Editorial
Changes to Professional Indemnity

Obstetricians in Hong Kong remember that Christmas 2014 felt chilly, despite normal winter temperatures. In that month, the Medical Protection Society (MPS) unilaterally directed that Hong Kong obstetric professional indemnity would change from an occurrence basis to a claim-made basis. Care of pregnancy beyond 24 weeks is considered obstetrics, and the gynaecological work of an obstetrician is also treated as claim made based indemnity by the MPS. The Hong Kong College of Obstetricians and Gynaecologists (HKCOG), Obstetric and Gynaecological Society of Hong Kong, and even the Hong Kong SAR Government made huge efforts to communicate and suggest logical amendments. We received firm NOs at all levels. The MPS declared that it was an important BUSINESS decision that should be implemented immediately in synchrony around the world, in contradiction of its own declaration that each region holds independent books. Doctors had to make a quick decision on whether to continue childbirth services, and patients were of necessity sometimes referred at very short notice to another obstetrician when their current obstetrician made the difficult decision to stop performing deliveries. Responses were in stark contrast to what we had expected based on a member-for-member institutional character. This article will not discuss the MPS, but rather analyse reasons and offer solutions.

Occurrence-based indemnity means that a doctor is insured for costs arising from a medico-legal dispute and covers both legal fees and any financial compensation that may be awarded. Claim made based indemnity protects the doctor only if the doctor was covered by the protection scheme both when the event being disputed happened and when the claim arises, or the case was reported and accepted by the insurer while the doctor was covered. It may look complicated. To clarify, with occurrence-based indemnity the doctor need not be concerned about future claims. With a claim-made basis, he must continue his indemnity indefinitely to guard against future litigation.

The root of the problem lies in huge amounts of compensation paid for problems that arise as a direct result of the delivery process, for example, asphyxia and birth trauma. These events are considered to be attributable to actions or inactivity of the attendant obstetrician. The problem is further aggravated by the length of time that may pass before a claim is filed. This delay may result in financial inflation, and changes to social norms, including the basis on which the court awards compensation. Doctors may not like the present judicial approach to compensation but we have to submit to society norms. In addition, the image of a powerful and unjust doctor against a suffering baby is not favourable. Obstetricians have had particularly bad publicity profile in 2015: an obstetrician in private practice who was recently disciplined by the Medical Council, and the long list of allegations against private obstetricians during the mainland obstetric saga, are still fresh in the public's mind.

It is true that occurrence basis to professional indemnity, and unlimited compensation are difficult to sustain, despite historic declarations by the MPS that these two features are their 'core values' that distinguish them from other providers. In 2015, the MPS removed both aspects from the protection it provided. Current practitioners may be envious of their predecessors who paid relatively small premiums, were not sued, and enjoyed virtually limitless immunity. We must acknowledge that 'the world has changed, and we have to change as well'.

Private delivery suites are not going to close overnight, but frost followed snow in Hong Kong with the mainland obstetrics event and then the indemnity problem. Readers should nonetheless not despair: the future is NOT fixed, but rather lies in our own hands.

The problem is not MPS, which is merely a provider, but the rapidly escalating indemnity costs. This in turn is due to escalation in the number of claims.

A doctor may face legal action after retirement and after he / she has stopped paying for indemnity. In claim-made indemnity, subscription amounts may continue to increase: a retired practitioner may not be able to afford such costs, despite claims by the MPS that subscriptions would remain affordable. No one knows, least of all the MPS, what will happen in future. Data informally released from the MPS indicated that up to 2% to 3% of claims occur 5 years after the index case. Thereafter the chance drops a lot, and it allows us to have a feeling of costs for the second and subsequent 5-yearly intervals of 'extended

reporting' for coverage. Compensation amounts are also likely to continue increasing. The obstetrician faces the prospect of losing everything he has worked for because of one bad case, if he cannot afford to pay for indemnity or if he lacks protection by the MPS.

When private obstetric indemnity is not protective, private practice ceases to be an attractive option. This may deter young doctors from entering the specialty. In terms of obstetrics and gynaecology, our specialty enters menopause — the specialty looking after reproduction will cease producing offspring.

Although the private sector will bear the brunt of these changes, the government is not unaffected. After two decades of experiment, Hong Kong has learnt that her health care system needs to be two-tiered with private practice running alongside public. Although the public-private overall admission rates now stand at about 88:12, in obstetrics it is about 60:40. With stabilisation of the private obstetric sector, private paediatrics and anaesthesiology also grow. A fatal attack on the private obstetric sector has serious implications for society and the government.

In an effort to continue providing services, adaptations may be required. Some patients return to the public sector for deliveries when supply in the private sector recedes. This is a further insult to public units that are already short-staffed and have difficulty in recruitment. Some trained doctors may transfer to the private sector despite taking apparently more risks, because they cannot tolerate the ever-increasing public sector workload. In the next decade, retirement will become a theme in human resource management of the Hospital Authority (HA), and the early departure of experienced doctors will add more pressure to the frail human resource backbone. The HA in theory may increase its headcount by assigning new and unwilling doctors. We have witnessed backlashes in many other historic events: it is hoped that the HA will have learnt the hard way that doctors may not be compliant when personal safety is at risk. We have also learnt from overseas experience that when claims escalate, obstetric compensation, even in the public sector, consumes a lot of resources to the extent that the sustainability of the health care system is jeopardised.

Labour ward risk management will be emphasised, whether doctors like it or not. In the private sector, it may infringe the autonomy that many doctors take for granted. It may be worth reminding readers that part of the reality of claims-made indemnity is that one generation of private doctors funds their own claims, instead of leaving it to the next generation when he retires. Therefore the long-held approach that we are not interested in what is happening next door may now be seen as harmful to our own wallets. Each doctor actually contributes to compensation paid for mishaps next door. It speaks strongly for open peer review and collective prevention of problems whenever possible. When annual indemnity premiums rise to unaffordable levels despite self-regulation, doctors will need to be attached to private hospitals in order to continue private practice. Obstetrics could then be institutionalised, meaning that private hospitals dictate the actions of doctors, whether or not they agree. If even private institutionalisation is not successful, and private teams cannot afford indemnity coverage, obstetrics will further be institutionalised under public organisations. Colleagues who wish to retain control of their own practice must now realise that self-discipline is an important tool, and make immediate changes while it may still work.

The author has stated earlier that the future is not yet determined. It is time for us to take a united stand and look for a solution. The MPS advises us that claims in Hong Kong are not out of control, although the rate of their increase is worrying. Hong Kong may be unique in that there exists no alternative provider of professional indemnity. A logical and important aspect of management is competition. The HKCOG has formed a subcommittee to examine this aspect, and we are open to all parties who may be interested in provision of such a service in Hong Kong.

The HKCOG is encouraging the focus to be on labour ward risk management, and is prepared to do everything possible in this respect. The author has explained that it is not a nosy exercise. Instead, it could be the difference between collective survival and extinction. Furthermore, unless we do everything seen as appropriate in self-regulation, it is difficult to lobby for social support from other areas of management, such as capping of claims and the maximum period for bringing a claim.

A most important part in the overall solution is tail coverage that will enable doctors to retire in peace. It may be difficult to estimate the total amount required for each doctor, as changes occur over time. Nevertheless some calculations may be feasible and some mechanisms to pool subscriptions may help each doctor significantly. The bare minimum may be coverage of legal fees and a modestly capped compensation. Nonetheless adequate cover is necessary to protect the doctor, as well as provide a valid

alternative to specialties for whom MPS indemnity remains occurrence-based.

Conceptually, any single indemnity provider may be liquidated. We have been given to understand that the MPS is financially stable, but we have witnessed the recent fall of so-called financial giants, and history is prone to repeat itself. In the 21st century with the half-life of everything shortening, it may be safer to seek indemnity support for the whole of Hong Kong on a year-by-year claim-made basis, in order to prevent liquidation of the insurer that would leave doctors unprotected. Furthermore, insurers are regulated by governments, but the MPS is not controlled by jurisdiction.

It may be an opportunity to review our existing mechanisms for resolving conflict. The MPS relies heavily on support from lawyers, and it may be fair to describe MPS as a financial facilitator with little other capacities. The future system may start with an individual service unit for conflict resolution, of which the author has experience. Each private delivery suite may set up such a mechanism. The importance of mediation might increase, as it is far more cost-effective than legal proceedings. Another way forward may be to install centralised clinical case handlers, who may advise early settlement of claims without recourse to lengthy and costly legal work. Legal support becomes part, instead of all, of the mechanism.

The College is doing everything possible to handle the matter, and a subcommittee has been established under the Professional Development Committee for this purpose. We are not able to produce regular announcements because changes frequently occur during negotiation, and any solution must be deliberated until it is deemed definitely sustainable. Colleagues please kindly accept our apologies that we are unable to rapidly produce sustainable, safe fixes. We welcome advice and communications. The author is also prepared to continue serving the fraternity on the matter after stepping down from present appointments.

Obstetrics and gynaecology is not as small as our membership number reflects. We have a huge stake in private medicine, and our high compensations make us high in the subscription / claim profile. We do not belittle ourselves when we try to find alternative(s). We shall be humble to every other stakeholder in Hong Kong and overseas. We need support. We need friends and allies, more now than ever, regardless of how we were treated (or shall be) at any time. We already have strong indicators from MPS membership electronic application forms that may next face similar treatment: orthopaedics, cosmetic surgery, and ophthalmology. Neurosurgery is close behind us in terms of subscription levels. The logic of the MPS that occurrence basis is difficult to maintain for minors applies to paediatrics and related fields, anaesthesiology and psychiatry. In the long run even general practitioners may not be immune. We shall tell 100% truth, and not conceal or exaggerate the truth, to enable our colleagues in other specialties to understand THEIR own problems.

This matter is not unique to obstetricians. It is a blight on medicine in Hong Kong. It may simply leave a scar on the dignity of doctors in Hong Kong, and change obstetrics and gynaecology for the worse. We may live to tell our story that private obstetrics in Hong Kong ended when we were active. Alternatively, we may tell our profession grandchildren that we oldies fought to provide them chances to serve. It may actually provide us an opportunity to review our system and find a proud solution, so that even our mother country may benefit. The outcome depends on ourselves, no one else.

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