Public Liability. Who Pays?
The Patient, the Public or the Doctor! Putting Things in Perspective

Judge CF Wall QC

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1. In the Weekend Australian Financial Review, 27-28.4.02 Alan Kohler said

> "This weeks insurance crisis is medical indemnity. Last week it was public liability."

Both are connected and in this paper I will attempt to demonstrate that connection.

2. **(a)** 70% of medical mistakes are caused by human error

(b) Such mistakes leave an estimated 50,000 people in Australia each year permanently disabled and 18,000 dead.

(1995 Quality in Australian Health Care Study, reported Courier-Mail 20.4.02.)

3. The incidence of someone dying from medical error in hospital is probably between 1 in 50 to 1 in 200 (Dr Michael Buist, Director of Intensive Care, Dandenong Hospital, Melbourne, Courier-Mail 20.4.02).

4. Early intervention by medical emergency teams can reduce in-hospital patient deaths from cardiac arrests. This includes tracking warning signs such as blood pressure and heart rate. At Dandenong Hospital in 1996 there were 56 deaths from cardiac arrest. This fell to 26 in 1999 after such teams were introduced (Buist study, British Medical Journal, February 2002, Courier-Mail 20.4.02)

5. 15 years ago the University of Illinios State Hospital in Chicago (UISH) (a public hospital) adopted a computerised physician drug order entry system. Only doctors prescribe drugs and they do so by computer to decrease transcription mistake and verbal errors between doctors and nurses. This reduced errors by between 50 and 75% (Study by Dr William Galanter, UISH, Courier-Mail 20.4.002). 1 out of 100 people admitted to the UISH suffers a medication mistake (current figures).

6. At the Royal Brisbane Hospital in 2001 reported medication errors increased from 46 in January – April to 119 in September and October (Courier-Mail 20.4.02).

7. At the Princess Alexandra Hospital, Brisbane reported medication errors increased 11% last financial year with 10 patients believed to have died after suffering adverse drug reactions (Courier-Mail 20.4.02).

8. In the Townsville General Hospital 230 medication errors were reported in the first 9 months of 2001 (Courier-Mail 20.4.02).

9. With this background is it fair to require victims of medical negligence to prove they are at least 15% disabled before they can proceed with court action and that damages be capped at $250,000 (AMA Qld, proposed Health Care Liability Act, Courier-Mail 20.4.02)

10. It may be inappropriate to compare (as does the AMA Qld, Courier-Mail 20.4.02) work and motor vehicle accidents with medical negligence because in the former there is state mandated compulsory insurance.

11. **(a)** It is, I consider, wrong to blame the legal system, eg, "Time is of the essence in reining in the Santa Claus tendencies of Australian Courts" (Janet Albrechtsen, The Australian, 3.4.02) and "Judiciary must end nation's blame culture" (Editorial, The Australian, 26.3.02). "Judges playing Santa Claus" was also part of the heading of a report by Ashley Crossland in The Australian Financial Review, 5.4.02.
(b) This is not to say that the legal system is not able to do something. See para 33.

12. This is a public liability issue because for doctors working in public hospitals normally liability is picked up by the state government or their agencies. It is also public because doctors seem to want the public to pay for, or contribute to, payment for their mistakes.

13. Until relatively recently most medical defence organisations (MDOs) (doctors "not for profit" insurers) have not been disclosing their "claims incurred but not reported" incidents. All other insurance bodies are required by law to incorporate these very real liabilities in the balance sheet. MDOs do not come under the APRA insurance regulation (The Weekend Australian, 6 – 7.4.02). Is there not a touch of FAI here? Provision for claims incurred but not reported currently total $580 million. See also para 28. It has been said (The Australian, 26.4.02) that MDOs can "ignore" claims incurred but not reported because "they are not regulated by APRA and have a discretion in paying claims."

The Courier-Mail, 23.4.02, reported that Sen. Helen Coonan, Assistant Treasurer, planned to bring MDOs under APRA's "umbrella to prevent the insurers collapsing". The Health Minister, Sen. Kay Patterson was also reported as warning that doctors medical indemnity premiums "would rise under regulation".

14. Speaking of accidents generally and in the context of public liability Sen. Coonan, said recently (The Australian Financial Review, 5.4.02)

> "It's time for people to start taking more responsibility for their own actions instead of always looking for someone to blame when things go wrong"
>
> "If someone is injured and it's the result of somebody else's fault, then obviously they should get compensation. But it's got out of whack, its got out of balance ... We need to have in place some limit so that people take responsibility for their own actions"

Isn't this also the position as far as doctors are concerned?

15. To suggest, as does Sen. Coonan, that the 'main drivers' in this state of affairs are the legal profession and the judges is unfair and has a tendency to overlook personal responsibility for events which occur long before lawyers and courts become involved and steps which could be taken to minimise those events. In this context, where Sen. Coonan wants "people to take more responsibility for their risky activities" the doctors seem to want to take less and want the community to subsidise their mistakes.

16. MDOs are said to be in serious financial trouble (The Weekend Australian 6 –7.4.02). Deloitte's Trowbridge Consulting Group report on medical indemnity in Australia estimates the total assets of Australia's major MDO's at around $1.2 billion and their liabilities, including claims incurred but not reported, at more than $1.5 billion. The difference between assets and real liabilities as at 30.6.01 was $330 million, or $6800 per doctor member in Australia. Have the MDO's been properly managed? See also paras 20 and 32. The Trowbridge report was used as a starting point by the public liability summit held in early April 2002 (Australian Financial Review, 5.4.02). See also para 22.

17. According to The Weekend Australian, 6 –7.4.02 no commercial insurer is prepared to take on medical insurance because it is not financially viable. Most of the MDOs have an insurance subsidiary which in turn reinsures the risk. A large number of these risks were insured with HIH.

18. Peter Cashman of Maurice Blackburn Cashman claims the problem is not with the law but with the insurance industry, which has not created sufficient reserves (Australian Financial Review 5.4.02). This may be so. See also paras 22 and 28 and 32.

19. " Prior to its collapse HIH was the dominant player in the Australian liability market. Its influence in professional indemnity insurance was pervasive. Its collapse has removed significant capacity from the market..."(Paper by Ron Ashton, Minter Ellison, 'The Effects of HIH and September 11 on Insurance Litigation' presented to DC Judges Conference, Brisbane, 27.3.02).

20. DK Derrington QC and Prof. Tony Tarr, Legal Issues Arising Out of The Collapse of HIH Insurance Group, (2001) 16 Australia Insurance Law Bulletin, no.5 pp 41,45 say

> "12 months after HIH Insurance was placed in provisional liquidation, Australia's insurance industry is still reeling from the company's collapse... The country's largest medical indemnity company appears to be on the brink of collapse..."

This according to Ron Ashton (para 19 p 7), was a reference to "the $56 million exposure to HIH carried by United Medical Protection" an MDO and it is now accepted that the company is UMP. UMP insures 90% of Queensland doctors and has recently "signalled a crackdown on its highest-claim members, after its dwindling reserves forced a $35 million government bailout" in March 2002 (Courier-Mail 23.4.02). The Courier-Mail report continued

> "Under the new system, doctors sued more often than their peers, will face even higher premiums and, in some cases, loss of cover.
> Stephen James, General Manager of UMP's financial and underwriting services, said United would take a 'much firmer line' with the 1% of members that generated a quarter of the claims. Doctors would receive visits from risk managers in a bid to bring down claim numbers which, in Queensland, had almost tripled per 1000 members since 1990"

Is this not a belated recognition by doctors (or at least one MDO) of the realities of professional indemnity insurance and practise? The "bailout" is a reference to the federal governments $35 million guarantee to UMP's insurance company Australian Medical Indemnity Ltd. "to prop up its capital base" (The Australian, 24.4.02).

A correspondent to the Courier-Mail, 26.4.02 wrote of the 1%/25% equation

> "If this is the cause of UMPs 'dwindling reserves,' why wasn't it addressed years ago? If litigation is what it takes to bring to light bad doctors and bad management of claims, I don't understand the argument that litigation should be curbed. The AMA must address the ills of the medical profession before it can argue credibly for changes to the indemnity system which will benefit only doctors."

21. Ron Ashton, (para 19 p 7) expressed the view that "the danger in relation to spiralling premiums relates not so much to HIH's collapse and departure from the market but to the extent to which it and those which followed it underpriced their risks for so long." The same would appear to be so with MDOs.

At page 10 he said

> "In soft insurance markets insurers will often take on loss-making business to achieve market share and funds flow. The appetite for this has been completely sapped. Ruthless decision making in the upper echelons of the major insurers is seeing abandonment of some lines of business and withdrawal from whole geographical markets. Coverage in some areas may not be available at any price. Those who stay are likely to charge high and play hard".

Are only lawyers and judges responsible for this situation? Has not the medical profession failed, until now, to recognise that perhaps their insurance market is not soft but in fact hard and has been hard for quite some time?

22. At the Judges' conference (para 19) Mr Ashton, speaking to his paper, claimed that premium increases would have occurred in any event in due course even had HIH not collapsed because competition had been met by reducing premiums and not "looking beyond next months cash flow position rather than considering what the capital asset position would be in 10 years". (Trowbridge Consulting *op cit*, found industry regulation would "undoubtedly require some level of capital accumulation to secure past liability obligations," Courier-Mail, 23.4.02). He also claimed that in fact liability insurance premiums have not yet, on average, returned to the levels of 1993; they just remained too low for too long. As to the suggestion that substantial awards of damages are increasing in number and amount he said this was not really true – as to number they are falling but the number of claims on insurers is rising rapidly (APRA statistics); more claims are being made and paid without going to the courts.

23. Kohler (para 1) suggests a combination of the following are responsible

(i) the '90s investment boom was more extreme and more prolonged than usual, so artificially low premiums and loose underwriting discipline became entrenched; underwriting returns were in fact poor. Trowbidge Consulting estimated that in 1999 insurance companies were losing $750,000 a day on their liability books

(ii) the way Australians view litigation. Large scale class actions and personal liability claims generated by two Melbourne solicitors firms also contribute and these have "educated Australians to pursue their rights" helped by a no-win, no-pay system. "And of course judges have been helping to promote the cause of the plaintiff lawyers with generous and growing awards to victims."

(iii) September 11 causing an increase in global reinsurance costs as a result of "underestimating the cost of the collapse of a skyscraper."

(iv) an almost frenzied period of rationalisation that has slashed the number of players in the game, in many cases to just one

(v) the collapse of HIH – both an effect and a cause

(vi) A downturn in insurance companies stockmarket investment returns

Insurance companies, Kohler says, are now belatedly attempting to "properly price and allocate capital" and consumers are "paying for the loss of the subsidy from investment income and the growth in claims, exacerbated in some businesses by the reduction in the number of players."

24. Plaintiffs do in fact fail, eg *Major v Cleland and State of Queensland,* unreported, DC, Townsville, 21.3.02, and *Breen v Larkin*, unreported, SC, Brisbane, 24.4.02, [2002] QSC 107.

25. The Report of The Liability Insurance Taskforce, Queensland, February 2002 recommended that common law damages for personal injury be reviewed and that further research be undertaken into determining whether capping damages claims and/or abolishing common law rights can result in lower premium costs (Recommendations 14 and 18).

26. The Taskforce (Report, p 34) had this to say about "structured settlements":

> "Changes to the way settlements are paid may offer some relief in terms of overall premium costs. Structured settlements involve periodic payments for a specific number of years or for life in cases where special medical care must be provided. Often such payments are funded by an annuity, and because the time value of money is contemplated in the settlement, a structured settlement is usually less costly to an insurer or self-insurer than a lump sum settlement.

> Structured settlement laws either mandate, allow defendants to request, or allow courts to require that some or all payments awarded by a judge or jury be made to the injured person over a long period of time. In other words, the injured consumer is prohibited from receiving payments in a lump sum".

27. Professor Harold Luntz, the George Patton professor of law at the University of Melbourne, has been reported (The Australian, 8.4.02) as saying that the High Court of Australia has "executed a u-turn on personal injury cases, making it much harder for plaintiffs to win".

Prof. Luntz said "generally the current mood of the High Court is to close down liability for negligence".

He said he did not think the High Court had much to do with the rise in insurance premiums. He spoke of a trend, which commenced in 2000, as "pro-defendant". He said the High Court's past expansion of negligence liability - for doctors and landlords for example – had generally been reversed. He described the 'turnaround' in personal injury cases as 'tremendous' with more emphasis being placed on 'individual responsibility in the event of an accident'.

I do though, recognise the points made by Judge McGill SC, (Paper, 'A View From the Bench' Australian PLA, Qld Conference 2002 pp 4,5) as follows:

> "People are more willing than has been the case in the past to claim from other people compensation for injury or loss that they suffer. This is no doubt partly because of the extent to which people are made aware by the media of others who have received compensation for various forms of misfortune, sometimes in unlikely circumstances, which encourages a view in the community that if you have suffered an injury there should be some compensation out there for you somewhere. As well people are less likely to accept personal responsibility for their own actions and seem to be more willing, sometimes eager, to find someone other than themselves to blame when something goes wrong. This attitude on the part of the public in general is, I suspect, not something which is susceptible to any change by legislators or anyone else.
>
> It is now much easier for somebody who wants to make a claim to be able to do so, thanks to one aspect of improved access to justice: many solicitors are willing to act on a "no win no fee" basis, and vigorously advertise the fact.
>
> Courts have (also) for some years been more willing than they were 20 or 30 years ago to find defendants liable for injuries in unusual situations, that is away from the ordinary motor vehicle accident or industrial accident case (where courts have been enthusiastically

finding defendants liable in almost every possible situation for decades)".

It is this last point which Prof. Luntz thinks is now trending the other way.

28. On the 23 April 2002 a "medical indemnity forum" was held in Canberra. Health Ministers and doctors attended. The federal government "refused further financial aid" to UMP but the Prime Minister said the government would ensure that doctors were not uninsured. The forum agreed to

- Support legislative changes to encourage structured tax free settlement in lieu of lump sum awards.
- Cap some legal pay outs
- Further discuss broader tort law reform (negligence laws) and "administrative efficiencies" at a meeting in late May 2002
- Establish a national database on medical negligence

(Courier-Mail 24.4.02 and The Australian 24.4.02).

The AMA president denounced the decision to refuse further financial aid to UMP as "a catastrophe for doctors and patients" and "a medical crisis." She said "it's not for the AMA to say what can be done" (ABC Radio News, 6pm, 23.4.02). No mention was made of any responsibility of the part of doctors for this state of affairs. The NSW health minister said "industry regulation is long overdue" (ABC TV News, 7pm, 23.4.02).

Sen. Patterson, the federal health minister said "the medical indemnity industry needed to 'bring itself up to scratch'" (Courier-Mail, 24.4.02).

From July 1, 2002 Australian Medical Indemnity Ltd (UMP's insurance company) will, according to reports, be required to have up to $144 million to meet new rules imposed by insurance regulations in the wake of the HIH collapse. Without the capital its licence could be revoked (ABC TV News, 7pm, 23.4.02 said the DMO's would be required to operate "like fully regulated insurance companies with reserves"). UMP chief executive Mike McLeod said the insurer would need millions in government support before it could renew doctors insurance policies potentially leaving doctors (60% are said to be covered by UMP) uncovered after 30 June 2002 (The Australian, 23.4.02). Is this all due simply to "a surge in claims"? (The Australian, 24.4.02). Mc Leod blames "a big claims spike (high damages awards) at the end of last year" (ABC Radio News, 6pm and ABC PM, 24.4.02) (see para 32). He said, (ABC TV

News, 7pm, 24.4.02), "It's a matter of time for us." He said UMP had 32,000 doctors (90% in NSW and QLD) "as members." ABC TV News, 7pm, 24.4.02 reported UMPs "potential liabilities at $350 million." UMP itself estimates it has $455 million worth of future claims incurred but not reported - for which it has put no money aside (The Australian, 26.4.02). A doctor quoted on ABC TV's 7.30 Report, 24.4.02 said that if the government does not bail out UMP "that will probably mean the end of obstetrics in this country." The Australian (26.4.02) reported that "doctors organisations say the collapse of UMP could cripple the nation's health services."

29. In fairness not all MDOs may be in the same position as UMP. A spokesman for Medical Indemnity Protection Society (MIPS) said (ABC Radio News, 6pm and ABC PM, 24.4.02)

> "It is inequitable to penalise other MDOs for their own prudence. UMP chose to cover doctors in the most litigious state in Australia – NSW. MIPS is prepared to insure UMP's doctors for future not past events."

On the other hand, The Australian, 26.4.02, reported that according to "industry sources at least two other MDOs face the same problems as UMP." ABC TV News (7pm, 26.4.02) also reported that "several other MDOs have unfunded claims."

30. Another correspondent to the Courier-Mail, 26.4.02, wrote of a reported AMA meeting with the federal government "to argue for the protection of doctors from litigation"

> "The medical profession has a history of secretiveness. Doctors rarely, if ever, voluntarily disclose medical mistakes to a patient. Other doctors are equally unforthcoming about a colleague's error when confronted by a patient seeking a second opinion... Apart from alarmist statements by doctors that insurance premiums are too high for sustainable medical practice, little concrete evidence seems to have been presented to support their argument."

31. Maybe doctors themselves, should share with courts, some responsibility for the decisions they complain of. In *Breen v Larkin* (see para 24) the plaintiff was a 9 year old child who sustained a spinal cord injury during birth. The defendant was an obstetrician who attended her mother during confinement and delivery. Evidence from 2 obstetricians supported the defendant. The plaintiff's case depended upon the evidence of a paediatrician that the objective of the obstetrician is to deliver an unharmed baby so that the birth of a damaged child is proof of negligence. The judge rejected this argument. The plaintiff lost.

32. The public and governments are being frightened, and possibly stampeded into action. Robert Gottliebsen, writing in The Australian, 26.4.02, wants parliaments to legislate "wider responsibilities into the court system." He continued

> "If left unchecked, the courts, in effect, will price top hospital cover out of the range of ordinary people and in the process do to medicine what they have done to community events.
> Public hospitals are covered by State governments. Surgeons simply won't operate in private hospitals if there's no cover for past or future claims.
> The causes of the problem are the legal bills that take 20 – 35% of the payments to those who have suffered, the generous judges who award damages that take no account of community cost and an insurance industry no longer prepared to lose a fortune."

Is all of this correct? Kohler (para 1) put things more objectively and less emotively when he wrote

> "While United Medical Protection is commonly called Australia's largest medical insurance company, it is not an insurance company at all and does not provide insurance – although it has an insolvent subsidiary that does.
> UMP is basically a doctors' friendly society that offers professional indemnity to doctors on a discretionary basis – that is, it can decide whether to meet a doctor's claim or not. If it needs liquidity, in theory it can call on its members, although in practice this almost never happens.
> For that reason, defence organisations (MDOs) such as UMP are not regulated as insurance companies. In fact, they're not regulated at all.
> As a result, they are undercapitalised and often badly managed. General accounting standards do not apply to them and, they often do not provide for claims incurred but not reported (IBNR). IBNR provisioning is one of the foundations of normal insurance because it allows a firm to meet long-tail insurance, like medical indemnity, where claims can be filed many years after an incident.
> In 1999, the two Victorian MDOs, MIPS and the Medical Defence Association, struck an IBNR provision and had to levy their members to pay for it. At the time, UMP declared that it would not levy its members, and a lot of MIPS and MDA members switched to UMP.
> Then, in 2000, UMP had to make a call on its members, but it wasn't enough. That's because of rapidly rising claims: MDOs typically have a cap of about $5 million on indemnity payouts, but that was blown away last year by the Calandre Simpson case, in which a cerebral palsy victim successfully sued her doctor and was awarded a record $12.9 million plus costs. The largest component of the payout was the cost of long-term care for Simpson.
> As a result, doctors are now pushing the Government to pick up long-term care under the welfare system to take the pressure off their MDOs. No doubt John Howard's refusal to support UMP is tied in with the Government's understandable reluctance to assume, in effect, responsibility for the cost of medical negligence.

> Whether or not the rest of Australia's MDOs follow UMP into oblivion, Australia's doctors, and therefore their patients, will have to face the prospect of paying the real price of their protection. That probably will mean actually buying insurance from an insurance company, instead of half-baked, limited, discretionary indemnity cover from a doctor's friendly society."

33. What can the legal profession and the courts do?

(a) I think structured settlements are a good idea provided there is a guarantee of continuation of payments, which of course, would not have been the case had the insurer making those payments been HIH.

Periodic payments could be made in respect of future care and perhaps future economic loss components. Such payments are much less capital expensive, cease on death, do not benefit estates and can not be spent or lost. They should be tax free.

Subject to how payments would be guaranteed, it is my view that courts presently have the power to structure a damages award to achieve such an objective.

Future labour hire costs, loss of income, medical and nursing expenses were awarded on a periodic basis (payable fortnightly) by Bredmeyer J. in *Kupil and Anor v PNG* [1983] PNGLR 350. Reliance was placed on s 155(4) of the PNG Constitution which gives power to the court to "make orders as are necessary to do justice in the circumstances of a particular case." The liability for income tax on the payments was not considered. The defendant was the state and the judge had "no reason to doubt that the payments ordered would be honoured."

(b) Be willing to accept that not all accidents are compensable.

(c) It has been suggested that judges could adopt a more robust approach to contributory negligence though I recognise that this may not be an issue in medical negligence actions. Up to now courts sometimes adopt (as a result of decisions such as *Sungravure Pty Ltd v Meani* (1964) 110 CLR 24 at 37, 38; *Vial v NSW Housing Com.* (1976) 1 NSWLR 388; *Com for Rys v Ruprecht* (1979) 142 CLR 563; *Marshall v Osmond* (1983) 2 All ER 225; *McLean v Tedman* (1984) 155 CLR 306; *Podrebersek v Australian Iron and Steel Pty Ltd* (1985) 59 ALJR 492; *Bankstown Foundary Pty Ltd v Braistina* (1986) 160 CLR 301 at 310; *Ghantous v Hawkesbury City Council* (2001) 75 ALJR 992 at 1027, 1040) what some contend to be a fairly benevolent approach, in portraying what really is contributorily

negligent conduct as 'mere inadvertence, carelessness, thoughtlessness, inattention or error of judgement, falling short of negligence'. I must confess I have done so myself. Is this not realistically a cute distinction?

34. What can the medical profession do?

(a) Adopt procedures, systems and training to minimise the risk of injury. Much more needs to be done here. A correspondent to the Courier-Mail, 27.4.02, referred to the need for doctors to do "their job properly" and to take "a good look at their qualifications and work practices."

(b) Recognise that they alone should not be immune from their mistakes and that any increase in claims and premiums is certainly not the fault of patients and realistically not the fault lawyers. There must be a genuine acceptance by doctors of accountability for error and the rights of patients and a real understanding of who may be responsible for the overall situation (error - insurance) they find themselves in.

(c) Better manage their insurance organisations; and provide proper reserves, no claims benefits and impose claims penalties.

(d) Recent US studies suggest a reduction in claims if doctors admit mistakes early and describe them as just that.

35. What can insurers and MDOs do?

Much better than they have done to date.

36. And Patients? Realistically are they to blame? They will probably have to pay. Dr Bill Glasson, President, AMA Queensland said (Courier-Mail, 23.4.02) that "the costs would not stop at the doctor's door. At the end of the day, it's not the doctor who pays, it's the patient who pays" Whose fault is this? Is it the patients? I don't think so. Is it the lawyers or the courts? I don't really think so. Is it the insurance companies? Yes. Is it the MDOs? Yes. Should it stop at the doctors door? Some would probably say yes. Negligence is compensable, and, as is apparent from *Rogers v Whitaker* (1992) 175 CLR 479 at 487, 489 and subsequent cases, courts assess conduct often on evidence given by other doctors; it is not decided in an evidentiary vacuum. Co-incidentally those doctors giving evidence for a plaintiff (and most of us will recall how hard it once was to find any doctor at all to give such evidence) are themselves probably "insured" by an MDO. Solicitors have adjusted to professional negligence and so should doctors. Solicitors have accepted responsibility when warranted, yet according to the AMA and other medical professional associations, doctors seem to require, expect or want a degree of

immunity (not available to other service providers) which may ignore logic and the realities of modern society, standards and community expectations. Up to now, have doctors been realistic about their "insurance" provider and the extent to which they are covered?

37. In the debate about these issues it may be that doctors have overlooked, underplayed or minimised the fact that sometimes they do make mistakes and the necessity for a pro-active attitude to risk and error management and training and their own responsibility for the insurance risk management deficiencies of their medical insurance organisations. In short, they may have lagged far behind other service providers in keeping up to date with risk management, protective strategies and proper insurance cover.

38. At the time of writing UMP announced that it and its insurance company, Australian Medical Indemnity Ltd., would seek the appointment of a provisional liquidator as it did not have sufficient reserves to meet claims. The Assistant Treasurer, Sen. Coonan said short term government assistance would be provided to the provisional liquidator probably by way of a financial guarantee. Two other MDOs blamed "mismanagement and accounting issues" for the plight of UMP.

39. Who is really to blame? Who will pay? Doctors?

CF Wall QC DCJ
Townsville
30 April 2002