



INDEMNITY HIKE STIRS UP DOCTORS



Dr Gerard Panting, MPS Communications and Policy Director.

The largest-yet hike in indemnity cover costs for local health care professionals has ruffled feathers in the 23 000-strong Medical Protection Society flock, prompting hardest-hit specialist groupings to explore migration to commercial insurers.

The MPS increase averages 23% across all disciplines as the not-for-profit member-based society adjusts its South African reserves to cater for an increasingly litigious climate and rising patient payouts.

Hardest hit will be practitioners of obstetrics and gynaecology, whose annual subscriptions rise by 43% (from R46 000 to R66 000) while hard-pressed GPs will take a 13% knock (from R5 300 to R6 000).

Historically, the larger MPS increases have resulted in small-scale exploration of commercial alternatives in spite of the playing field being littered with the bodies of wounded or dead commercial ventures.

Izindaba discovered that specialist negotiations with Glenrand began almost immediately after Dr Tim Hegan, the MPS' international

marketing manager, conducted an initial whistle-stop tour briefing specialist groupings (mid-November).

Explaining why the premium increases were so high, Hegan said total payout costs in South Africa had increased by 600% over the past 5 years (an average of 51% per year) compared with minimal payout increases in the preceding 6 years.

'I would say that up to 80% of all specialists are ready to jump ship. Some of them, particularly gynaes and ophthalmologists who do refractive surgery, are really fed up,' he added.

'From '93 to '99 it was pretty steady but it has peaked as plaintiff lawyers are getting better and shifting their focus to doctors. It's not about doctors being (any more) negligent – it's about patients increasingly demanding their rights.'

Ernst Ackerman, a director of Healthman, one of the country's largest commercial health care management

consultancies, claimed Glenrand's insurance rates were lower in general for specialists than those of MPS. He described specialists as 'very unhappy with the MPS feedback. I would say that up to 80% of all specialists are ready to jump ship. Some of them, particularly gynaecologists and ophthalmologists who do refractive surgery, are really fed up,' he added.

Two of his co-directors had been in discussions with Glenrand since the MPS briefings and were (3 weeks later) 'finalising negotiations so that something can go out to specialists'.

His staff were 'making sure' that the Glenrand cover was the same or better than MPS and that it would cost the migrating doctor 'no more at the end of day, especially when he stops practising'.

Discontent

Ackerman said the discontent included the MPS rating of ENT surgeons and ophthalmologists doing refractive surgery changing from medium to high risk in 2003 after the MPS took over clients left in limbo by the Medical Defence Union's 2002 pull-out.

Dr Gerard Panting, MPS International Communications and Policy director, expressed mild surprise upon hearing of the potentially large migration of specialists.

'Our priority is making sure we remain financially sound – we'll be doing a great disservice to doctors and their patients if we allow ourselves to be under-funded,' he stressed.

Cautionary note

'We're not against competition – if people want to look at Glenrand or anyone else, they're entitled to, but when you compare a claims-based insurance policy with an incident-based indemnity, you need to make absolutely



sure about the differences.' He was confident that when doctors made this comparison they would question the wisdom of migrating. 'Clinical negligence is a long-term game, so thinking short-term is short-sighted,' he added. He said a historical look at commercial insurers world wide showed that 'when the going got tough, commercial insurers got going (left)'.

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Panting cited St Paul's 2 years ago dropping doctors from its client base altogether and locally, Proton, hundreds of whose clients MPS had 'rescued'. Asked what MPS would do in response to the Glenrand move, Panting replied 'we'll be on the phone to the specialists asking them what their specific concerns are'.

Premium reductions were possible, 'if someone can show us that we got it completely wrong – and that's not just sitting around a table being persuasive – we'd have to take the data back to our actuaries'.

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Work cut out

Hegan frankly admitted to having had his work cut out. Asked to 'show us the bruises,' he chuckled knowingly and

said of his audiences, 'they were shocked and concerned but reasonable and grateful for the briefings'.

Asked what needed to change systemically in order to stem costs, he said changing patient behaviour was impossible, so 'some sort of caps on awards of damages by working with the State' was the next most likely route.

He cited Australia, where loss of earnings claims were capped at three times the plaintiffs' annual average earnings, but said South Africa's health system, socio-economic profile and dual economy 'puts it in a completely different league'.

The chances of the MPS negotiating anything similar with the South African government were 'highly unlikely', given the current socio-political climate and dynamics.

Important differences

Hegan emphasised that MPS was a non-profit mutual company that offered discretionary cover with no exclusion clauses. This gave them the flexibility to offer much wider coverage than regular insurance companies. 'We've never turned anyone down unless they were paying the wrong category of subscription – our sole purpose is to protect doctors,' he said.

In contrast to insurance companies, as long as a subscriber was correctly paid up at the time of the incident, they were covered to beyond the grave. Subscribing to claims-based companies meant purchasing 'run-off cover for when you stop paying subscriptions'.

While at first glance such insurance packages might seem attractive, in the long term they could not compete with MPS benefits. Hegan said assets of the 112-year-old company, started by doctors, now stood at 620 million UK sterling, and were owned by its members.

The latest increase was based on expert actuarial calculations around what was needed in 2005 to cover

doctors in South Africa for the next 20 years.

MPS staff at the coal-face warned that doctors who migrated and then became unhappy with a commercial insurer would effectively have to pay double subscriptions for the time they were away, if they chose to rejoin MPS. 'We've bailed gynaecologists and others out before, but we cannot just keep rescuing them, especially on any large scale,' one warned. Plastic surgeons, with their 'scalpel safaris', were particularly vulnerable to overseas claims, a couple of which could 'blow a commercial insurer out of the water'.

One in the eye

Dr Hubrecht Brody, a former chairman of the ophthalmological society, said the MPS hike for colleagues doing refractive surgery increased annual subscriptions from R6 000 per annum to R26 000, which he said was 'simply unjustified, given the facts'.

Laser eye surgery case loads at the Cape Eye Hospital (for example) had dropped from 700 per month in 1990 to around 60 per month currently, which meant that the backlog of cases had been 'all but worked off'.

Refractive surgery could be done in less risky ways while Hegan's argument of claims emerging up to 18 years later



Dr Tim Hegan, MPS International Marketing Manager.





did not hold water in their particular case because patients complained within weeks or months if the operation went badly.

Hegan had promised to assess their new data and 'get back to us'.

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Panting agreed that this dramatic change in demography deserved a re-assessment.

'It's jolly difficult for us to be up to speed with all the changes in all the specialities and then apply a crystal ball to predict how the risk will be affected,' he stressed.

Dr Jan Talma, chairman of the South African Medical Association's Specialist Private Practice Committee, said doctors had become a soft target, forced to practise defensive medicine because of medico-legal threats that the country could ill afford.

The medical funding industry created public suspicion of doctors by laying the blame for medical inflation and perverse incentives at their door when the data showed the exact opposite to be true, sculpting an environment for opportunistic litigation.

Courts patient-friendly

Meanwhile, in a landmark ruling on 2 November 2004, that illustrated the

MPS argument of an increasingly patient-friendly legal environment, the High Court made a prescription ruling in which a blinded patient, Marthinus Deyssel, won the right to sue two ophthalmologists – a decade after first laying a complaint against them.

Hegan described this as 'concerning'.

'These are the kind of things which can have a major impact on business but we'll need to wait and see the outcome and not get too excited just yet,' he added.

Deyssel obtained a positive expert opinion 7 years after undergoing a series of cataract and then corneal operations to his remaining (then) sighted eye. In allowing Deyssel to go ahead and sue the ophthalmologists, Acting Justice RN Mlonzi said the plaintiff had 'trawled the highways and byways of professional practice, from lawyers to specialist doctors, to medical professional bodies, to constitutional bodies and parliamentary structures, with information of his treatment and operations at hand, seeking tirelessly and effortlessly (*sic*), for an expert opinion which might enable him to institute an action'.

This was after being advised 'categorically, justifiably so, by his attorneys at various stages that to institute an action without such expert opinion would be defamatory'.

The judge said it was 'legally inconceivable' that a malpractice case would see its day in a South African court of law without a litigant obtaining knowledge from a medical expert that the symptoms complained of (or the resultant consequence) were 'indicative of some degree of incompetence or negligence, constituting a wrongful act'.

The unprecedented ruling effectively means that prescription now commences from the day the plaintiff obtains their first report to establish where negligence lies – provided the plaintiff takes 'reasonable steps' to institute such action. Hegan said this implied that a patient could access medical files under the Freedom of Information Act, take them to a lawyer to elicit expert opinion on what transpired and from that time have the prescribed 3 years to bring an action.

MPS lawyers would focus on what 'reasonable steps' were taken by the patient on a case by case basis. The ruling has conditionally extended patient rights, but Hegan says it is not cause for undue alarm.

Asked about the millions of rands in legal costs racked up in the defence of specialists recently found guilty in an HPCSA 'kickbacks' hearing (the Illes and Partners hearing), Hegan said it would require '100 such cases' to have an inflationary effect on MPS subscriptions.

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If a doctor refused top legal advice from the MPS to plead guilty and argue mitigation, they were 'on their own' – unless subsequently acquitted.

'It's all done on a case by case basis and this kind of scenario is rare – the overriding principle is one of innocent until proven guilty,' he stressed.

Chris Bateman