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The problem of professional liability insurance for health care providers and, more particularly, for medical doctors and hospitals, has been described as a "crisis." This crisis is usually viewed from the perspective of the physician, because he has been most vocal in his response, and this reaction, which closely parallels that of the public, has been widely reported.[1] His concern has also been more widely publicized because it has taken the form of work stoppages, retirement, removal to other jurisdictions and, more commonly, threats of such action.

The physician's complaint is that malpractice coverage has simply not been available or that it has been available only at increased rates. In Indiana the problem of unavailability has been attacked by the legislature through provision in the new Act for a residual market for insurance for doctors and hospitals unable to obtain coverage through the private market.[2] An effort to reduce the cost of insurance has been made by lowering the amount for which a doctor can be sued, thus

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A number of sources were used in the preparation of this article and deserve the special attention of one interested in the impact of the malpractice crisis on the insurance industry. See G. DIETZE, AMERICA'S POLITICAL DILEMMA 85 (1968); Havighurst & Tancredi, *Medical Adversity Insurance: A No-Fault Approach to Medical Malpractice and Quality Assurance,* 1974 INS. L.J. 69; Keeton, *Compensation for Medical Accidents,* 121 U. PA. L. REV. 590 (1973); O'Connell, *Expanding No-Fault Beyond Auto Insurance,* 22 U.C.L.A.L. REV. 925 (1975); Parham, *Malpractice Fever—A Social Disease,* 61 J. FLA. MED. ASS'N 866 (1974); Bell, *The Revolution of Rising Entitlements,* 91 FORTUNE 100 (April 1975); NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, THE CRISIS IN MEDICAL MALPRACTICE: WHICH WAY TO A SOLUTION? 4 (March 1975); MEDICAL SOCIETY OF THE STATE OF NEW YORK, REGULATIONS GOVERNING THE PROFESSIONAL MEDICAL LIABILITY INSURANCE AND DEFENSE PROGRAM OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK (unpublished and undated); DEFENSE RESEARCH INSTITUTE, MEDICAL MALPRACTICE POSITION PAPER (1974); ST. PAUL FIRE AND MARINE INSURANCE COMPANY, PRESERVING A MEDICAL MALPRACTICE INSURANCE MARKETPLACE: PROBLEMS AND REMEDIES (unpublished and undated); STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 1ST SESS., AN OVERVIEW OF MEDICAL MALPRACTICE (Comm. Print 1975); STAFF OF THE HOUSE WEDNESDAY GROUP, THE MEDICAL MALPRACTICE CRISIS (Jan. 1975) (unpublished).

[1] *See, e.g.,* Byrnes, *The Media and Medical Malpractice,* U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, Appendix at 654 (1973).

[2] IND. CODE §§ 16-9.5-8-2 to 8 (Burns Supp. 1975).

lowering the amount of coverage which he must purchase to protect his personal assets from suits by patients.[3]

Whether the new law will serve to make the insuring of doctors attractive to private insurers remains to be seen. If we are to make any prediction in that regard, we must try to understand the legal climate in which the present "crisis" situation exists.

For many years, doctors were offered professional liability coverage at an annual premium less than that which they might pay for a family automobile policy on two or three cars driven by teen-agers. Suits against doctors were unusual,[4] and were shunned by many attorneys as expensive and difficult to prepare and very difficult to prove. Patients were reluctant to sue the family doctor or the respected surgeon of the community, and a very real respect for the ability and dedication of doctors gave the patient conviction that a poor result was not the doctor's fault—he had done the best that could be done given the circumstances and the state of the art of healing.

Eventually, new or enlarged theories of liability were employed by appellate courts, and these new guidelines made the preparation of such cases more attractive and easier to pursue.[5] Parallel increases in awards brought publicity to huge recoveries and various law societies publicized techniques for successful prosecution.[6] A new wave of patients was given a medical "education" by dozens of medical television shows in which miraculous cures were commonplace and failure so rare as to be unbelievable. Man's faith in modern medicine made failure the hallmark of negligence and quackery.

Partly as a result of these developments, 90 percent of all malpractice cases ever filed have been filed within the past ten years.[7] Furthermore, there has been a ten percent increase in the number of such cases

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[3] IND. CODE § 16-9.5-2-2 (Burns Supp. 1975).

[4] Bloomington Daily Herald-Telephone, Jan. 14, 1975, at 1, col. 3.

[5] *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Tomei v. Henning, 67 Cal. 2d 319, 62 Cal. Rptr. 9, 431 P.2d 633 (1967); Clark v. Gibbons, 66 Cal. 2d 399, 58 Cal. Rptr. 125, 426 P.2d 525 (1967); Ybarra v. Spanyard, 25 Cal. 2d 486, 154 P.2d 687 (1944) (res ipsa loquitur); Cobbs v. Grant, 8 Cal. 3d 299, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (informed consent); Guilmet v. Campbell, 385 Mich. 57, 188 N.W.2d 601 (1971); Robins v. Finstone, 308 N.Y. 543, 127 N.E.2d 330 (1955) (contractual malpractice).

[6] *See, e.g., Lawsuits: A Growing Nightmare for Doctors and Patients*, 78 U.S. NEWS & WORLD REP., Jan. 20, 1975, at 53-54; *Malpractice: The High Cost*, NEWSWEEK, Dec. 23, 1974, at 50; Schachat, *Patients Can Get Redress for Poor Denistry*, RETIREMENT LIVING, March 1974, at 8.

[7] *See generally* U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (1973).

filed each year.[8] One out of every three practicing physicians can expect to be sued during his career, and doctors in specialties involving surgery and anesthesia may expect a higher frequency of claims. Thus, in an era when the American public has available to it better over-all health care than any other nation in history, there is more medical malpractice alleged than was ever dreamed of when medicine was administered by witch doctors and barbers.

The problem facing hospitals is even more dramatic. While statistics in the medical malpractice field are somewhat speculative (such statistics are not assembled in a very scientific manner), respectable opinion indicates that 74 percent of malpractice claims against doctors arise in hospitals.[9] Since the hospital is often made a defendant along with the doctor, hospitals, for all practical purposes, face the same insurability problems as doctors—and hospitals have a greater exposure to risks.

Indiana doctors have been protected for many years by liability insurance written by eleven companies offering "medical malpractice" or professional liability policies. Certain basic insurance principles are as mysterious to doctors as the most common medical technique is to the nonprofessional. To understand the problem of insurance availability these basic principles must be explored.

(1) Insurance is a business-science where basic rules of predictability of loss permit a professional risk bearer to fix a small premium to be charged against a large number of risks so that the large losses of a few of the premium payers can be paid and their personal loss minimized. The larger the number of risks covered or insureds protected, the better this principle works, as the laws of probability are more easily applied as the number of risks analyzed increases.

Thus, in the insuring of lives and other similar risks, very exact predictions of loss can be achieved because accurate statistics are available and insureds can be expected to suffer loss in highly predictable patterns of frequency and causation. Property insurance, such as the insuring of residences against loss by fire, is likewise capable of a high degree of predictability within statistically arranged classes of risk, location, and type of loss. A prominent insurance leader has put it this

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[8] Address by Thomas F. Sheehan, President of GATX Insurance Co., Inc., A.B.A. Section of Insurance, Negligence, and Compensation, ABA National Convention, Montreal, Aug. 11, 1975.

[9] U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 9 (1973).

way: "We are in the business of taking risks, not betting on sure losers."[10]

(2) The premiums or contributions of each risk to the fund from which losses are to be paid must produce enough money to meet the losses which are expected to result and the costs of operating the system. If the rate charged for one class of business is inadequate to meet this goal, the capital funds of the insurer and the reserves it has built up for its insureds in other classes of business must be invaded to meet the shortage. This process can only be sustained on a limited basis and for a limited time. In the absence of an adequate rate, the losing class of business must be abandoned or the insurer will become insolvent or be forced to overcharge other classes of insureds to pay for the shortage in the unprofitable line.

The application of this second principle is further complicated by the fact that insurance loss statistics are slow to accumulate and often difficult to analyze. Furthermore, upward changes in rates of insurance premiums must be justified to state regulatory agencies before they can be effective. Thereafter, the increased rate can only be applied effectively at annual or longer intervals, depending on renewal dates. Thus, for example, disastrous loss experience in one year will probably not result in an effective increase in premium based on that experience for three to five years. In a period of growing inflation, such an increase is always insufficient by the time it is effective.

The application of these two principles to the insuring of professional liability of doctors is complicated by other factors. First, there are currently only about 275,000 doctors practicing in the United States. About 5,000 are practicing in Indiana.[11] There is, then, an insufficient number of risks to produce credible statistics for prediction of the frequency and size of losses. To use the same equation to construct a premium rate for the 5,000 doctors (divided into five classes of practice) in Indiana, expecting the same accuracy as the actuarial premium determined for a million motor vehicles in the same area, is obviously fraught with danger.

Secondly, one of the basic elements of rate determination for a premium is the predictability of losses as to frequency and cost. In the medical malpractice field in the United States, as well as in Indiana, the growth of claims has been almost geometric in both frequency and

[10] Roberts, *A Course for Confidence*, 36 J. INS. 2 (Sept.-Oct. 1975).

[11] I use the qualifying word "about" because such statistics are heavily affected by educated guesses based on licensing, associating memberships, and interpretation.

amount. Furthermore, an attempt has been made to classify doctors by areas of special practice and to charge rates on five classes (seven in some areas) which vary in their exposure. Likewise, rates differ from state to state so as to reflect the greater generosity of courts and juries in one state than in another when moved by compassion for an injured patient. The more of these variables which occur, the more difficult is a determination of an adequate rate.

As a result of all of these factors—a limited number of risks, a resistance to adequate rates, and a blossoming jungle of ever-increasing losses on medical malpractice—the top eleven insurers which have insured 90 percent of the doctors in the United States have experienced growing difficulty. This is the malpractice insurance dilemma.

Insurers have experienced losses paid and reserved during the last ten years which are estimated to be two to three times the total premiums collected, and the experience has been getting progressively worse as inflation and social attitudes have continued to raise this ratio of loss to premium each year. As of January 1975, when the Indiana General Assembly met, eleven states were considered to be in the midst of crises of availability and premium rate, and the medical profession was in a state of alarmed concern over both availability and price. The problem was being discussed in Congress, in every legislature, and by every medical association. In addition, insurers who did not write professional liability insurance were alarmed by proposals, and by legislation in some states, forcing them into joint underwriting associations to help cover the losses of medical malpractice insurance companies by spreading them to the cost of automobile, fire, and other policies.

The many studies made of the problem in 1973 and 1974 suggested various remedies for the claimed defects in the system of compensating malpractice claimants. These ranged from substitution of a no-fault system for the present tort litigation system to minor changes in the present system.

Changes recommended to the legislature, which were based on congressional, insurance industry, and medical association studies, included proposals to:

1. Abolish or control contingent fees to dampen the enthusiasm of plaintiff attorneys.

2. Shorten statutes of limitation to eliminate "long tail" cases where claims were brought twenty or more years after the service was rendered or the injury received.

3. Limit the amount of recovery to figures representing economic loss, ceilings on any recovery, or workmen's compensation measures of recovery.

4. Prohibit dollar demands stated in pleadings for publicity value.

5. Abolish the collateral source rule.

6. Mandate review of claims by professional peer panels before suit can be tried, with either party entitled to introduce the panel's opinion in court.

7. Mandate binding arbitration either by statute or by contract between patient and doctor.

8. Prohibit recovery based on a guarantee of successful result unless in writing.[12]

9. Limit the informed consent doctrine.

10. Eliminate res ipsa loquitur in malpractice cases.

The implication of these studies was that a program which met all or most of these problems and which permitted an adequate rate would solve the availability problem. A method could not be suggested which would guarantee a reduction in premium rates without a substantial reduction in the rights of patient-claimants.

The Indiana legislature, in its final refinement of the Medical Malpractice Act,[13] adopted some of these remedies:

a. It prohibited money amount demands in the complaint.

b. It provided for a mandatory medical review panel to screen all cases before trial.

c. It shortened the limitation period for minor claimants to two years unless the service was rendered before their sixth birthday; in which case the two years began to run on the sixth birthday.

d. It limited the recovery for damages from malpractice to $500,000, with $100,000 being the limit of liability for any one defendant, and provided a state fund by surcharge on premiums from which excess awards up to the $500,000 limit would be made, to the extent funds are available. The limitations of liability set forth in the Act are made available only to health care providers who pay the surcharge.

e. It denied recovery for failure to achieve a certain result from treatment unless the guarantee was in writing.

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[12] *See* Note, *Express Contracts to Cure: The Nature of Contractual Malpractice,* 50 IND. L.J. 361, 377 n.58 (1975).

[13] IND. CODE §§ 16-9.5-1-1 *et seq.* (Burns Supp. 1975).

f. It created a new residual market from which health care providers who are refused coverage by two professional insurers can get the coverage required by the statute, but at a rate exceeding that charged by the professional insurers—probably by 200 percent.

CONCLUSION

We return to the question: Will the new Indiana Medical Malpractice Act make the insuring of doctors' professional liability attractive to insurers? More specifically, will private insurance coverage remain available to doctors?

Half, or more, of the doctors in Indiana have been insured with one company. The rest have been spread among eight or ten other companies, with the largest embracing about 20-25 percent of the market, and most companies insuring 5 percent or less of the state's doctors. If the hazards of great exposure and long tail liability set out above were the only characteristics which made the business unattractive, we could expect that, with a freely competitive rate structure, companies would continue to write doctors' professional liability insurance or even increase their writings. However, this is not universally true, and since the Act only applies to occurrences which result from treatment rendered or omitted after July 1, 1975, IBNR—incurred but not reported—losses are a continuing threat to proper rate determinations. Another uncertainty is the legal effect of the shorter limitation for suit by minors, and whether it can be interpreted to apply to occurrences before July 1, 1975, or only to occurrences after that date.

Also, even with the $100,000 limit of liability for each health care provider, a company which writes policies for only 200 doctors in Indiana, with a possibility that six or more will be sued each year, has only a chance to break even on the business. If any losses occur beyond that figure the hazard is greater, and with so few insureds the expense and overhead make the figures marginal.

The hazards of judicial interpretation of the Act are very real—including the fear of some companies that the language of the statute would impose a duty to provide a policy whose terms conform to the wording of the Act, so that some writers of "claims-made" forms would have to guarantee renewal for the period of the statute of limitations after retirement.

The $100,000 limitation on liability is attractive, but there is no limit on the aggregate liability of the company and any such limit (as 100 each occurrence, 300 each year) might be held invalid. Similarly,

the statutory provision as to conformance of the policy might require later changes by amendment of the policy. Whether or not these fears are well-founded, they affect the available market.

Moreover, the state regulators have refused to approve a "claims-made" form of policy, and one company (St. Paul), which felt that was the only form of policy which it was willing to offer, has effectively left the market, with the result that 20 percent of the doctors in Indiana will have to find new coverage as their present policies expire.

Generally, it may be expected that doctors will continue to be insured. The insurer who has 50 percent or more of the market has faith in the Act and expects to enlarge its writings. Companies with a very small part of this business will probably stay in the market for a while as an accommodation to long time insureds, and to wait and see what impact the Act will have. Some smaller writers will feel they have already stayed in the market too long at the request of the state and the Medical Association, and will gradually cease writing new business.

The net result will be that although professional liability coverage will be available for all doctors, the price will be high until practice under the new Act can be analyzed. Moreover, insurance will tend to be placed either with one company or with the state-operated residual market—at a 200 percent premium.

It can also safely be predicted that the Indiana Medical Malpractice Act does not completely resolve the crisis in the professional liability insurance industry. The legislature will undoubtedly face the issue again in future sessions.