resolution function called “Community Relations”, by which many dental patients who have a treatment problem arising from attendance at a **member** practice can receive assistance to address their concerns. We refer letters of demand and solicitor’s letters directly to our preferred professional indemnity insurer Guild Insurance Limited (GIL), but to the extent possible, we seek to resolve enquiries and complaints before they become claims, and so reduce the cost of claims and litigation to the community and the profession. This would seem to be consistent with the Government’s objectives for the Bill.

Definitions

There do not appear to be any definitions in the Bill of

- “claim”
- “complaint”
- “claims manager”
- “registered health practitioner”.

Our concern at the use of the term ‘complaints’ alongside ‘claims’ in S.5(a) of the draft relates to our distinction between matters which can be dealt with through direct conciliation versus those that are formally considered claims, and must therefore be referred to the professional indemnity insurer and their solicitors. Once this referral occurs, the parties incur significant additional expense. The term “statement of claim or complaint” appears in this section whereas in subsequent sections the reference is to “notice of claim”. We suggest that the latter term should be used in S.5(a).

The ADAVB is concerned that our very effective dispute resolution mechanisms may be overlooked by the Government, with the effect that matters which could have been resolved cheaply and effectively to the complainant’s satisfaction, and without recourse to the formality of the pre-litigation procedures specified in the Bill, will all now become subject to formal notification in the form of an insurance claim.

The reference to a claims manager in the Bill appears to define the role of any person assigned responsibility for negotiating with a claimant on behalf of a respondent. This term is usually assigned to an employee of an insurer or indemnifier however, and the wider application of the title may lead to confusion amongst those parties affected by the Bill.

The reference to medical practitioners being required to provide comment on the stabilisation of injuries (S.6) fails to recognise that only dentists would be equipped to provide such reports in relation to oral injuries, diseases and treatment failures. Registered health practitioners should therefore be recognised alongside registered medical practitioners, as they are under Transport Accident and Workers’ Compensation legislation in Victoria.

Attention is also drawn here to the need for all parties to recognise that misadventure is a common cause of such failures, and that negligence should **not** always be assumed. As we argued in our recent correspondence to the Premier regarding the Wrongs Bill:

“In our view, the debate about professional indemnity seems to have removed the concept of misadventure from consideration, and to assume that any treatment problem or failure must have resulted from some level of negligence. This is a disastrous development which has the community encouraged to assume that their health needs are all mechanistic problems which simply require the delivery of “off the shelf” and “tried and true” remedies, when in fact the correct diagnosis of health problems is extraordinarily complex and the provision of the most appropriate treatment plan and health care is so often dependent on other factors outside the practitioner’s skill and training, including the patient’s own cooperation before, during and after the implementation of the recommended procedure. Even the best treatment forms have limitations, as they apply to a biological system that is not fully understood, and so they can still lead to adverse outcomes.

This is not to deny that negligence problems exist and require attention, but it has eliminated a more balanced view of the complexity of health care, and removed recognition of the fact that in some cases, the best practitioner, on their best day, using the best facilities in the world will still have treatment failures resulting from misadventure and limitations of treatment – not negligence.”

On another matter, the Human Rights and Equal Opportunity Commission (HREOC) confirms that it would prefer the term “handicapped person” not be used in legislation (s.3), with “disabled person” being the accepted alternative.

Exemptions

We support the views expressed by the AMA Victoria that all medical complaints should be compulsorily referred to the Office of the Health Services Commissioner for conciliation via the Health Services (Conciliation and Review) Act 1987, before being permitted to proceed to courts or tribunals. In the case of dental injuries, we would want the Branch’s own complaint resolution processes to be allowed to operate before such a referral to the HSC, and any subsequent formal pre-litigation processes, should they be required. The absence of any mention or recognition of such alternative dispute resolution systems and structures is of concern to us, as it implies that the established and successful measures by which to achieve dispute resolution (without generating inappropriate costs), will not be used. We note that there is no mention of the role of the HSC or of professional associations throughout the Bill.

If the administrative measures described in the Open Disclosure standard currently being circulated for comment, are expected to be applied in small office practices under the auspices of the Personal Injuries Procedures Bill, then we would oppose the inclusion of dental injuries amongst the personal injuries addressed by this Bill. The bureaucracies required to address the proposed Open Disclosure standard are well beyond the capacity of small health practices, and would place **unreasonable** demands on practitioners and practice owners. An amendment to specifically exclude allied health complaints and claims would therefore be in order, and this might be accompanied by referral of such matters to the Health Services Commissioner – as suggested above.

Likewise, it is not clear what implications will arise for consideration of small claims regarding dental treatment by the Victorian Civil and Administrative Tribunal (VCAT), and whether it would be necessary to list claims before the VCAT in the exemption list (S.4).

Under S4, provision is made for exemption of persons who are suffering a disability. Given the complex interaction of symptoms in some of the cases we have seen over the years, the claimant may well claim to have been disabled in part by the incident which triggered their claim. How is this illogical exemption to be addressed?

Health Records

Access to copies of treatment records needs to be in accordance with the Health Records Act (2001), including provision for practitioners to charge the statutory fees for copies of documents, radiographs etc., supplied at the patient's request.

Professional Indemnity

The Bill recognises that contributors to a claim may be joined by respondents, but there does not appear to be any compulsion to involve an insurer or MDO, even where the health practitioner has been obliged to take out professional indemnity insurance as a condition of registration (refer S.13). This failure to oblige the involvement of insurers may also lead to difficulties and delays in resolution of matters, which could otherwise be handled in a straightforward manner.

Compulsory Conference

The ADAVB considers that the compulsory conference provisions in the Bill will be unlikely to simplify or streamline complaint resolution. Indeed, we believe these measure may have the effect of making the process top heavy and expensive, as there would inevitably be a requirement that legal representatives attend for each party, and such high-level mediation activity would only be repeated in the event the matter proceeded to court anyway.

The experience of the Health Services Commissioner in this regard is informative. Procedures for conciliation of health service complaints have been amended on the basis of experience, so that conciliation does not in fact require a meeting between the parties. If conciliation can be achieved without such costly and cumbersome activity, then this should be recognised and encouraged under the legislation.

In Conclusion

The ADAVB urges the Victorian Government to make provisions for a system of resolving medico-legal disputes that does not involve adversarial litigation, promotes effective use of existing alternative dispute resolution mechanisms, and makes better use of medical (and other health care) experts.

ADAVB representatives would be pleased to amplify any of the matters raised above, in direct discussions with staff from your Department, if this would be of assistance.

Yours sincerely,



Dr David J Curnow
President

CC: The Hon. Bronwyn Pike MLA, Minister for Health
The Hon. Mr David Davis MLC, Opposition Health Spokesperson
Mr Peter Ryan, Leader, National Party
Independent MPs; Mr Craig Ingram and Mr Russell Savage
Ms Beth Wilson, Health Services Commissioner
Dr Robyn Mason, AMA Victoria
Ms Jennifer Lake, Australian Physiotherapy Association, Vic. Branch
Ms John Ilott, Australian Pharmaceutical Society Vic. Branch
Mr David Brown, Guild Insurance Limited