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## Is Malpractice Insurable?

GEOFFREY SEGAR\*

It is interesting to note, with respect to medical-professional liability insurance, that as of October 15, 1975, there was *no* insurance market in the State of North Carolina. As of that same date there was virtually *no competitive* insurance market in the State of Indiana. While several months ago there were many insurance carriers in the medical-professional liability business, over the last several months these have dwindled to a mere handful.<sup>1</sup>

While much of the attention aroused by the current "malpractice crisis" has been centered upon the insurance industry, it is at most only partially an insurance industry problem. The issue here is much broader than the availability and cost of insurance. It must be remembered that medical liability insurance is not social insurance designed to compensate patients for their medical-related injuries, but is insurance designed to protect the assets of the insured in the event of negligently induced injury. In this connection, most commentators have lost sight of the important difference between "malpractice" and "malpractice claims."<sup>2</sup> Malpractice is negligent conduct on the part of the professional. Malpractice claims, however, are merely allegations that an injury to a patient was caused by the professional's negligent conduct.<sup>3</sup> "Claims made" far outnumber the true cases of negligent conduct. The real challenge may lie in developing a method to compensate those individuals who have suffered a medical injury although negligent conduct was not involved. (While there are many proposals for "no-fault" compensation systems, no such system has been implemented in this

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<sup>1</sup> See Stewart, *The Malpractice Problem—Its Cause and Cure: The Physician's Perspective*, 51 IND. L.J. 134, 137 (1975), *infra*; Note, *A Constitutional Perspective on the Indiana Medical Malpractice Act*, 51 IND. L.J. 143, 143 n.3 (1975), *infra*. See also STAFF OF SUBCOMM. ON EXECUTIVE REORG. OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., 1ST SESS., *MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN* 2 (Comm. Print 1969).

<sup>2</sup> U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, *REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE* 6 (1973) [hereinafter cited as COMMISSION REPORT].

<sup>3</sup> Indeed, some malpractice studies are based upon "claim file" statistics. These data, although useful, represent "potential" claims which have not yet, and may never, take the form of an allegation in a complaint. *Id.*

country.<sup>4</sup>) This socially desirable objective obviously cannot be met by charging the professional liability system with the task as that system was simply not designed to accomplish this goal.

In a recent discussion of the medical malpractice problem, Eli Bernzweig, who was the Executive Director of the HEW Commission on Malpractice,<sup>5</sup> and who is now a special assistant to the Administrator, Federal Insurance Administration, stated that:

Many trial attorneys firmly believe that malpractice suits coerce doctors into being more careful . . . [b]ut this is a partial truth at best. Although there are probably some [doctors] who practice better medicine because of their fear of malpractice suits, there undoubtedly are more who practice worse medicine because of this fear. More important, malpractice litigation does not reach the day to day problems of medicine very often or very well. The system is an extremely remote and roundabout way of approaching a problem which undoubtedly exists, but which needs a more direct solution.<sup>6</sup>

Mr. Bernzweig has touched upon one of the most common misconceptions with regard to the current atmosphere surrounding malpractice litigation. The current adversary system is recognized as failing to reach the underlying problems of the practice of medicine. The adversary system presents an unnecessary, expensive, and probably socially unjustified burden on the health care delivery system. The current method of compensating the injured party has become an economic, social, and to some degree, psychological burden thrust upon a portion of society which has no means of bearing that burden.

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<sup>4</sup> Some scholars have gone so far as to advocate strict liability. See, e.g., Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for Medical Malpractice*, 31 U. CHI. L. REV. 279 (1964); Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 439 (1972); O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973); O'Connell, *Elective No-Fault Insurance for Many Kinds of Accidents: A Proposal and an "Economic Analysis"*, 42 TENN. L. REV. 145, 146-47 (1974); Comment, *Continuing the Common Law Response to the New Industrial State: The Extension of Enterprise Liability to Consumer Services*, 22 U.C.L.A.L. REV. 401, 427-30 (1974). But see Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 616 (1973), which rejects the strict liability approach.

Courts have suggested that a strict liability approach would be desirable under some circumstances. See, e.g., *Clark v. Gibbons*, 66 Cal. 2d 399, 414, 426 P.2d 525, 535, 58 Cal. Rptr. 125, 135 (1967) (Tobrinor, J., concurring); *Helling v. Carey*, 83 Wash. 2d 514, 521-22, 519 P.2d 981, 984-85 (1974) (concurring opinion). But the majority of jurisdictions have rejected this view. See, e.g., *Carmichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); *Silverhart v. Mount Zion Hosp.*, 20 Cal. App. 3d 1022, 98 Cal. Rptr. 187 (1971); *Magner v. Beth Israel Hosp.*, 120 N.J. Super. 529, 295 A.2d 363 (1972). See generally, Roth & Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, COMMISSION REPORT, Appendix 450; Bernstein, *"No-Fault" Compensation for Personal Injury in New Zealand*, COMMISSION REPORT, Appendix 836.

<sup>5</sup> COMMISSION REPORT at x.

<sup>6</sup> *The Malpractice Problem: The Need for Perspective*, in 1 ASSOCIATION OF TRIAL LAWYERS OF AMERICA, QUALITY MEDICAL CARE—THE CITIZEN'S RIGHT 57, 70 (1975).

While there is substantial disagreement, even among insurance industry representatives, depending upon the particular company involved or even upon the particular geographic area, as to certain elements of the malpractice crisis, there are problems which seem common to the industry. It is almost uniformly recognized that insurance carriers dealing with professional liability insurance have a valid actuarial problem, which may be described as the "credibility" of any actuarial basis for premium determination. The data involved in making the actuarial determination of premium rates may well be insufficient to allow the actuaries a truly credible base for premium determination. For example, within a given state there may be a few doctors who form the premium base rate in that area. Most claims are against doctors in the high-risk area. The numbers involved in those high-risk areas are so small as to present an insufficient actuarial base for accurate determination.<sup>7</sup> An actuary would not think of using such a small base in making up classifications for pricing in almost any other field of liability insurance. It appears unreasonable to require him to do so in the area of professional liability coverage.

Secondly, the insurance industry, because of substantial recent changes in the number of claims being made,<sup>8</sup> and perhaps in the amounts of settlements and verdicts,<sup>9</sup> has had difficulty with what has been described as the "long tail." This means that the industry is dealing with disposition of losses on the basis of perhaps twenty percent in the first year, perhaps thirty percent in the second year, maybe another thirty percent in the third year, etc. Thus, the pattern of payments stretches out over a period of several years, while the premium charge has been made two, three, four, or five years earlier. Premium charges have failed in the past to adequately reflect this so-called "long tail" or future payment pattern.

Until a few years ago, the insurance industry treated medical-professional liability insurance within the same general framework as other liability coverage. This is no longer true, and at least within the past year or so, the industry has looked upon this coverage as "catastrophic insurance." For example, there were sixteen verdicts reported in California in the year 1974 in excess of \$1,000,000. Illinois within the past

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<sup>7</sup> See Gray, *The Insurer's Dilemma*, 51 IND. L.J. 120, 123 (1975), *supra*. See also Kendall & Haldi, *The Medical Malpractice Insurance Market*, COMMISSION REPORT, Appendix 492.

<sup>8</sup> See Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 940 n.4. See also COMMISSION REPORT at 6-7.

<sup>9</sup> See AMERICAN TRIAL LAWYERS ASSOCIATION, *MEDICAL MALPRACTICE—THE ATL SEMINAR* 31-32 (1966), discussed in depth in Project, *supra* note 8, at 940 n.4. See also COMMISSION REPORT at 6-7.

year or so has had four \$1,000,000 plus judgments. Settlements in large amounts have become frequent. The industry, then, justifiably or not, regards this area of coverage as one in which potential catastrophic-sized verdicts are becoming fairly commonplace. Partly due to this approach and this fear, many of the companies involved in the field have become skeptical as to the advisability of writing the coverage at all.

The companies which have been involved in the medical-professional liability insurance business have been unable to keep abreast of the changing trends in this peculiar area. The reasons for the changes are many, and have been discussed at length by almost every writer who has analyzed the current "crisis."<sup>10</sup> Companies writing "occurrence" insurance have traditionally relied upon at least some analysis of historical patterns. These patterns have proven unreliable in this area of insurance. For this reason, some companies now look toward a so-called "claims-made" form of policy whereby (at least to some degree) current charges are made on the basis of current claims—the claims-made policy being more in the nature of a term insurance policy which provides coverage only for "claims reported and made" during the policy period rather than all "occurrences" during that same period.<sup>11</sup> Even this form of coverage, however, still faces the potential of years of delay before cases are terminated, and this failing may render even the claims-made policy actuarially unreliable.

Insurance companies have also been influenced by the unpredictability of the frequency of claims made over the past year or so. Over the period of the 1960's there was a constant frequency of approximately nine percent; that is, nine claims per one hundred insured doctors.<sup>12</sup>

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<sup>10</sup> See 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* §§ 5.01--11 (1973); Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View*, 6 WILLAMETTE L.J. 225, 227-30 (1970); Brown, *Social Resource Allocation Through Medical Malpractice*, 6 WILLAMETTE L.J. 235, 247-52 (1970); Carlson, *Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care*, 35 LAW & CONTEMP. PROB. 849 (1970); Lave & Lave, *Medical Care and Its Delivery: An Economic Appraisal*, 35 LAW & CONTEMP. PROB. 252 (1970); Mechanic, *Problems in the Future Organization of Medical Practice*, 35 LAW & CONTEMP. PROB. 233 (1970); Roemer, *Controlling and Promoting Quality in Medical Care*, 35 LAW & CONTEMP. PROB. 284 (1970). Cf. Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 889-90 (1971); Introduction: *The Indiana Act in Context*, 51 IND. L.J. 91, 92 (1975), *supra*.

<sup>11</sup> See generally, Kendall & Haldi, *supra* note 7, at 508; Elsen, "Claims-Made"—*Miracle Drug for Medical Malpractice Insurance Market?*, 16 FOR THE DEFENSE 25 (1975).

<sup>12</sup> See COMMISSION REPORT at 12, which reports 6.5 medical malpractice files were opened for every 100 active practitioners in 1970. See also Assembly Select Comm. on Medical Malpractice, *Preliminary Report*, in 1 ASSOCIATION OF TRIAL LAWYERS OF AMERICA, *QUALITY MEDICAL CARE—THE CITIZEN'S RIGHT* 128, 133 (1974), which notes that the number of malpractice claims filed in California have increased from 13.5 per 100 physicians in 1965 to more than 18 per 100 physicians in 1974.

This figure was used as an actuarial basis for premium determination. While statistics in this area are not totally reliable, it now appears that, at least in the high risk categories, claims (not actual malpractice, but claims) are made on the basis of roughly one claim for every four insured doctors. The companies which relied on past trends at the time when they made up the premium base did not consider or predict the size of this frequency increase.

Insurance carriers face problems other than uncertainties in pricing their product. For example, the reinsurance market has become almost nonexistent. American companies which over the past several years were active in the reinsurance field have abandoned the current market. In fact, only a few remain. Even Lloyds of London, which used to be actively involved in certain areas of primary coverage, as well as in the excess and reinsurance markets, has little current interest in this type of business.

The insurance industry today is apprehensive about the medical-professional liability business. There is concern that the various types of pooling arrangements which are being designed to solve the availability problem will result in subsidies to certain professionals financed through a tax on other insurance customers. For this reason alone, some companies not only do not intend to increase their writings, but would prefer to abandon the business entirely.

Some companies have developed an almost paranoid apprehension toward insurance regulatory bodies, as a result of the pressures being applied to the industry in the medical malpractice field. In many states hostility has developed between insurance commissioners, other regulatory personnel, and certain companies which either have or have not remained in the marketplace.

Certain industry members have indicated that this area of underwriting has become unpopular because of the severe hostility that exists between the medical profession and the insurance industry in some locales. Concern has also been expressed about hostility between the medical profession and the legal profession.<sup>13</sup> This underlying malaise reinforces some of the conflicts preventing a solution to the current problem. Until some of the hostilities are overcome, adequate solutions will be most difficult to achieve.

Because of the fact that there is really *no competitive* insurance market in Indiana, the carrier currently involved as both the principal primary insurance carrier and "Risk Manager" under the new law

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<sup>13</sup> See Mallor, *A Cure for the Plaintiff's Ills?*, 51 *IND. L.J.* 103, 108 (1975), *supra*.

virtually controls the insurability of physicians in Indiana. To a degree, the determination of which professionals will be insured at primary insurance rates and which will be passed on to the Indiana Risk Manager, at substantial premium increases, rests with the carrier. To a certain extent this system places control of the practice of medicine in Indiana with an insurer. This practical effect upon the operation of the professional liability insurance industry was obviously not intended by the legislature, and should be remedied.

It is likely that the current malpractice problem is adversely affecting the delivery of medical care by the health care professions. It is absolutely necessary that a solution be found to allow the health care professions to concentrate upon their fundamental objective—the best patient care possible. Perhaps current legislative attempts will remove the roadblocks to the solution of the underlying problem. The atmosphere in Indiana has cleared to some extent since lawyers, health care professionals, and the insurance industry have made attempts to jointly resolve the real problems involved. Perhaps, if this cooperation continues, adequate solutions will finally evolve.