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Dunbar R. Uthhoff

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# MEDICAL MALPRACTICE — THE INSURANCE SCENE

DUNBAR R. UETHOFF \*

## INTRODUCTION

IN California, only two insurance companies remain as important writers of doctors' professional liability insurance. In New York, one carrier steadfastly continues to insure the vast majority of doctors. Nationally, few companies are writing this insurance to any great extent.

So-called "Good Samaritan" laws,<sup>1</sup> currently receiving increasing attention, symptomize the growing reluctance of doctors to involve themselves in emergency situations with their consequent exposure to claims or suits for malpractice.

Many high jury awards, some in excess of a million dollars, seem to be less a measure of actual damages than of public attitudes toward the medical world in general. The doctor—and his insurer—feel that court action supplies not justice, but exposure to whim or caprice.

In many states, limited availability of the insurance protection so requisite to practice has nudged elderly physicians into retirement when they still have years of good service to offer their communities. Others have retreated into teaching or advisory medicine, or other fields of limited exposure.

For years, discussions of the medical malpractice problem have featured such familiar culprit terms as "doctor shortages," "social attitudes," "inflation," "medical complexities," "plaintiff legal practices," "decline of the traditional doctor-patient relationship." Today, the developments denoted by those terms are blending into a disconcertingly accelerating total force. The effect upon the medical com-

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\* Vice President and Actuary, Employers Insurance of Wausau.

<sup>1</sup> A usual "Good Samaritan" law provides that if a doctor or nurse stops to render assistance at an accident scene, he cannot be held negligent for malpractice in his actions at that scene.

munity of claims for alleged malpractice (or more often mispractice or nonpractice<sup>2</sup>) is simply getting out of hand, with results described by informed observers as already deleterious to medical progress, and of potentially disastrous impact in the future.

There is confusion within the medical profession. A common variety of *negligence*, as a plain man understands that word, used to be a fundamental requisite to a finding of liability for damages, against either a doctor or anybody else. New standards are being substituted—standards whose measures and definitions vary from state to state, court to court, and jury to jury. Nor are these measures and definitions static, which would permit them to be learned and used as guides. They continuously change, even within single jurisdictions, and the changes are usually toward even greater liberality, thus reflecting the changing attitudes of our dynamic but increasingly permissive society.

All this operates as a restraint upon medical advance, as a holdback upon proper and necessary experimentation with drugs and therapies, as an inhibition on choice of treatment. Doctors are inexorably impelled toward a safe mediocrity.

There is both direct and indirect inflationary effect on medical bills. The doctor "plays it safe" with tests, consultations, and other defensive practices. Of course some of this results in better diagnosis and care, and is thus a benefit to the patient, but some may be extraneous to the actual case needs. And indirectly, in the long run the patient picks up the whole malpractice check. Doctors, like other business men, must pass their operating costs, including insurance, along to their customers. ←

There is alarm as well as confusion. As insurance companies find the medical malpractice exposure more complex and difficult, more dangerous and more expensive to underwrite, availability of insurance protection—"the market"—becomes more and more severely limited. Fortunately, a few of the more stable and resourceful carriers

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<sup>2</sup> EMPLOYERS INSURANCE OF WAUSAU, MALPRACTICE INSURANCE IS TOO EXPENSIVE 9 (1967) makes the distinction that "the majority of alleged acts of malpractice are not 'mal-' at all."

consider it their responsibility to *find* ways and means of providing protection to the community whole. It is difficult to visualize a medical profession deprived of access to the insuring safeguards.

The confusion and alarm are justified. Pessimism is not. As usually happens with the advent of general awareness of a general threat, the very seriousness of the danger generates corrective forces. The medical fraternity is demonstrating increasing acceptance of the hypothesis that doctors themselves possess the most effective potential remedy. They are showing willingness to use that potential. They are readily accepting suggestions born of case-by-case statistical studies.<sup>3</sup> They are applying new energies to the problem in their medical societies—regional, state, and national. They are concerning themselves with self-disciplinary measures<sup>4</sup> and state disciplinary agencies. They are redirecting their attention to the root causes of insurance rates—the malpractices, real or alleged—rather than to the insurance carrier, or to the premiums which ultimately (often too late) must be only the result of losses arising from such malpractices, real or alleged.<sup>5</sup>

But as doctors know better than anyone else, rehabilitation is apt to be a much slower process than onset. Our problem patient can respond only slowly, and it would be the height of complacency to expect a rapid cure. Actual loss experience still fails to afford relief. The Insurance Rating Board in New York, after approval by state insurance regulatory authorities, recently promulgated notable increases in rates in many states, and more are expected. However, it is common knowledge that insurance carriers have consistently lost money insuring the malpractice hazard and the new rate increases have yet to prove any more

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<sup>3</sup> See "Case Studies" periodically issued by Employers Insurance of Wausau, Dr. O. Tod Mallery, Jr., Medical Director.

<sup>4</sup> AMA News, October 28, 1968, at 12 where Dr. Robert B. Hunter, in an address before the National Congress on Medical Ethics, declared: "The public has a right to know, and the public has a right to the assurance that a profession placed in such a high position . . . is acting to cleanse itself, acting to discipline itself, and acting to raise the quality of standards of practice in our country."

<sup>5</sup> See 1968 REPORT OF THE MALPRACTICE INSURANCE AND DEFENSE BOARD TO THE COUNCIL OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK.

adequate to the steadily worsening pattern than increases promulgated in the past. But without them, the relatively few underwriters still hopefully in the field might be compelled to leave it, or drastically curtail their commitment to it.

While everybody—carriers and physicians alike—must deplore the step-by-step escalation of rates, the steps must be climbed until we reach a platform: a leveling-off place from which we may hope to begin a descent. The steps must lead either to such a platform, or to a jumping-off place. One is reminded of David Balfour's fearsome midnight ascent of the winding stair outside his rascally uncle's House of Shaws in Robert Louis Stevenson's *Kidnapped*, when a timely lightning flash revealed the void into which one more step would have plunged him. He carefully withdrew his foot; cautiously descended whence he had come. Let us hope that the growing medical awareness will provide the platform that we need; the end to the cost spiral—that neither doctors nor carriers will have to choose between disaster and retreat.

#### THE TERM "MEDICAL MALPRACTICE"

Literally, "malpractice" means "bad practice." But the word "bad," with its moralistic overtones, doesn't contribute much at this point to an insurance-oriented discussion (although further along we will glance at the "good-bad" impression as one of those elusive and constantly changing elements that can indeed be a factor in the difficulties of providing a malpractice type of insurance).

For this conversation, we'll define "medical malpractice" in lay (or jury) terms as an alleged medical act, whether of commission or omission, offering a basis for an injury claim upon which a specified monetary value is placed by the complainant.

Later, we may have to distinguish between known or identifiable acts of malpractice and those which must be inferred from the circumstances or results. This distinction often plays a part in "late reportings," which can be due to deliberate or unnecessary delay on the part of the claim-

ant, or to an extended interval between the alleged act of malpractice and its first manifestation. We will distinguish between "claims" and "suits," and between "awards" and "settlements." But we shall avoid like a plague any pretense of definition allied to merit in the ethical sense, a concept on which the most enterprising legal authorities fear to tread. When we talk about the merits of a case, we refer to those recognized principles upon which one may predict, with fair accuracy, that a court will indeed assign to an alleged medical act some degree of malpractice liability.

#### WHAT IS "PROFESSIONAL LIABILITY INSURANCE"?

All insurance can be divided into two categories. One of them is loss or "first-party" insurance; the other is liability or "third-party" insurance. *Loss* insurance is of a specific thing or quantity or asset, whether it be a man's house or his life or a ship's cargo or a business' credit or a woman's fur coat, against the perils described in the policy. *Liability* insurance is protection against the legal judgment or award which could be recovered from the policyholder as a consequence of his injuring or wronging a third person. Your bodily injury and property damage coverages in your automobile policy are liability insurance; the collision and comprehensive coverages in the same policy are loss insurance.

Loss insurance is relatively simple. The traumatic event for which a claim is made is usually plain to see; the amount of the loss comparatively easy to measure. Moreover, the perils covered by loss policies don't change from place to place and from year to year as do the liability perils. Fires and thefts, illnesses and deaths, are defined today in pretty much the same terms as they were a hundred years ago. It's very different with liability insurance. For one thing, it revolves around the concept of *fault*, which has resisted definition since the days of Solon. For another, the injury or wrong for which recovery is sought is often much harder to translate into dollars; nobody has ever invented a reliable money yardstick for pain and suf-

fering. For still a third, our liability concepts change with changing technologies, the advent of new forces, the development of new behavior patterns. New liabilities can be instantly created by legislatures or by supreme courts.

Professional liability insurance, of which medical malpractice insurance is an example, is a highly specialized form of protection. A "professional" is a person representing himself to be particularly trained and qualified in the techniques, disciplines, and literatures of a special calling. By the mere act of assuming and publishing his label, he claims expertise in his line. "Professionals" are expected by the public to be less prone to error than ordinary people, and this expectation is backed by the force of law.

An insured doctor's malpractice policy provides, with respect to the professional acts or omissions defined in the policy, that in consideration of a specified premium for a specified term the carrier will protect the doctor against any suit or claim alleging injury or death, and on account of which damages are sought. This protection includes the furnishing of legal defense and indemnification, to the limits of the policy, against any recovery made.

#### IS DOCTORS' PROFESSIONAL LIABILITY PROPERLY INSURABLE?

It is not within the province of this paper to explore the doctrines of law, or provide the case-by-case examples, underlying the fantastic variations of degrees of fault or negligence which characterize medical malpractice concepts. It is important, though, that the existence of these extremes be understood if one is to comprehend their result—that the market available to the insuring doctor is highly volatile, and presently very limited.

In fact, there has been so kaleidoscopic an activity of ventures into, and exits (often hasty) from the malpractice field by many insurance carriers that one might ask the fundamental question: is the medical liability exposure a proper subject for insurance at all?

Given our existing socio-economic capsule, the answer has to be yes if the insurance profession is to do its whole duty—not just to doctors, but to the public. Only very

rash or very wealthy physicians would dare pursue active medical practice with no means of sharing their liability exposures. Society cannot dispense with its doctors; the doctors cannot dispense with indemnity protection, and under our prevailing structure, insurance is their only source for it.

Insurability is determined by several tests. Let's apply them to the medical practice exposures:

1. *The event or condition insured against must be fortuitous.* At first blush, there would seem to be no question but that any act of medical malpractice must be fortuitous. It would certainly not be premeditated or intended by the doctor.

But the doctor is not the only party to the question of fortuity. The patient, even though unlikely to desire a bad result or deliberately injure himself, can nevertheless do either or both of two things that may bring about a malpractice claim. First, he can *construct* an event or physical condition that may lend credence to such a claim. Second, he can *construe* an event or a condition to be malpractice.

This may involve actual fraud or an element of it, such as often attends feigned injuries in an auto accident. But in malpractice actions, much more frequently than in auto cases, the plaintiff is not so much consciously dishonest as a victim of self-deception or self-pity.

As the patient may have influence upon the way a medical act may be constructed or construed, a court and jury—which after all is just a collection of patients or potential patients—expresses innate personal desires and prejudices in their interpretations and judgments. The judge and the jurors are only steps in time removed from the plaintiff's position they are expected to pass upon impartially.

It is not altogether easy, therefore, to say that the criterion of fortuity is fully met. Too many personal influences are possible.

2. *The insurance contract must have a "functional worth" commensurate with the work and expense of distributing losses among the insuring community.* This "worth" may be measured by the difference between a) the premium per insurer and b) the potential loss if not insured. For example, if a dental service policy costs \$100 to insure against \$500 aggregate dental costs, there is much less functional worth than attaches to a "basic limit" malpractice policy costing \$50 and providing up to \$5000 per claim and \$15,000 total coverage. The basic limit policy, in turn, is of



less worth than a policy costing \$100 and providing limits of \$100,000 per claim and \$300,000 total aggregate.<sup>6</sup>

We may conclude that medical malpractice insurance contracts notably satisfy the "functional worth" criterion.

3. *The event or condition insured against must be sufficiently definable to initiate, with reasonably little question, the operation of the insuring agreement.* For example, it is possible to insure against bad weather. But the kind and degree of the "badness," to be truly insurable, must be stipulated in terms of calendar, duration, and instrument readings at specified times and places.

Again, as with the fortuity criterion, no ideally precise definition of an act of malpractice is available in advance. It must emerge ultimately through due process. Of course we lack definitive language for every shade of error insured against under most liability contracts. But the vast majority of events which give rise to other-than-malpractice liability actions have sudden or traumatic or otherwise obvious characteristics. The happening is plain; the questions deal mostly with pricing the damage done.

With many malpractice cases, the policy provisions have to be interpreted *de novo* and continuously as the case evolves. What must be assessed is the community's current attitude, and whether it will translate to a degree of malpractice in terms of that particular case. It may be of little or no value as a guide to the handling of the next similar case that comes along. One might paraphrase the defense and indemnification provisions of the policy as: "The company agrees to participate in the legal processes of defining the nature and extent of the malpractice, if any, and the amount of damages appropriate thereto."

The failure of malpractice insurance to satisfy this criterion of definability is a major element in our problem. When we reflect on the speed with which public attitudes are changing, and the direction the changes are taking, and the vulnerability of the malpractice policy to these attitudes, it is not hard to understand how the malpractice exposure can strike fear into the hearts of insurance underwriters accustomed to firmer ground. Hence the steadily adverse relationship between losses and premiums, and the resultant narrowing of the "market."

4. *The group insured, and its exposures, must be wide enough and deep enough to provide adequate "spread."* Obviously, there are enough doctors in the country for loss spreading and to permit the

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<sup>6</sup> Reference to the schedule of rates shown in the Appendix will reveal the surprisingly small additional premiums necessary to provide very high and almost certainly adequate limits of coverage. A \$100,000 per claim limit costs about twice the premium for a \$5,000 per claim policy; a \$1,000,000 per claim policy costs only slightly more—about  $2\frac{1}{4}$  times the basic \$5,000 coverage.

law of large numbers to operate. But in practice, our insured doctor "group" does not include all the doctors in the country. There are many communities of insureds, segregated by state and by company, and many of the units are very small. We cannot say that our candidate for malpractice satisfies this requirement of size.

In summary, then, regarding theoretical insurability, most of the commonly-accepted criteria are met barely or not at all. An insurer can expect trouble in its attempts to handle this line of insurance. A continued build-up of spread and of experience is mandatory, and carriers who have failed to accumulate them have been badly burned. Many underwriters have withdrawn, some without real comprehension of the basic difficulties which might have been revealed by an analysis like the foregoing.

#### THE INSURANCE COST PROBLEM FROM THE DOCTOR'S VIEW <sup>7</sup>

In 1950, the average premium per insured doctor in New York was \$75. In 1967 it was \$324, an increase of 332 per cent or well over four times the 1950 figure. Both frequency and severity of loss have increased, and the worsening of these two loss factors has produced a third element of cost—the need for higher limits at increased premiums. In 1950 a \$100,000 limit expressed unusual prudence; today over 90 per cent of doctors buy at least that much coverage; three-quarters of them buy \$200,000 or more, and limits of \$1 million or higher are no longer rarities.

It can be argued that the 332 per cent increase cited ought to be discounted by that part of the boost that has purchased higher limits, and if we do this the increase becomes 102 per cent. But the lower limits were generally adequate to the doctor's needs in 1950, while the higher

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<sup>7</sup> Rates cited and discussed are those used in the State of New York by Employers Mutual Liability Insurance Company of Wisconsin. See Appendix for current rate schedule and note increase from 1967 to 1968 in the Metropolitan area. This Wisconsin Company initiated its program with the New York Medical Society July 1, 1949, hence the 17-year comparison of the average premium of the first full year, 1950 to the latest completed year, 1967.

limits were required in 1967. As a measure of what a doctor must spend to protect himself, the figure of 332 per cent gives the truer picture.

Parenthetically, let's note a few other cost indices. Between 1950 and 1967, the period we are dealing with, the value of the gross national product increased 170 per cent. The Bureau of Labor Statistics Consumer Price Index increased 36 per cent. The New York Stock Exchange composite price index increased 376 per cent; the Bureau of Labor Statistics average weekly gross earnings in manufacturing 97 per cent; physicians' fees 81 per cent; hospital charges 246 per cent; average income 117 per cent.<sup>8</sup>

#### THE INSURANCE COST PROBLEM FROM THE INSURANCE COMPANY VIEWPOINT<sup>9</sup>

Simply stated, losses have been increasing faster than premium rates. Specifically, while premiums increased 332 per cent, the loss increase has been approximately 375 per cent.

Because premium rates are set up by deliberate calculations and step by step, carrier managements and actuaries might be asked why the loss trends have not been adequately anticipated. There are several answers. The primary basis for future rates is past losses, but in this case the unprecedented magnitude and acceleration of the loss movement has deprived the past experience of credibility. The difficulty of loss valuation has been compounded by the extended delays—unique to malpractice insurance—between the alleged act, our first notice of it, and ultimate trial or other disposition, during which inflation and liberalizing attitudes play a significant part. In New York, there is a notable surge of first notices by malpractice claimants just before the running-out of the three-year statute of limitations. It is not easy to make proper investi-

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<sup>8</sup> For a convenient source of these and other indices, and their relation to expected average liability claim costs, see Masterson, *Economic Factors in Liability and Property Insurance Claims Costs 1935-1967*, 55 PROCEEDINGS OF CASUALTY ACTUARIAL SOCIETY 1 (1968).

<sup>9</sup> The viewpoint of Employers Insurance of Wausau.

gations of claims two or three years old when we first learn of them. Crowded court calendars add still further to the lapse of time between first valuation of the loss and its final determination, if the case must actually be tried.

Perhaps even this combination of difficulties would not excuse the insurance managements and actuaries for consistently drifting below the accelerating cost target. But there are still other factors. The state rate-regulating authorities are an inhibiting influence. So are doctors themselves, who are often reluctant to believe that the situation can be as bad as pictured. Finally, an important reason for premium failure springs from within the insurance industry itself. Competitive price cutting is nurtured by failings of less experienced underwriters to adequately measure losses currently being incurred but for which true valuations require lengthy seasonings of maturity. While it is true that the statutory loss reserving formula of an insurance company's annual reportings to regulatory authorities is intended to guard against optimistic undervaluations, experiences have shown this to be inadequate for many companies.<sup>10</sup>

The element of trusteeship is prominent in malpractice insurance. The receipt of premiums involves the insurer in a long-term distribution arrangement, as liabilities may appear, on behalf of all of its insuring doctors. Because the premiums have not been even remotely adequate, the carriers have had to use funds earned from other sources to fulfill the liability obligations incurred in their malpractice writings. Often this necessity has not been realistically determined until optimism has led to multiplying outstanding malpractice policies, which have then been dropped in a panicky wave of cancellations. The sudden distress mar-

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<sup>10</sup>The Schedule P of the casualty company annual statement blank requires a minimum estimate, for the last three policy years, that incurred losses and loss adjustment expenses shall be 60 percent of premiums. Adherence to such a loss ratio, in setting up reserves for losses and the attendant adjustment expenses, could be reasonably defined as foolish optimism, in light of more recent malpractice underwriting results. Until premium rate increases can be accelerated more rapidly to overtake loss acceleration, a 100 percent ratio would be safer, which would of course leave no part of premiums for the considerable expenses of policy issue, taxes, etc.

ket thus created exerts further strain on the carriers who are still trying to stay alive in the malpractice field.

In its 1967 report to the Council of the Medical Society of the State of New York, the Malpractice Insurance and Defense Board particularly noted the rapid latter-year increases in loss costs:

The following comparison of the cost of closed cases during the past few years illustrates the marked trend toward higher disposal costs. These figures are the result of dividing the total cost of all closed cases during the year shown by the number of suits plus the number of claims settled, eliminating reported events that did not develop into suits or claims, as well as claims closed with no payment to the claimant:

1963	\$4,740
1964	5,760
1965	6,790
1966	8,810

The simplest reason why closing costs have increased is inflation. A survey of suits closed in 1966 shows that the policy year when the alleged malpractice occurred preceded the year of closing by an average of over five years. This means that premium rates, if they are to be adequate, must take into account future inflation, which it is generally conceded will amount to from three to five percent a year, provided it is kept within "acceptable" limits.

In addition to payments for pain and suffering and for wage loss, both of which are increased by inflation, a settlement or a jury verdict includes the cost of doctor and hospital bills, whether or not these have been paid by the plaintiff. These costs too are subject to inflation. An article in the *AMA News* of March 20, 1967, states that hospital daily charges during 1966 increased 16.5 percent and that the average annual increase from 1950 to 1965 was 5.8 percent.

That quotation from the Society Board report offers a fine example of how doctors more recently are identifying with insurers in their views of the cost problem. It shows awareness that interests and objectives must indeed be similar in the search for solutions to the malpractice problem.

#### A BASIC INSURANCE RATEMAKING ANALOGY

To doctors, insurance specialists are laymen. To an actuary, it's the doctor who is the layman. It is vital to

the purposes of this article that its readers be acquainted with the bare bones of ratemaking. Let's see if we can accomplish this by a simple analogy.

If a non-crooked coin is properly flipped by a non-crooked flipper, we have a fair subject for a fifty-fifty bet. Now, let's suppose a doctor has a nightmare in which he is compelled to toss a coin five times. If all five tosses turn up tails, he must pay \$10,000 to a disgruntled patient. This, we further assume, composes his malpractice exposure.

Rather than accept this risk himself, he asks a professional taker of chances—an insurance company—what premium it would charge to take the risk, leaving the doctor simply to enjoy watching the five tosses, and also dream pleasantly about practicing medicine. What should the premium be?

Mathematically, the chance of seeing five tails is one-half raised to the fifth power ( $\frac{1}{2}$  multiplied by  $\frac{1}{2}$  five times). This works out to a probability of seeing it happen once per 32 trials of five tosses each. By payment of \$10,000 divided by 32, or \$312.50, our doctor friend may transfer his risk to the entrepreneur (who presumably is collecting a lot of these premiums, while occasionally suffering the \$10,000 loss).

The risk-taker is not depending on luck, which might be good or bad if his business is small and vulnerable to purely chance fluctuations. He depends upon spread and enough volume to assure smooth operation of the law of large numbers. He is not in the game just for sport either, so he may be expected to load his \$312.50 premium for expenses, taxes, and a livelihood, plus a small contingency for things somehow not coming out right. If we lump all this expense loading at 20 percent, the final premium would be \$390. This would leave \$312 (80 percent of \$390) for loss payments.

So far we have the elements of an insuring agreement—the calculated expectation of loss and expense, and its assumption for commendable reasons by someone in that kind of business. But now one more step, if you please. The coin, alas, is of strange vintage, or affected by unexpected and malign influences of some sort. The

five-tail ogre keeps popping up once in every 30 trials of five tosses each, instead of the expected once in 32. Another misfortune, inflation, forces the risk-assumer to use an average of \$11,000 to satisfy each original \$10,000 obligation. The doctor sleeps at ease; the nightmare has passed to his insurer.

Fortunately, the insurer has surplus adequate to permit him to stay with the game while he seeks to correct the odds. Now actual experience comes into play. If no further new malfunctions are expected, the arithmetic is easy. The \$390 rate is increased to accommodate the frequency and cost data compiled so far, and becomes \$457. That figure continues the 20 percent premium expense loading. If the loss platform has been reached, it should be adequate, since taxes, commissions, etc., are usually in terms of fixed premium percentages and therefore direct functions of premium, and other expenses tend to move parallel to the economy.

Thus far, however, our risk-taking friend has lost money—about 17 percent of the \$312 per doctor intended to be used for the \$10,000-type payments. In other words, he had a \$53 underwriting loss per doctor. Now he has several options. He can decide that doctors are bad medicine, and try his luck elsewhere. Or he can attempt to select particular doctors who he believes have been, or are likely to be, blessed with better fortune as coin-flippers. Or he can bravely tighten his belt, flourish his slide rule, and bend his prophetic skills to the task of finding odds that will allow him to continue to serve a whole medical community—perhaps fortified in his resolve by the man who said most things better than anybody else:

There is a history in all men's lives,  
 Figuring the nature of the times deceas'd,  
 The which observed, a man may prophesy,  
 With a near aim, of the main chance of things  
 As yet not come to life, which in their seeds  
 And weak beginnings, lie intreasur'd.

*(King Henry IV, Part II)*

## DOCTORS ARE DIFFERENT, ONE FROM ANOTHER

This seems an elementary proposition. But reference to the schedule of rates used in New York State by a leading carrier in the establishment of classification rate difference (see Appendix) shows that the implementation of this axiom produces wide variations.

When one doctor's exposure to loss is shown by statistically fortified premium rates to be ten times that of another's, the potential for disaster to an insurance company pursuing or accepting inadequately classified and rated segments of the doctor population is apparent. Unsophisticated and segmented underwriting is likely to result in misfortune and withdrawal from the market.

In 1955, a carrier with little or no previous experience in writing medical professional liability entered a surgical segment, usually categorized as most difficult. The early *known* experience appeared to justify optimism and a small dividend was begun. Eight years later, as the true loss picture emerged, the company withdrew from the malpractice field entirely—though it is undoubtedly still indexing new claims and coping with inflation in the handling of old ones.

Only a company with considerable volume can have adequate statistics, discernment, and administrative judgment for effective doctor-by-doctor rating.

Until 1958, in New York there were no established methods for classifying doctors by specialty and practice, so no rate differentials were employed. The first classification system, initiated in 1958, was simple: surgeons and physicians. Because proper class rating requires assignment by specialty and practice, it then became possible to begin organization of a statistical system for accumulation of loss experience by such categories. This was begun with policies issued in 1958, and is now a valuable instrument for equitable distribution of insurance costs among doctors.

Although statistical experiences are actually maintained for all of the many segments of specialties and counties (a total of close to ten thousand possible com-



binations) it should not be thought that each of these segments independently determines its own rate. In many segments the volume—even though accumulated for many years—is not adequate to serve as a reliable sample. Improper reliance could produce improper separate rates. Instead, observation first of frequencies for specialty groups and second of average case costs (when larger volumes are available), as well as medically informed judgment, lead to grouping into fewer rate classifications. These rate classes receive their relativity treatments in turn, with the final step being a merging into an overall required rate level based on broader calculations.

Territorial differences also receive the relativity-type treatment. In the September 1, 1968 rates (see Appendix), territorial relativities can be expressed approximately as follows, placing an index of 1.00 upon the Metropolitan rate level:

Suburban I (Orange and Westchester Counties), 80 percent of Metropolitan rates; Suburban II (Rockland, Suffolk, Sullivan and Ulster Counties), 110 percent of Metropolitan; Upstate (all other counties), 60 percent of Metropolitan.

#### CLASSIFICATION UNDERWRITING

One of the curious aspects of the tightening market can be a particular carrier's abrupt withdrawal from a classification of doctors as though they had suddenly become toxic. This kind of selective action leaves deplorable connotations about underwriting ability or judgment.

Only through many years accumulation of class statistics can there be sound bases for distinctive rates or class grouping underwriting selections. Few insurance carriers write enough volume for enough years to have these bases. Of those that do, the responsible carrier should first take the obvious action of adjusting rates accordingly. Smaller companies with more limited volume don't have to rely on their own experience—which, as we have seen, can get them into trouble with further deterioration of

the overall market. They can follow the larger carriers' rate differences, or several of them can combine to pool their experience data.<sup>11</sup>

For example, anesthesiologists seem to have been picked on by some companies as a poor risk group. There seems to have been a grapevine route for on-the-street word that underwriters should be very careful about these doctors. Some carriers stopped writing them altogether—a disturbing market influence. Actually, this group's statistics are no worse, relative to going premium rate levels and to the practical avenues for correction, than the doctor average. There is an element of high frequency which may have triggered underwriting avoidance—because it was not considered in conjunction with a lower average case severity. This demonstrates the need for both full and credible statistics and for more careful analysis before precipitate action.

The market is becoming concentrated among a relatively few skillful underwriters. Although many insurance companies have medical malpractice policies in force, the major volume is underwritten by a handful. A few carriers have traditionally specialized in writing insurance for individual doctors, but the high-volume companies deal mostly with whole societies or through specialty-group franchise arrangements.

The group approach offers the single advantage, to both parties, of a full and intelligent partnership between insurer and insured. In the last analysis, it is for doctors, not their insurance carriers, to control their insurance costs. Medical societies contribute a great deal to the partnership that individual doctors could not be expected to provide. They organize prevention activities; they

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<sup>11</sup> Through Act of March 9, 1945, ch. 20 § 3, 59 Stat. 34, *as amended*, 15 U.S.C. § 1013 (1964), Congress made it possible for certain insurers, through duly licensed rating bureaus and under state-by-state regulatory provisions, to combine experiences according to the principle that larger statistical volumes permit more dependable application of Bernoulli's Law of large numbers, which may be phrased as a practical matter as follows: The greater the number of exposures, the more closely the actual results obtained will approach the probable result which would be expected with an infinite number of exposures.

establish expert committees to review alleged malpractices; they assist their carriers in the formulation of rates for doctors offering special or unusual exposures. This kind of effort goes a long way toward keeping the whole group "insurable" in spite of the doubts discussed in our section on theoretical insurability.

### ALTERNATIVE COST-REDUCING DEVICES

In the long run, we believe that the only way to reduce the costs of medical malpractice insurance is to reduce the frequency and severity of medical malpractice claims. We also believe that the only way to reduce auto insurance costs is to stanch the flow of blood on our highways. But just as auto owners continue to seek some way of having accidents without paying for them, many doctors quite understandably continue to search for escape from onerous malpractice premiums by some route other than avoiding claims and suits. Let's look at some of them:

1. *Deductibles.* A deductible feature in his malpractice policy requires the doctor to contribute a specified sum to the award or settlement. In return, the premium is reduced. Some carriers use deductibles primarily as a device for reducing their own loss payments, with little or no premium reduction. Some approximate calculations will indicate the relatively small savings of average deductibles:

\$ 500 deductible	Reduction: 3 per cent
1000 deductible	Reduction: 6 per cent
2000 deductible	Reduction: 10 per cent
5000 deductible	Reduction: 20 per cent

Thus a premium of \$1,000 would drop to \$800 in return for the doctor's agreement to pay up to the first \$5,000 toward disposition of any one malpractice claim or suit. These are not likely ever to be widely attractive. Delays, often of years, before trial or settlement, leave the amount of contribution uncertain; the premium reduction is not too significant; loss settlements become issues of potential disagreement between insured and insurer.

2. *Assigned Risk Plans.* These don't operate to reduce premium; on the contrary, they are more likely to elevate it. Their purpose is only to make the insurance available. They would

probably operate on a state, society, or group basis. Under such a plan, any doctor who could show that he had been refused by a specified number of insurance companies would be assigned to a carrier who would have to provide him with at least a designated minimum of protection. At present there are special "rating-up" arrangements in many states, by which doctors presenting unusually high exposures may buy insurance. It is still quite rare—and we hope the rarity continues—for a properly eligible physician to be unable to buy insurance. There is a danger that an assigned risk plan may force ordinary doctors to share the insurance cost burden imposed by the experience of doctors who are careless, or whose practice or specialties by their nature provoke a high degree of frequency or severity of malpractice claims. But if there were adequate disciplinary procedures, an assigned risk plan could be helpful.

3. *Doctor-owned insurance companies.* It is inevitable that any definable group with insurance problems, whether of high rates, ailing market, or something else, will ponder the do-it-yourself insurance company. This has been done successfully, but not in circumstances analagous to those of the American doctor today. The American College of Surgeons tried it and failed a few years ago. The California Medical Association recently ruled against it. Other Societies have considered it, but have been deterred by these difficulties:
  - (a) The loss possibilities require a tremendous investment in capital and surplus, the continuous handling of which would be a major project in itself.
  - (b) The captive company would have to be assured of participation by the great majority of individual members of the organizing group. It was this hurdle that defeated the movement in the California Medical Association; their 1967 poll disclosed that 41 per cent of their doctors did not think premium rates were excessive, and only 3.9 per cent thought the Association should provide them with insurance.<sup>12</sup>

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<sup>12</sup> 1968 REPORT BY THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION has these conclusions drawn from their study of the physician-owned company:

It is the inescapable and unalterable conclusion of this study that the formation of a physician-owned or controlled malpractice insurance carrier by CMA would not be in the best interest of either the physicians or the public.

It is further concluded that the recent action of the carriers in California are not causes of the malpractice problem.

Therefore, the formation of a new, additional carrier would not solve any problems; but rather, would create new, additional problems.

- (c) Many highly-specialized skills and disciplines are essential to the delivery and service of malpractice insurance—prevention activities, claims investigation, legal, underwriting, actuarial, and others. Experienced personnel with these skills are in short supply; a new company is unlikely to attract and hold them without difficult and expensive timing problems. The capital investment would have to be supported by rapid premium growth, but because reporting of claims and suits lags much further behind premiums in malpractice than in other insurance areas,<sup>13</sup> the highly-skilled (and highly-paid) claims-legal staff could neither be dispensed with nor used to anything like its full potential for a long time, perhaps for years.
- (d) The underlying problem leading to the organization of a “captive” company—adverse loss ratios and consequently rising costs—are not likely to be any less severe for a new company, or easier to solve, than for those already in the business. Lacking some drastically new and effective approach, the newcomer would be, if anything, more vulnerable to danger than the experienced carriers, who themselves are having to rationalize their continued presence in the market with at least a smattering of altruism.

One final penetrating thought emerges: If a community of doctors is well enough organized to think and act, effectively and together, about all the details involved in organizing and administering an insurance company, they are already in excellent position to seek a better alternative. Good doctor organization is the first prerequisite to soliciting assistance from a well-organized, well-financed, and experienced professional carrier to underwrite a group or society program. Such a program

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It is further concluded that the formation of a physician-owned or controlled malpractice insurance carrier would be so detrimental to the best interests of both the physician and the patient that the medical profession might never recover from its devastating effects. *A.M.A. News*, Nov. 18, 1968, at 15.

<sup>13</sup> New York loss reportings show these incidences: Only 26 percent of losses are known by the end of the same calendar year in which they are incurred. After two years, 40 percent of the losses have not yet been reported to the insurance company. These losses will trickle in as the years go on, some not being reported for eight years or longer after they are incurred. These late reporting figures may be expected to vary, more or less, by types of exposures, such as surgery versus general practice excluding surgery.

offers all of the potential of a doctor-owned company, with fewer of the hazards:

1. Coverages are tailored to both groups and individual needs.
2. The group experience ultimately determines the rates.
3. Loss settlement and defense practices can, to a substantial degree, defer to the desires of the group.
4. Advisory and prevention efforts are coordinated between the doctors and the company, with maximized effectiveness.
5. The doctors can assist with underwriting, and with the disciplinary selections so important to either a group program or a specialty company.

#### INCREASED RATE LEVELS

As noted, premium rates have recently been raised substantially in most states, including New York. As also noted, however distasteful this remedy, it is both sensible and necessary. However, like many remedies this one may be attended by unfortunate side-effects. The increases may encourage some carriers with marginal malpractice experience and underwriting skills to enter (or return to) the market. This in turn could reduce the pressure to pursue true and long-lasting solutions.

These pressures, upon all the parties concerned—the doctors, the companies, the public—have become very strong. Attitudes are changing, complacencies are disappearing, organized action is on the horizon. It would be unfortunate if this impetus were lost, even though the impetus is itself produced by misfortunes:

Sweet are the uses of adversity  
Which like the toad, ugly and venomous,  
Wears yet a precious jewel in his head.

*(As You Like It)*

#### LEGISLATION?

In a special report in the AMA News for November 18, 1968, there are some comparisons between the medical malpractice scene in Canada and that in the United States.

Canadian doctors pay \$25 a year for what amounts to defense insurance, rather than indemnity against damages. Very few cases are settled, or lost in the courts. The Canadian doctor is not "fair game" either to the public or to lawyers. Attorneys cannot accept cases on a contingent basis, and they have been known to tell a claimant "You haven't got a case, and I won't take it." Other Canadian features—the rules of negligence and of evidence, trial usually by judge without jury—are also unfavorable to a litigious climate.

It's tempting to ask "Why can't it be like that here?" But the United States can't legislate itself back to its old days of amicable coexistence between patients, doctors, lawyers, and the judging public—the conditions that still prevail in Canada. Some safeguards might be legislated, though at the risk of yet further deterioration of the medical public image, which has already been identified as one of the root causes of our problems. But legislation cannot be looked to for substantial or permanent solutions.

#### SUMMARY

Like the policeman in *The Pirates of Penzance* (or like the goalie in a hockey game) the malpractice insurance underwriter may complain that his lot is not a happy one. But if he belongs in his job, he'll keep working at the malpractice problem, not retreating from it. He and his company will continue to press for general awareness that:

1. There must be many kinds of malpractice *prevention*.
2. There must be self-discipline by the medical fraternity by which improper hazards may be dislodged, paving the way for effective underwriting and rating.
3. There must be expert medical assistance available to the defending doctor.
4. There must be understanding, by the public, of its role of patient as well as jury, and of the harm redounding to it as patient if it misplays its part as plaintiff and jury.

5. There must be understanding by the legal profession of its role of public defender, in which it owes a duty to the doctor who is also a public defender, and that to fail in this duty is to fail in its duty to us all.

## A P P E N D I X

## RATES AND INFORMATION

Effective for Policies Dating on and after September 1, 1968

Limit No. 1 is the limit of liability for loss resulting from any one claim or suit or all claims or suits because of injury to or death of any one person and Limit No. 2 is the total limit of liability on account of all acts or omissions occurring in any policy period.

## METROPOLITAN AREA

(The five counties of New York City and Nassau County)

<i>Limit No. 1</i>	<i>Limit No. 2</i>	<i>Class 1A</i>	<i>Class 1B</i>	<i>Class 1</i>	<i>Class 2</i>	<i>Class 3</i>	<i>Class 4</i>	<i>Class 5</i>	<i>Class 6</i>
\$ 25,000/	75,000	\$1,350	\$1,023	\$ 986	\$627	\$514	\$296	\$206	\$132
50,000/	150,000	1,488	1,127	1,086	691	566	326	227	146
100,000/	300,000	1,542	1,168	1,126	716	587	338	235	151
200,000/	600,000	1,565	1,185	1,142	726	596	343	239	153
300,000/	900,000	1,595	1,208	1,165	740	607	349	243	156
500,000/	1,500,000	1,634	1,238	1,193	758	622	358	249	160
1,000,000/	1,500,000	1,741	1,319	1,271	808	663	381	266	170

Additional premiums required if the following procedures are to be covered.

<i>Limit No. 1</i>	<i>Limit No. 2</i>	<i>Superficial X-Ray Therapy</i>	<i>Deep and Superficial X-Ray Therapy and/or Isotope Teletherapy</i>	<i>Electroshock Therapy</i>
\$ 25,000/	75,000	\$ 56	\$ 92	\$ 53
50,000/	150,000	62	101	58
100,000/	300,000	64	105	60
200,000/	600,000	65	106	61
300,000/	900,000	67	108	62
500,000/	1,500,000	68	111	64
1,000,000/	1,500,000	73	118	68

Rates for physicians employed full time by the Federal Government (but not in military service) are 25% less than those quoted above.



## RATES AND INFORMATION

Effective for Policies Dating on and after September 1, 1967

Limit No. 1 is the limit of liability for loss resulting from any one claim or suit or all claims or suits because of injury to or death of any one person and Limit No. 2 is the total limit of liability on account of all acts or omissions occurring in any policy period.

## METROPOLITAN AREA

(The five counties of New York City and Nassau County)

Limit No. 1	Limit No. 2	Class 1A	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
\$ 25,000/	75,000	\$1,023	\$ 901	\$539	\$442	\$260	\$190	\$125
50,000/	150,000	1,127	993	594	487	287	210	138
100,000/	300,000	1,168	1,029	615	505	297	217	143
200,000/	600,000	1,185	1,044	624	512	302	220	145
300,000/	900,000	1,208	1,065	636	522	308	225	148
500,000/	1,500,000	1,238	1,091	652	535	315	230	151
1,000,000/	1,500,000	1,319	1,162	695	570	336	245	161

Additional premiums required if the following procedures are to be covered.

Limit No. 1	Limit No. 2	Superficial X-Ray Therapy	Deep and Superficial X-Ray Therapy and/or Isotope Teletherapy	Electroshock Therapy
\$ 25,000/	75,000	\$56	\$ 92	\$160
50,000/	150,000	62	101	177
100,000/	300,000	64	105	183
200,000/	600,000	65	106	186
300,000/	900,000	67	108	189
500,000/	1,500,000	68	111	194
1,000,000/	1,500,000	73	118	207

Rates for physicians employed full time by the Federal Government (but not in military service) are 25% less than those quoted above.

## RATES AND INFORMATION

Effective for Policies Dating on and after September 1, 1968

Limit No. 1 is the limit of liability for loss resulting from any one claim or suit or all claims or suits because of injury to or death of any one person and Limit No. 2 is the total limit of liability on account of all acts or omissions occurring in any policy period.

## UPSTATE AREA

(All Counties except New York City, Nassau, Westchester, Suffolk, Orange, Rockland, Sullivan and Ulster)

Limit No. 1	Limit No. 2	Class 1A	Class 1B	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
\$ 25,000/	75,000	\$664	\$540	\$426	\$269	\$227	\$127	\$ 90	\$62
50,000/	150,000	731	596	469	297	250	140	99	68
100,000/	300,000	758	617	486	308	259	145	103	70
200,000/	600,000	769	626	494	312	263	147	104	71
300,000/	900,000	784	639	503	318	268	150	106	73
500,000/	1,500,000	803	654	515	326	275	153	109	75
1,000,000/	1,500,000	856	697	549	347	293	163	116	79

Additional premiums required if the following procedures are to be covered.

Limit No. 1	Limit No. 2	Superficial X-Ray Therapy	Deep and Superficial X-Ray Therapy and/or Isotope Teletherapy	Electroshock Therapy
\$ 25,000/	75,000	\$56	\$ 92	\$53
50,000/	150,000	62	101	58
100,000/	300,000	64	105	60
200,000/	600,000	65	106	61
300,000/	900,000	67	108	62
500,000/	1,500,000	68	111	64
1,000,000/	1,500,000	73	118	68

Rates for physicians employed full time by the Federal Government (but not in military service) are 25% less than those quoted above.

## RATES AND INFORMATION

Effective for Policies Dating on and after September 1, 1968

Limit No. 1 is the limit of liability for loss resulting from any one claim or suit or all claims or suits because of injury to or death of any one person and Limit No. 2 is the total limit of liability on account of all acts or omissions occurring in any policy period.

## SUBURBAN AREA I

(Westchester and Orange Counties)

Limit No. 1	Limit No. 2	Class 1A	Class 1B	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
\$ 25,000/	75,000	\$1,023	\$ 815	\$695	\$440	\$368	\$224	\$139	\$ 92
50,000/	150,000	1,127	898	766	485	405	246	153	101
100,000/	300,000	1,168	931	794	503	420	255	159	105
200,000/	600,000	1,185	945	806	510	426	259	161	106
300,000/	900,000	1,208	963	822	520	435	264	164	108
500,000/	1,500,000	1,238	986	841	533	445	271	168	111
1,000,000/	1,500,000	1,319	1,051	897	568	474	288	179	118

Additional premiums required if the following procedures are to be covered.

Limit No. 1	Limit No. 2	Superficial X-Ray Therapy	Deep and Superficial X-Ray Therapy and/or Isotope Teletherapy	Electroshock Therapy
\$ 25,000/	75,000	\$56	\$ 92	\$53
50,000/	150,000	62	101	58
100,000/	300,000	64	105	60
200,000/	600,000	65	106	61
300,000/	900,000	67	108	62
500,000/	1,500,000	68	111	64
1,000,000/	1,500,000	73	118	68

Rates for physicians employed full time by the Federal Government (but not in military service) are 25% less than those quoted above.

RATES AND INFORMATION

Effective for Policies Dating on and after September 1, 1968

Limit No. 1 is the limit of liability for loss resulting from any one claim or suit or all claims or suits because of injury to or death of any one person and Limit No. 2 is the total limit of liability on account of all acts or omissions occurring in any policy period.

SUBURBAN AREA II

(Suffolk, Rockland, Sullivan and Ulster Counties)

Limit No. 1	Limit No. 2	Class 1A	Class 1B	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
\$ 25,000/	75,000	\$1,243	\$1,023	\$ 986	\$627	\$514	\$296	\$206	\$132
50,000/	150,000	1,370	1,127	1,086	691	566	326	227	146
100,000/	300,000	1,419	1,168	1,126	716	587	338	235	151
200,000/	600,000	1,440	1,185	1,142	726	596	343	239	153
300,000/	900,000	1,468	1,208	1,165	740	607	349	243	156
500,000/	1,500,000	1,504	1,238	1,193	758	622	358	249	160
1,000,000/	1,500,000	1,603	1,319	1,271	808	663	381	266	170

Additional premiums required if the following procedures are to be covered.

Limit No. 1	Limit No. 2	Superficial X-Ray Therapy	Deep and Superficial X-Ray Therapy and/or Isotope Teletherapy	Electroshock Therapy
\$ 25,000/	75,000	\$56	\$ 92	\$53
50,000/	150,000	62	101	58
100,000/	300,000	64	105	60
200,000/	600,000	65	106	61
300,000/	900,000	67	108	62
500,000/	1,500,000	68	111	64
1,000,000/	1,500,000	73	118	68

Rates for physicians employed full time by the Federal Government (but not in military service) are 25% less than those quoted above.