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## Medical Liability Insurance Student Symposium - A Study of Medical Malpractice in Texas.

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## MEDICAL LIABILITY INSURANCE

Under the present system of tort recovery, medical liability insurance is no longer a precautionary device; it has become a necessity for medical professionals. At the same time, more insurance companies are abandoning the medical liability field or have been reducing their commitments in this area.<sup>426</sup> The sum of these problems has created the immediate concern about availability of medical liability coverage for providers of health care.

The availability, or assurability, of medical liability insurance is only part of the larger problem of insuring medical professionals today. As a short-term solution, however, adequate insurance coverage must be made available to all health care providers.<sup>427</sup> The reaction in most instances has been to force the private insurance carriers to continue providing coverage by legislative decree, at least for the present.<sup>428</sup>

A more important facet of the medical liability problem is the development of long-range remedies in order to rectify the deficiencies of the present medical malpractice compensation/insurance protection system. Proposed long-range remedies have extended from complete revision of the tort system, including workmen's compensation type plans and no-fault proposals, to such modest proposals as improving the existing actuarial system and insurance practices.<sup>429</sup>

Insurance is based upon the assumption that future costs of providing present coverage can be accurately predicted. In the malpractice area,

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426. 121 CONG. REC. 2170 (daily ed. Feb. 19, 1975) where it is stated that: "Suits against physicians are increasing at the rate of 10% a year. One doctor in three can now expect to be sued . . ." See Rubsamen, *The Malpractice Crisis: How Did We Get There, Can We Get Out?*, MODERN MED., Vol. 43, No. 7, April 1975, at 30, where it is stated that "[t]here are now approximately nine companies writing medical malpractice insurance; this is to be compared to more than twice this number just a few years ago." See also Daenzer, *Risk Management of the Professional Liability Exposures*, WEEKLY UNDERWRITER, Oct. 10, 1973, where the author states:

Medical Malpractice presents a special situation with the greatest danger of big loss to the risk manager. He may well be advised to tell his principals to get out of the business, to drop as easily as can be done those ventures in the medical field or those services provided which include medical exposure.

*Id.* at 10.

427. The most common method has been to insure that insurance is available without regard to price or to possible effects of "forced availability" of medical liability insurance.

428. Various means have been employed, such as the Joint Underwriting Association, the captive company, or the assigned risk pool. See Curran, *The Malpractice Insurance Crisis: Short-Term and Long-Term Solutions*, NEW ENGLAND J. MED., Vol. 293, No. 1, July 3, 1975, at 24.

429. See Fuchsberg, *Approaches to Handling Medical Malpractice Litigation*, BEST'S REVIEW, Vol. 74, No. 7, Nov. 1973, at 36; Gibbs, *Medical Malpractice Insurance Crisis*, 80 CASE & COM. 8, 14 (1975).

however, there are three basic reasons why predicting losses has become increasingly difficult: (1) the base or "market" for medical malpractice insurance is relatively small; (2) the last 10 years have seen dramatic increases in the amount of claims, settlements, and in the increased frequency of such claims which have resulted in the insurer losing the ability to determine "frequency and average claim cost"; and (3) the long "tail" with which the insurer must deal necessitates projecting losses over decades, with a resulting lack of certainty.<sup>430</sup>

The insurer's problem in predicting losses accurately has produced economic set-backs requiring it to either raise rates or withdraw from the medical malpractice field. Part of the recent increase in premiums can be seen as a protective measure by the insurers to recoup recent losses while remaining increasingly cautious about future predictions.<sup>431</sup> Many of these problems can be traced to the same factors that have caused dramatic changes in other areas of the law, especially personal injury recoveries. Inflation, development of consumer protection, as well as sympathetic juries and courts have resulted in more frequent and greater recoveries in every area of law.<sup>432</sup> The insurance companies have also been caught in the depressed investment climate resulting in poor returns and, in many cases, tremendous losses.

Health care providers are also plagued by other factors peculiar to their profession. While all professionals are held to higher standards—both legally and in the public's opinion—health care providers are perhaps held to even greater standards by their patients.<sup>433</sup> Additionally, medicine itself by its increased efficiency and complexity has subjected the profession to claims that would not have arisen a few years ago. Modern medical treatment, due to advancements in techniques, drugs, and equipment, has actually increased rather than diminished the possibilities of a malpractice suit.

While there is no universal agreement on the types or degree of change, all parties involved with medical malpractice must concede that change is essential. The cost of reimbursing an injured patient is becoming more than

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430. HEW, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, APPENDIX, Pub. No. (OS) 73-89, at 41 (1973) [hereinafter cited as MALPRACTICE COMMISSION REPORT, APP.]; see *Malpractice Insurance: States Act to Ease Medical-Legal Dilemma*, J. AM. INS., Vol. 51, No. 2, Summer 1975, at 12; cf. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 83, at 550 (4th ed. 1971).

431. See Gibbs, *Medical Malpractice Insurance Crisis*, 80 CASE & COM. 8, 9 (1975), where the author discusses the importance of the underwriters expected loss figures as bearing on the process of rate setting. The medical malpractice problems have combined with the general market decline to produce the critical level of losses. *Id.* at 11; Rubsamén, *The Malpractice Crisis: How Did We Get There, Can We Get Out?*, MODERN MED., Vol. 43, No. 7, Apr. 1975, at 34.

432. See, e.g., G. PETERS, PRODUCT LIABILITY AND SAFETY 1-5 (1971); *Medical Malpractice Insurance*, BEST'S REVIEW, Vol. 73, No. 6, Oct. 1972, at 78.

433. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32, at 161 (4th ed. 1971).

the individual practitioner, and his insurance carrier, can bear. If the present compensation system is to be maintained, radical and innovative modifications must be made, including a revision of the current means of providing medical liability insurance.

### *Study Commissions*

The medical malpractice problem has recently come under the scrutiny of state and federal governments.<sup>434</sup> While the general goals are similar—providing the best possible medical care for the greatest number of people—the approaches of each have not been uniform.<sup>435</sup> The federal proposals have emphasized sweeping alterations such as no-fault insurance or mal-occurrence systems.<sup>436</sup> On the state level, the most enlightened procedure has been to enact temporary legislation to deal with the pressing short-term problem of availability of professional liability coverage for the health care providers, while simultaneously initiating plans to resolve the complex problems involved and to promulgate long-range remedies.<sup>437</sup> Because of the divergent interests involved and the general lack of facts this necessitates a thorough examination of the malpractice problem. Consequently, many state legislatures have enacted statutes creating study commissions or committees for the purpose of formulating the most feasible solution to the medical malpractice dilemma.<sup>438</sup>

The primary functions of these study commissions is to determine the scope and extent of the malpractice problem, to make recommendations, and to draft model legislation for long-term solutions. Typically, commissions are established for a duration of one to two years. The membership of the study commissions reflects the interests involved, with most comprised of equal numbers of representatives from the medical profession, the legal profession, insurers, the state insurance commissioner, and the attorney general.<sup>439</sup>

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434. There are at least seven bills before Congress at this time. As of August 15, 1975 at least 35 states were taking some sort of action regarding the medical malpractice problem. See *Malpractice Insurance: States Act to Ease Medical-Legal Dilemma*, J. AM. INS., Vol. 51, No. 2, Summer 1975, at 10-11.

435. To date, proposed federal action is more liberal than the conservative state action.

436. See Comment, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1158-60 (1975).

437. Most of the recent state legislation concerning medical malpractice has been temporary in nature, with the provision for some form of study commission.

438. E.g., Ind. Laws 1975, Pub. L. No. 146, § 2, at 867; Tex. Laws 1975, ch. 331, § 2, at 867, amending TEX. INS. CODE ANN. art. 21.49-3 (1963); Wis. Laws 1975, ch. 37, § 13, at 53, codified in WIS. STAT. § 655.27 (Supp. 1975).

439. E.g., Ind. Laws 1975, Pub. L. No. 146, § 2, at 867; Tex. Laws 1975, ch. 331, § 2, at 867, amending TEX. INS. CODE ANN. art. 21.49-3 (1963); Wis. Laws 1975, ch. 37, § 13, at 53, codified in WIS. STAT. § 655.27 (Supp. 1975).

## TEXAS INTERIM STATUTES

The 64th Texas Legislature has enacted two short-term statutes providing immediate relief for the burgeoning medical malpractice insurance crisis.<sup>440</sup> This crisis centers around the increasing number of insurance companies which are either reducing their commitments or completely withdrawing from the medical malpractice field. The companies remaining in this field have steadily increased their premiums and are becoming increasingly nervous as fewer and fewer companies spread the risk of insuring medical professionals against malpractice.<sup>441</sup>

While the situation in Texas has not been as critical as some areas of the country,<sup>442</sup> the nation-wide problem is affecting the insurability of medical practitioners in this state. Texas, along with several other states, has enacted temporary legislation to relieve the present problems while seeking to establish long-term remedies to alleviate the malpractice problem.<sup>443</sup> The Texas statutes are designed to be effective for two years in order to provide the study commission with adequate time to propose more concrete solutions to the present difficulties.<sup>444</sup>

*Professional Liability Insurance Act*

The Professional Liability Insurance Act provides for the regulation of rates by the State Board of Insurance, the reduction of the limitation period for the filing of claims, the requirement of a 90 day cancellation notice, and exclusive use of annual premiums.<sup>445</sup>

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440. Tex. Laws 1975, ch. 330, at 864, *amending* TEX. INS. CODE ANN. art. 582 (1963); Tex. Laws 1975, ch. 331, § 2, at 867, *amending* TEX. INS. CODE ANN. art. 21.49-3 (1963).

441. See AMA, *MALPRACTICE IN FOCUS: A NATIONAL PROBLEM THE STATES MUST SOLVE*, at 21 (1975); Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VAL. U.L. REV. 152, 159 (1972) stating: "It appears that malpractice insurance has proven to be a losing proposition for the insurance companies. Not one insurance company has made money in writing medical insurance in recent years." The reason is said to be the "difficulty in estimating costs has led many insurance companies to withdraw from the malpractice field." *Id.* at 161.

442. New York, for example, is such a state where the primary insurer, Argonaut, left the medical malpractice field; California is another state which traditionally has more lawsuits and higher awards.

443. *E.g.*, Cal. Laws 1975, ch. 93, at 303 (Deering); Fla. Laws 1975, ch. 75-9, § 14, at 16; Me. Laws 1975, ch. 442, at 515-16; Mass. Laws 1975, ch. 362, at 311, *amending* MASS. GEN. LAWS ANN., ch. 13, § 10 (Supp. 1975); N.Y. Laws 1975, ch. 109, at 139, *as codified in* N.Y. INS. LAW art. 19, § 681-95 (McKinney Supp. 1975); N.C. GEN. STAT. § 58.173.34 (Supp. 1975); N.D. CENT. CODE, § 26-40-01 (Supp. 1975); *see also* AMA, *MALPRACTICE IN FOCUS: A NATIONAL PROBLEM THE STATES MUST SOLVE*, at 30-31 (1975).

444. Tex. Laws 1975, ch. 330, § 2, at 866, *codified in* TEX. INS. CODE ANN. art. 5.82 Supp. 1976) (provides for termination on Dec. 31, 1977); Tex. Laws 1975, ch. 331, § 3, at 873.

445. Tex Laws 1975, ch. 330, §§ 4, 6, 7 and 8(b), at 865-66.

Of these statutory provisions, the most important and the only substantive change involves the time period for filing a claim against a medical professional. The statute provides that:

[N]o claim . . . whether for breach of express or implied contract or tort . . . may be commenced unless the action is filed within two years of the breach or the tort complained of or from the date the medical treatment that is the subject of the claim or the hospitalization for which the claim is made is completed, except that minors under the age of six years shall have until their eighth birthday in which to file . . . such claim.<sup>446</sup>

Essentially, this section negates the "discovery rule" exception to the Texas Statute of Limitations. The "discovery rule" measures the limitation period from the time the plaintiff discovers, or should have discovered in the absence of negligence, his injury or cause of action.<sup>447</sup> The new statute, however, provides for the running of the limitations period from the time the act or injury occurs,<sup>448</sup> with the plaintiff's knowledge of his injuries being irrelevant.<sup>449</sup> The Texas courts have only applied the "discovery rule" in limited circumstances, such as medical malpractice cases in which there has been some type of concealment.<sup>450</sup>

446. Tex. Laws 1975, ch. 330, § 4, at 865.

447. *E.g.*, *Hays v. Hall*, 488 S.W.2d 412, 414 (Tex. 1972); *Gaddis v. Smith*, 417 S.W.2d 577, 580 (Tex. 1967), noted in 46 TEXAS L. REV. 119 (1967). *Gaddis* overruled the existing law as stated in *Carrell v. Denton*, 138 Tex. 145, 147-48, 157 S.W.2d 878, 879 (1942) in which the statute of limitations began to run at the time of the negligent act, with the court rejecting the "fraudulent concealment" argument. *Nichols v. Smith*, 489 S.W.2d 719, 722 (Tex. Civ. App.—Fort Worth), *aff'd*, 507 S.W.2d 518 (Tex. 1974). See also Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597, 615 (1969) where it is stated: "The discovery doctrine . . . emphasizes not only the fiduciary relationship, but also equitably distributes the responsibility of the parties by emphasizing the latent nature of the injury."

448. *Allen v. Ortho Pharmaceutical Corp.*, 387 F. Supp. 364, 365 (S.D. Tex. 1974). For an in depth discussion of the traditional rule and its exceptions, see Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597, 608 (1969). See also A. HOLDER, *MEDICAL MALPRACTICE LAW* 319 (1975).

449. *Allen v. Ortho Pharmaceutical Corp.*, 387 F. Supp. 364, 365 (S.D. Tex. 1974); see *Metal Structures Corp. v. Plains Textiles, Inc.*, 470 S.W.2d 93, 98 (Tex. Civ. App.—Amarillo 1971, writ ref'd n.r.e.).

450. *E.g.*, *Hays v. Hall*, 488 S.W.2d 412 (Tex. 1972) (supreme court added vasectomy cases to the general exception); *Nichols v. Smith*, 489 S.W.2d 719 (Tex. Civ. App.—Fort Worth), *aff'd*, 507 S.W.2d 518 (Tex. 1974) (fraudulent concealment); *Martisek v. Ainsworth*, 459 S.W.2d 679 (Tex. Civ. App.—Houston [1st Dist.] 1970, writ ref'd n.r.e.) (concealment of injury). According to the Texas Supreme Court:

[t]his is not an extension of the limitation period but is merely a recognition that in certain situations it is difficult if not altogether impossible to discover the existence of a legal injury.

*Hays v. Hall*, 488 S.W.2d 412, 413 (Tex. 1972). The problem, as stated by a federal district court, is that

the legislature and the courts are confronted with two conflicting policies, the policy of protecting the physician or surgeon against the instigation of stale or fraudulent lawsuits, and on the other hand, the policy of protecting patients against the negli-

The majority of jurisdictions, including Texas, have only recently adopted this rule, and then only in a manner limiting its applicability to foreign objects or fraud.<sup>451</sup> Now it is argued that actuaries cannot perform their function of predicting future losses because of this exception to the general rule concerning the limitations period.

Limiting the period in which to file claims has been one of the most sought after modifications to the present medical malpractice system, especially by the insurance companies. The restriction of the limitations period, it is argued, is the most effective way to control the long "tail" associated with malpractice claims.<sup>452</sup> Such a restriction will decrease the exposure of the insurance company to liability by decreasing the period of years in which claims may be filed. After two years from issuance of a policy, the carriers are free of any liability and can close their books on an insured. This promotes greater certainty and accuracy in forecasting policy losses which in turn leads to stability in insurance companies.<sup>453</sup>

The other provisions in this Act are aimed primarily at regulating the insurance companies. Provisos, however, were inserted to protect the insurance carriers so that they would not operate at a loss,<sup>454</sup> and so that no part of the Act would be construed as negating the use by the carriers of risk-classification.<sup>455</sup> The statute enables the State Board of Insurance to begin compiling statistics which are to be used in setting rates and premiums.<sup>456</sup> Once sufficient data is gathered and collected, the board may effectively regulate the insurance carriers. Regulation of insurance rates is presently very difficult, since insurance carriers possess the sole source of information.

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gence of medical practitioners, which often is incapable of being discovered within the statutory period of limitation.

*Shinabarger v. Tatoi*, 385 F. Supp. 707, 710 (D.S.D. 1974). The solution was the introduction of the discovery rule.

451. *Shinabarger v. Tatoi*, 385 F. Supp. 707, 710 (D.S.D. 1974). In *Lopez v. Swyer*, 300 A.2d 563, 566 (N.J. 1972) the discovery rule is equated with a rule of equity, used to alleviate unjust results. The discovery rule is the device most suited to balancing the inequities of the injured person, ignorant of his cause of action, with the burden placed on the physician in defending a lawsuit years after its alleged occurrence. The better view would be to apply the discovery rule wherever equity and justice demand it. The reluctance of the Texas Supreme Court to expand the discovery rule is discussed in *Thrift v. Tenneco Chems., Inc.*, 381 F. Supp. 543, 546 (N.D. Tex. 1974).

452. "Tail" is the period that the carrier has to remain liable for a particular policy. See, e.g., Rubsamen, *The Malpractice Crisis: How Did We Get There, Can We Get Out?*, MODERN MED., Vol. 43, No. 7, Apr. 1975, at 34.

453. Comment, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925, 933 (1975).

454. Tex. Laws 1975, ch. 330, § 2(a), at 865.

455. *Id.* § 2(b), at 866.

456. *Id.* § 5, at 866. The section provides that insurance companies "shall file annually with the State Board of Insurance a report of all claims and amount of claims, amounts of claims reserves, information relating to amounts of judgments and settlements paid on claims, and other information required by the board." *Id.* § 5, at 866.

*Medical Liability Insurance Underwriting Association Act*

In addition to creating a study commission, the Medical Liability Insurance Underwriting Association Act established a Joint Underwriting Association (JUA) composed of all insurers authorized to write liability insurance in the state on or after January 1, 1975.<sup>457</sup> The expressed purpose of the association is to provide medical liability insurance on a self-supporting basis. The statute provides for the JUA to cease issuing policies in two years.<sup>458</sup> As a temporary remedy, it is designed to provide liability insurance for medical professionals who cannot obtain protection elsewhere. As a result, most subscribers will either be high-risk specialists, or be from geographically high risk areas, or practitioners that have been sued for malpractice one or more times in the past. In an effort to alleviate the burden of providing coverage for these risks, the JUA is utilized as a risk-pooling device in order to spread the risk of loss over the broadest possible base. But this does not increase the number of medical professionals who constitute the actual base for risk-spreading. This small base has been a major problem with the advent of large awards and settlements, and has been recognized as one of the primary reasons many carriers desert the medical malpractice field.<sup>459</sup>

By requiring all liability insurers in the state to carry medical malpractice insurance (that is, to be a member of the JUA) as a condition to doing business in the state, the statute assures that all medical practitioners are covered.<sup>460</sup> The premium cost, however, is not controlled by the Act.<sup>461</sup> It may be assumed that the members of the association will not undercut their own policies, nor underestimate their collective expenses of operating the JUA. Therefore, the cost of premiums, while not as critical as the availability of coverage, remains a serious problem. In many areas, particularly with regard to specialists, the exorbitant premiums alone have either forced medical professions to retire, to abstain from the high-risk endeavors, to enter governmental or teaching positions, or attempt to pass their premium costs on to their patients.

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457. Tex. Laws 1975, ch. 331, § 3, at 867.

458. *Id.* § 11, at 871; see Maisonpierre, *The Carrier's View of the Malpractice Menace*, *PHYSICIAN'S MANAGEMENT*, Vol. 15, No. 8, Aug. 1975, at 52.

459. See 121 CONG. REC. 2170, 2172 (daily ed. Feb. 19, 1975); Uthoff, *Medical Malpractice—The Insurance Scene*, 43 *ST. JOHN'S L. REV.* 578 (1969); cf. *Report of the DRI: Medical Malpractice Litigation Committee and IAIC Professional Liability and Malpractice Committee*, 42 *INS. COUNSEL J.* 165, 165-66 (1975).

460. Tex. Laws 1975, ch. 331, § 3(a), at 868; see *Solution: 'Keep Washington Out of It'*, *PHYSICIAN'S MANAGEMENT*, Vol. 15, No. 8, Aug. 1975, at 51.

461. "The resultant premium rates shall be on an actuarially sound basis and shall be calculated to be self-supporting." Tex Laws 1975, ch. 331, § 4(b)(4), at 869. See also *Doctor's Business*, *MED. WORLD NEWS*, Vol. 16, No. 20, July 14, 1975, at 103, where it states that, "[t]he JUA rates are also much higher than what is available on the voluntary market. A high-risk surgical specialist in Austin has to pay over \$16,000 for this basic coverage." *Id.* at 103.



Another criticism of the Texas JUA is that the coverage limitation is too low. The Act provides for a top limit not to exceed \$300,000.<sup>462</sup> For many specialists and health care associations this is not enough basic coverage to qualify them for most excess insurance coverage now being offered.<sup>463</sup>

The Joint Underwriting Association will not play a dominant role in Texas, or any other jurisdiction, unless the major insurer of medical professionals in each state abandons the medical liability practice. The JUA is essential in situations where availability of insurance is a problem, not where, as in most states, the primary concern is premium cost. Even if the JUA is necessary, it obviously represents only a temporary relief, not a cure to the medical liability situation.

#### LIMITATION OF LIABILITY

One of the more volatile issues in the area of medical malpractice insurance is that of limits placed upon a health care provider's liability in negligence cases. This action has been taken in several states as one immediate solution to the medical malpractice insurance crisis.<sup>464</sup> The "model" Indiana statute sets the limit on an individual medical professional's liability at \$100,000,<sup>465</sup> while other jurisdictions have set limits to personal liability from \$100,000 to \$500,000.<sup>466</sup> It is important to note that this limit is placed upon the liability of the individual medical professional; it is not a "cap" or limitation upon what an injured patient may recover.<sup>467</sup>

The reason for setting a limit on the individual health care provider's liability is that he and his insurer are no longer able to bear the entire risk involved under the present tort system of recovery in negligence cases. Unlimited personal liability has forced the insured to acquire higher and more comprehensive coverage, and this forces the insurer to charge increasingly higher premiums. The awards and settlements obtained and the premiums now being charged have reached a level which necessitates an

462. Tex. Laws 1975, ch. 331, § 3(b)(1), at 868.

463. Many specialists now need base coverage of \$200,000 occurrence and \$600,000 cumulative insurance in order to qualify for excess coverage.

464. Tex. S.B. 635, 64th Legis. Sess. § 7(b)(1) (1975) (proposed limit of \$100,000 failed on third reading in House); Wis. Laws 1975, ch. 37, at 49, *codified in* Wis. STAT. § 655.23 (Supp. 1975) (\$200,000 per claim and \$600,000 per year or the maximum liability limit of the medical professional). The proposed Texas limit was not applicable to acts constituting gross negligence.

465. Ind. Laws 1975, Pub. L. No. 146, ch. 2, § 2(b), at 856.

466. Fla. Laws 1975, ch. 75-9, § 15, at 18, *codified in* FLA. STAT. § 627.353 (Supp. 1975) (\$100,000); N. DAK. CENT. CODE § 26-40-01 (Supp. 1975) (\$500,000); see *Malpractice Insurance: States Act to Ease Medical-Legal Dilemma*, J. AM. INS., Vol. 51, No. 2, Summer 1975, at 19-11 (chart).

467. *But see* Ind. Laws 1975, Pub. L. No. 146, ch. 2, § 2(a), at 856 ("cap" of \$500,000).

evaluation of the "fault system" or at the very least, society's responsibility for fully compensating injured people.<sup>468</sup> The ability of the physician to pass on the costs to his clients is directly related to his ability to predict what his future premium costs will be. Obviously the medical professional is less prepared for this task than the insurer. Also, while the individual clients are directly affected, the public is ultimately burdened with the increased medical costs. Necessarily, limits must be placed upon individual liability; the medical profession, patients, and insurance companies can no longer operate under the present system's demands.

Insurance as a risk-spreading device has not proved adequate in the face of unlimited liability. As a protective device, it is becoming increasingly more difficult and sometimes impossible to obtain for many medical specialists. This raises the question of the primary purpose of medical liability insurance. Insurance is obtained for individual professional protection by indemnification; yet compensation of injured patients seems to reflect that juries are considering insurance more than simply a means of professional protection.<sup>469</sup> To regain its protective purpose, maximum limits on liability must be considered.

Setting a \$100,000 - \$300,000 limit on the liability of an individual medical professional would preserve most of the advantages of the present system, including the deterrence of negligence and the improvement of practice and treatment, while it would concurrently remedy many of the present disadvantages.<sup>470</sup> This limitation would initially help to reduce the insurer's actuarial problem in trying to include the unlimited awards into his loss development plans. To the physician the advantages are obvious: with a limit on his personal liability, he need only purchase that amount of

468. See Anderson, *Comments on Medical Malpractice Insurance*, BEST'S REVIEW, Vol. 76, No. 1, May 1975, at 14; Samuels, *Commentary: An Economic Perspective on the Compensation Problem*, 21 WAYNE L. REV. 113, 130 (1975). For a discussion of one alternative system see Bernstein, *No-Fault Compensation for Personal Injury in New Zealand*, MALPRACTICE COMMISSION REPORT, APP., at 836.

469. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 82, at 542 (4th ed. 1971) where a statement is made in reference to auto liability insurance, the concept is appropos to the medical situation:

Thus far liability insurance has been quite inadequate to provide and assure compensation to those who suffer such injuries. It had its inception solely as a device for the protection and benefit of the insured who paid for it, and not as any part of a scheme for social betterment; and it has largely retained that original character.

*Id.* at 556.

470. G. CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (1970). While this also refers to auto liability, it is analogous to the medical liability situation:

The fault system may have arisen in a world where one injurer and one victim were the most that society could handle adequately. . . . Today accidents must be viewed not as incidental events linking one victim with one injurer, but as a more general societal problem.

*Id.* at 307-308.

coverage, probably at lower rates than he is presently paying. Therefore, the physician or hospital is relieved of the necessity of obtaining umbrella coverage, as well as from the anxiety that he has enough coverage.<sup>471</sup> Similarly, the patient benefits because he has a better chance of being fully compensated, especially for "catastrophic" injuries which often exceed the limits of the health care provider's policy.<sup>472</sup>

### Damages

Recently, there has been a sharp increase in all facets of compensation; one estimate is that the average claim cost has doubled in the last five years.<sup>473</sup> Not only are the awards and settlements getting larger, with many exceeding the million dollar mark, but the frequency of claims has increased significantly.<sup>474</sup> Clearly, the trend is upward with no ceiling in sight. As can be expected, there are many reasons for the dramatic increase in the amount of compensation awarded to victims of medical malpractice. Perhaps the reason most often cited for increased damages is the decreased purchasing power of the dollar due to inflation.<sup>475</sup> The general damages rule is that when there has been an injury, the compensation shall be equal to the injury.<sup>476</sup> According to the United States Supreme Court: "The injured party is to be placed as near as may be, in the situation he would have occupied if the wrong had not been committed."<sup>477</sup> With inflationary trends and the resultant decrease in the value of the dollar, it takes larger awards to return the victim to his previous condition. Courts have recognized the inflationary effects upon the purchasing power of the dollar.<sup>478</sup>

471. See MALPRACTICE COMMISSION REPORT, APP., at 508 (1973) stating that many insurers are now unwilling to write this type of protection.

472. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 84, at 556-57 (4th ed. 1971) (referring to the analogous automobile situation).

473. AMA, MALPRACTICE IN FOCUS: A NATIONAL PROBLEM THE STATES MUST SOLVE, MALPRACTICE COMMISSION REPORT, APP., at 1.

474. *Id.* at 14-15. In 1970 approximately half of the awards were under \$1,000, and only three per cent were over \$100,000.

475. M. BELLI, THE MORE ADEQUATE AWARD 12 (1952); 2 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 18.11, at 557 (1973). *But see* Johnson v. Penrod Drilling Co., 510 F.2d 234, 236 (5th Cir. 1975), *cert. denied*, — U.S. —, 96 S. Ct. 69, 46 L. Ed. 2d 58 (1975) (mem. opinion) (too speculative to include in present rule for calculating future damages), *noted in* 7 ST. MARY'S L.J. 432 (1975).

476. Black v. Burd, 255 S.W.2d 553, 556 (Tex. Civ. App.—Fort Worth 1953, writ *ref'd n.r.e.*) where the court states "in awarding damages for an injury, that rule should be followed which will best afford just compensation for the pecuniary loss sustained and place the injured party as nearly as possible in the same position that he would have occupied had the injury not been inflicted." *Accord*, RESTATEMENT OF TORTS § 903, comment *a* at 540 (1939). (Tent. Draft No. 19, 1973).

477. Albemarle Paper Co. v. Moody, — U.S. —, 45 L. Ed. 2d 280, 287, 95 S. Ct. 2362, 2372 (1975), *quoting* Wicker v. Hoppock, 73 U.S. (6 Wall.) 94, 99 (1867).

478. Moses v. Kirtley, 510 S.W.2d 281, 282 (Ark. 1974); Edwards v. Sims, 294 So. 2d 611, 616 (La. Ct. App. 1974); Hammond v. Stricklen, 498 S.W.2d 356, 364 (Tex.

Another general element involved in the increase of awards has been the changing attitudes of juries combined with more effective and more skillful trial attorneys.<sup>479</sup> This is complimented by the discretionary concept bestowed upon the trial judge or the jury.<sup>480</sup> This is especially true when it comes to excessive awards. The general test provides that the award is allowed to stand on appeal unless it "shocks the conscience" of the appellate court.<sup>481</sup> Other expressions of what constitutes an excessive award are equally as strong, such as "the test is whether the verdict is so high as to result in a miscarriage of justice,"<sup>482</sup> or that it "is so inordinately large as obviously to exceed the maximum limit of a reasonable range within which the jury may properly operate."<sup>483</sup> Jury awards, however, often do exceed the level of "just" compensation, yet they are permitted.

The conflict between those who advocate increased awards and those who favor reduced awards involves divergent views of what adequately compensates the victim. On the one hand it is contended that even greater awards are needed, while on the other hand it is argued that the spiraling cost of jury awards is becoming unmanageable. The latter view purports to be in the best interest of society; it has become too expensive to fully compensate victims of such personal injuries as medical malpractice.<sup>484</sup>

A key element in this argument involves the issue of pain and suffering. Many have proposed to eliminate this element to compensation to medical malpractice cases, as well as in auto liability cases.<sup>485</sup> The arguments

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Civ. App.—Tyler 1973, writ ref'd n.r.e.); *Austin v. Hoffman*, 378 S.W.2d 103 (Tex. Civ. App.—Austin 1964, no writ); see D. DOBBS, *HANDBOOK ON THE LAW OF REMEDIES* § 8.7, at 575 (1975).

479. See O'Connell & Simon, *Payment for Pain and Suffering: Who Wants What, When and Why?*, 1972 U. ILL. L.F. 1, 4.

480. See *Blair v. Buksnys*, 521 S.W.2d 652, 655 (Tex. Civ. App.—San Antonio 1975, no writ); *Hammond v. Stricklen*, 498 S.W.2d 356, 364 (Tex. Civ. App.—Tyler 1973, writ ref'd n.r.e.).

481. *Mileski v. Long Island R.R.*, 499 F.2d 1169, 1173 (2d Cir. 1974); *Kirk v. Beachner Constr. Co.*, 522 P.2d 176, 180 (Kan. 1974); 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 18.11, at 556 (1974). In *Blair v. Buksnys*, 521 S.W.2d 652 (Tex. Civ. App.—San Antonio 1975, no writ), the test is stated as:

[B]efore an appellate court will disturb a judgment rendered upon a jury verdict, there must be circumstances tending to show that it was the result of passion, prejudice or other improper motive, or that the amount fixed was not the result of a deliberate and conscientious conviction in the minds of the jury and the courts, or so excessive as to shock a sense of justice in the minds of the appellate court.

*Id.* at 655.

482. *Williams v. Stevart Motor Co.*, 494 F.2d 1074, 1085 (D.C. Cir. 1973).

483. *Id.* at 1085.

484. See NAIC, *Medical Malpractice Insurance*, *BEST'S REVIEW*, Vol. 73, No. 6, Oct. 1972, at 78, 80 (social and economic considerations must be examined before deciding whether to compensate all victims and to what extent).

485. O'Connell & Simon, *Payment for Pain and Suffering: Who Wants What, When and Why?*, 1972 U. ILL. L.F. 1, where the authors state:

[W]ith the contingent fee, and with an increasingly affluent society full of more and more people sensitive to suffering, payment for nonpecuniary loss has become

against allowing recovery for pain and suffering are that such award is too speculative and open to extreme fluctuation, that it really serves to compensate the lawyer who takes his contingent fee out of this element of damages, and that it is even less susceptible to measurement than damages to persons in general.<sup>486</sup>

It is well settled that the plaintiff need not prove this element of his damages with any great precision.<sup>487</sup> Unlike other elements of damages such as medical expenses or lost wages, there is

no objective standard available to measure the amount of damages which should be awarded for the non-pecuniary elements of injury; they must be left to the jury, or court when it is the trier of fact.<sup>488</sup>

Given this freedom, juries often have the tendency to award sums exceeding their actual judgment of what would adequately compensate the victim, rationalizing that the insurance company or the hospital can easily afford it.

Recovery for pain and suffering also comes under criticism because of its imperceptible nature; in many awards it comprises approximately half of the damages awarded. Some of the reasons for this substantial figure have already been mentioned; others include the majority rule that this element is not to be reduced to present value,<sup>489</sup> and that the use of per diem formulas appear rather insignificant until multiplied by the number of units involved in future pain and suffering cases.<sup>490</sup>

Another method of approaching modifications of compensation, as contrasted to amounts which should be recovered, is to examine the manner of

not smaller and smaller but greater and greater in relation to pecuniary loss. . . . Payment for pain and suffering in the great mass of smaller and medium-sized negligence cases has become so cumbersome and bloated and dysfunctional that it seems ready to topple of its own weight.

*Id.* at 109; *see also* D. DOBBS, *HANDBOOK OF THE LAW OF REMEDIES* § 8.1, at 550 (1973).

486. *Atlanta Transit Sys., Inc. v. Robinson*, 213 S.E.2d 547 (Ga. Ct. App. 1975). The court states that "[t]he sole measure of damages for pain and suffering is the enlightened conscience of fair and impartial jurors." *Id.* at 549; *see* D. DOBBS, *HANDBOOK ON THE LAW OF REMEDIES* § 8.1, at 545 (1973); J. O'CONNELL, *THE INJURY INDUSTRY* 39 (1971); Uthoff, *Medical Malpractice—The Insurance Scene*, 43 *ST. JOHN'S L. REV.* 578, 582-83 (1969).

487. *Morrison v. State*, 516 P.2d 402, 406 (Alas. 1973).

488. 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* § 18.08, at 552 (1973); 6A J. MOORE, *FEDERAL PRACTICE* § 59.08, at 3824 (1975) where it is stated that:

[T]he court should avoid substituting its judgment for that of the jury. But nevertheless, the exercise of discretion will necessarily vary for some trial courts will allow the jury's verdict unless it shocks the conscience or is grossly excessive or inadequate, while others are more disposed to grant relief in less extenuated circumstances.

*See* 4 M. BELLI, *MODERN TRIALS* § 173, at 218 (Supp. 1966).

489. *Morrison v. State*, 516 P.2d 402, 407 (Alas. 1973).

490. *See* *Mileski v. Long Island R.R.*, 499 F.2d 1169, 1173 (2d Cir. 1974); J. O'CONNELL, *THE INJURY INDUSTRY*, 41-42 (1971) (discussion of "blackboard argument").

dispersing the award. Whatever limitations are placed, if any, on recoveries for victims of medical malpractice, they will continue to receive such amounts in a single lump sum.<sup>491</sup> This lump sum dispersal has many disadvantages and only one advantage. The single advantage is the facility of making one payment of compensation to the successful plaintiff. This ease in administration has dominated the serious problems found in calculating and paying a lump sum.

To arrive at a single, one-time payment figure which will adequately and fairly compensate a medical malpractice victim for the remainder of his life is an extremely difficult task to submit to juries. Necessarily, many factors must be arrived at by estimation, speculation, and reliance on life expectancy and other "averages."<sup>492</sup> This leads to contradictory results. An injured person may live longer than anticipated by insurance actuaries, or he may incur increased medical expenses due to complications or price fluctuations. Moreover, there are cases of unjust enrichment by windfall judgments due to assorted factors such as overestimation of certain expenses, life expectancy, or the seriousness of the injury.<sup>493</sup> In addition to problems of accuracy in the amount of compensation, the injured person or his relatives must deal with the difficulties of properly investing the award to ensure adequate and safe returns. This additional pressure on the victim is unnecessary.

It is submitted that an annuity system of dispersing awards would be a viable alternative to the present system of lump sum awards.<sup>494</sup> Compensation could be provided on an annual basis, or even better on a monthly basis similar to other social benefits such as welfare.<sup>495</sup> The costs of administering the annuity system could in part be recouped by the reduction of "windfall" awards, or return on investments since the money is not being paid out in one payment, or perhaps by reducing some benefits currently

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491. See D. DOBBS, HANDBOOK OF THE LAW OF REMEDIES § 8.1, at 540 (1973). For a critical examination of this rule see J. O'CONNELL, THE INJURY INDUSTRY 16-19 (1971).

492. See J. O'CONNELL, THE INJURY INDUSTRY 16-17 (1971).

493. See Rubsamen, *The Malpractice Crisis: How Did We Get There, Can We Get Out?*, MOD. MEDICINE, Vol. 43, No. 7, Apr. 1975, at 39.

494. See Hassard, "Change Tort System?", MED. WORLD NEWS, Vol. 16, No. 19, Sept. 8, 1975, at 60, where the author discusses the alternative of periodic payments:

[S]o that the injured party or dependents would be fairly and adequately compensated throughout his or her lifetime. In view of the compensatory purpose of damages, this mode of administering future damage awards would be fair to all parties and would help to reduce inflated verdicts.

*Id.* at 64.

495. This is the type system used by the New Zealand Accident Compensation Plan. See Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice,"* 31 U. CHI. L. REV. 279, 286 (1964) (advocating weekly indemnity as the basic unit of compensation); Palmer & Lemons, *Toward the Disappearance of Tort Law—New Zealand's New Compensation Plan*, 1972 U. ILL. L.F. 693, 698; cf. Wis. Laws 1975, ch. 37, § 10, at 41, codified in WIS. STAT. § 655.015 (Supp. 1975).

being received. Alternatively, more attention could be devoted to other facets of compensation of the injured patient, such as rehabilitation and retraining, as a trade-off for reduced cash benefits.<sup>496</sup>

#### PATIENT COMPENSATION FUNDS

Limitation of individual liability must not be confused with limitations upon the injured person's right to recover for damages suffered. Patient Compensation Funds (PCF) of various types are one means of limiting liability of individual medical professionals while simultaneously allowing maximum recovery by the injured patient.<sup>497</sup> Patient Compensation Funds are a method of broadly spreading the risk of medical malpractice and are more equitable than present methods.

Presently, the majority of PCFs are patterned after the Indiana fund which was created by legislation and funded by a surcharge on health care providers.<sup>498</sup> In its simplest form the fund provides excess coverage for the insured beyond his typical base coverage of \$100,000.<sup>499</sup> Besides relieving the medical practitioner of the need to obtain umbrella coverage—excess coverage—from a private carrier, the PCF spreads the risk of the “catastrophic” losses among all health care providers in the state.

An additional benefit accrues to the occasional injured patient who sues a health care provider who has inadequate insurance coverage or personal assets.<sup>500</sup> The PCF offers assured availability of excess coverage for the medical professionals, while simultaneously providing for excess coverage of all practitioners by requiring participation in the PCF.

Perhaps a more important benefit to be realized from a Patient Compensation Fund is the greater control and centralization over premiums, claims, settlements, costs, and the alleged “offending” health care providers.<sup>501</sup> The availability of complete information on all claims against health care providers in the state would aid in understanding the malpractice problem. This accumulated knowledge would not only allow accurate adjustment of the

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496. See Ehrenzweig, *Compulsory “Hospital-Accident” Insurance: A Needed First Step Toward the Displacement of Liability for “Medical Malpractice,”* 31 U. CHI. L. REV. 279, 289 (1964) (for other economic advantages); Hassard, “*Change Tort System?*”, MED. WORLD NEWS, Vol. 61, No. 19, Sept. 8, 1975, at 60, 64.

497. At present, these funds are the only system in use to perform this function.

498. Ind. Laws 1975, Pub. L. No. 146, art. 9.5, ch. 4, §§ 1-3, at 857.

499. Fla. Laws 1975, ch. 75-9, § 15, at 18, *codified in* FLA. STAT. § 627.353 (Supp. 1975) (\$400,000); Wis. Laws 1975, ch. 37, § 10, at 50, *codified in* WIS. STAT. § 655.27 (Supp. 1975).

500. This situation will increase if medical professionals attempt to take their chances of practicing without liability coverage in protest of high premiums.

501. With one central fund for all medical practitioners in a state, trouble areas could be detected more easily and perhaps more efficiently than the old method of a private insurer simply cancelling the offender.

annual surcharge, but more importantly, would provide the necessary data and the resources for more adequate "in-house" scrutiny and supervision of the medical profession. Since all health care providers are taxed equally under the PCF, there is the added impetus of economics to detect the negligent practitioner or the under-qualified or overworked medical professional. The incentive to police their own ranks should prevail since, in effect, all the medical professionals in the state are subsidizing the frequent "offenders."

Further, Patient Compensation Funds help to relieve the pressure on the high-risk specialists in obtaining liability coverage. The availability of excess coverage would ease the acquisition of base coverage. The PCF performs valuable risk-spreading functions as they relate to the high-risk specialists. While this does not affect their base insurance premium rates, they only have to pay the same surcharge as all other medical professionals, regardless of their field or practice.<sup>502</sup> This provides needed relief for the specialists, and in turn benefits everyone by the improved health care possible if the specialists are given the opportunity to advance present medical knowledge and expertise. Furthermore, it would operate to dissuade those in training from avoiding the high-risk, high-premium specialties.

Patient Compensation Funds work to alleviate the medical malpractice insurance problem in other ways, such as requiring that all health care providers be contributing members to the fund.<sup>503</sup> An excellent complementary program was incorporated into the Wisconsin PCF statute.<sup>504</sup> This statute provides for the simultaneous creation of a Patient Compensation Panel, with the creation of the Patient Compensation Fund. The panel is empowered to make determinations of negligence and injury and to make appropriate settlements from the fund.<sup>505</sup>

Since PCFs have the capability of assembling the data concerning medical malpractice occurrences (frequency, cost, etc.) on a state-wide basis, logically, integration of the fund with some form of health care review panel should occur.<sup>506</sup> These panels could also serve as the required agency for the administration of monthly or yearly payments to victims of medical malpractice, thereby eliminating the primary argument against annuity-type compensation systems—the administrative problems of disbursement.

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502. MALPRACTICE COMMISSION REPORT, APP., at 508. This is especially important since the availability of excess insurance is extremely scarce at present.

503. Fla. Laws 1975, ch. 75-9, § 15, at 17, *codified in* FLA. STAT. § 627.353 (Supp. 1975).

504. Wis. Laws 1975, ch. 37, § 3, at 37, *codified in* WIS. STAT. § 20.680 (Supp. 1975).

505. Wis. Laws 1975, ch. 37, § 10, at 42-48, *codified in* WIS. STAT. §§ 655.02-21 (Supp. 1975); *see* Tex. S.B. 635, 64th Legis. Sess. § 13 (1975) (failed on third reading in House).

506. *Accord*, Wis. Laws 1975, ch. 37, § 10, at 42-48, *codified in* WIS. STAT. §§ 655.02-21 (Supp. 1975).



Patient Compensation Funds are not a form of self-insurance even though they are funded entirely by health care providers. There have been, however, experiments with self-insurance on a limited scale within the medical profession.<sup>507</sup> At a Florida medical center, approximately 500 medical practitioners, including the hospital, have been paying their premiums into an insurance trust fund, instead of purchasing private malpractice insurance.<sup>508</sup> This private insurance trust has proved so successful that they have been able to steadily decrease the amount of private excess coverage required each year. As may be expected, this particular experiment involved a select medical group operating under favorable conditions.<sup>509</sup> As a model it does offer an innovative approach to medical liability insurance. As with all self-insurance, both the incentive for self-improvement and the implementation of safety and screening procedures would remain at a high level. The deterrence of malpractice occurrences would have immediate economic impact on the group and would therefore be a constant incentive.

Self-insurance can also be viewed as an alternative or backup to obtaining coverage through a Joint Underwriting Association or private carriers. A modified version has been effectuated by the Texas Hospital Association, which features the creation of a Hospital Exchange managed by a private agency. The purpose of this policyholder-owned reciprocal exchange is to provide coverage similar to that offered by the Texas Joint Underwriting Association, except at anticipated lower premium rates.<sup>510</sup> While participation is limited exclusively to hospitals, this plan appears to be a move in the right direction, especially in contrast to a Joint Underwriting Association.

The Patient Compensation Fund (PCF), is not the only proposed means of spreading some of the risk now being distributed by private insurers and reinsurers. One alternative to the PCF is the legislative reinsurance fund which also provides the needed risk-spreading in the medical malpractice field.<sup>511</sup> This plan offers reinsurance—the process of one insurance company absorbing part of the risk of a policy of another insurance company for a

507. See Gray, *Florida's Medical Malpractice Insurance Trusts*, 42 INS. COUNSEL J. 399 (1975); Uthoff, *Medical Malpractice—The Insurance Scene*, 43 ST. JOHN'S L. REV. 578, 596 (1969).

508. Gray, *Florida's Medical Malpractice Insurance Trusts*, 42 INS. COUNSEL J. 399, 400 (1969).

509. *Id.* at 400.

510. See Uthoff, *Medical Malpractice—The Insurance Scene*, 43 ST. JOHN'S L. REV. 578, 598 (1969) where five advantages are set forth: tailored coverage; individual group determines the rates; group has some control over settlements and trial defenses; preventive and educational efforts can be effectively coordinated; and improved relationship between the insurers and the medical practitioners. Cf. MALPRACTICE COMMISSION REPORT, APP., at 515.

511. However, PCF is the most popular legislative enactment to date. See N.C. GEN. STAT. § 173.38 (Supp. 1975) which created the North Carolina Health Care Liability Re-Insurance Exchange.

premium—by way of a governmental fund collected from the general revenues of the state or collectively from all casualty insurers in the state.<sup>512</sup> Essentially, this performs a function that was previously provided by private reinsurers until the risks of catastrophic awards and the general deterioration of the medical malpractice market which made reinsurance either impossible to obtain or prohibitively expensive.<sup>513</sup> The medical profession obviously benefits by having reinsurance made available again, no matter what type of financing is utilized. The only advantage, however, that the legislative reinsurance fund would have over that of a PCF would be the reduced expense and effort necessary to initiate and operate the respective plans. The PCF requires the creation of an insurance administration apparatus while the reinsurance fund simply utilizes the present private insurer system.<sup>514</sup>

The Patient Compensation Fund offers a more viable alternative to present medical liability insurance systems than Joint Underwriting Associations, legislative reinsurance funds, and similar risk-spreading plans. The PCFs seem to best fit all three desirable goals of risk distribution: (1) risk-spreading over the broadest scope of people and time; (2) the allocation of losses upon those people or activities which are in the best position to pay; (3) the allocation of losses on those activities or people who were responsible for them, in whatever degree.<sup>515</sup> In addition, for the protection of all recipients of health care, it is essential that loss be placed, at least partially, on those who are in a position to change and correct situations and on professionals who are responsible for malpractice. This deterrent effect is also a factor which distinguishes the PCF from all other proposed alternatives.<sup>516</sup> Since the deterring force is placed upon the entire medical profession of a particular state, improvements on a large scale are likely to occur. Consequently, better medical care may be provided by rewarding the elimination of dangerous practices and professionals. Finally, PCFs interrelate and allow more improvements and innovations to the present system of medical malpractice insurance. The PCF provides a much needed innovation without radical alteration of the tort system or the compensation system.

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512. See Atla, *A Position of Responsibility*, 11 TRIAL 49, 55-56 (1975); Rubsamen, *The Malpractice Crisis: How Did We Get There, Can We Get Out?*, MODERN MED., Vol. 43, No. 7, Apr. 1975, at 34.

513. MALPRACTICE COMMISSION REPORT, APP., at 546-47.

514. Legislative reinsurance is likely to be opposed because of its basic subsidy approach.

515. G. CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 21 (1970).

516. See Quayle, *Those Lawyers are Forcing Us to be Better Doctors*, MED. ECONOMICS, Vol. 52, No. 18, Sept. 1, 1975, at 60, where a physician expresses his opinion that: "There is unhappily some truth in what the tort lawyers tell us—that their actions against us keep us more honest and force us to improve our practices." *Id.* at 62.

## CLAIMS-MADE VS. OCCURRENCE

Another innovation in the medical liability field is the appearance of the claims-made type of insurance as opposed to the traditional occurrence policy. Claims-made insurance was created and first promulgated by Lloyds of London. The claims-made policy provides for coverage of all claims made exclusively in the year of a policy. This is in contrast to occurrence-type policies which provide coverage for all claims arising from the year of the policy.<sup>517</sup> The difference obviously lies in the fact that the claims-made policy has no "tail" to worry about in that it covers only those malpractice events which are claimed within the policy period.<sup>518</sup> The rationale is economically simple: an insurer could either offer only claims-made insurance or abandon entirely the medical malpractice field.<sup>519</sup> The primary advantage of the claims-made policy, as stated, is that it removes the uncertainty over the adequacy of current rates by reducing the long "tail" associated with medical malpractice cases.<sup>520</sup> It allows the insurance company to offer "pay-as-you-go" insurance protection rather than trying to predict far into the future policy costs and necessary reserves.<sup>521</sup>

The dispute over claims-made insurance has primarily been between the insurance companies and the medical profession which opposes it.<sup>522</sup> It may be argued, however, that claims-made insurance would aid state insurance boards or other regulatory bodies in supervising carriers of medical malpractice insurance. Claims-made policies are easier to regulate in terms of premiums charged, frequency and amount of claims received against the insureds, and costs of providing the insurance. A supervisory agency could react more quickly to possible overcharging or padding by the carriers. It also allows the carriers to respond quickly to changes which affect premium rates, whether good or bad. This speed with which insurers can react to changing conditions, both in the law and in claims experience, that is, losses, will lead to more equitable premiums and better coverage. The probability of the carrier or the regulatory board overreacting would also be diminished by the ability to correct and modify rates every year on the basis of current information.

517. *Samuel N. Zarpas, Inc. v. Morrow*, 215 F. Supp. 887, 888 (D.N.J. 1963) (depending on the policy, claims-made is retroactive).

518. See Comment, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925, 928 (1975) where the "tail" is described as "the lapse of time between the date of error and the time when a claim is made. The result is less certainty in computing premiums."

519. Swain & Sammons, *Claims Made vs. Occurrence*, MED. WORLD NEWS, Vol. 16, No. 15, July 14, 1975, at 77.

520. *Id.* at 85.

521. See Comment, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925, 928 (1975).

522. See Swain & Sammons, *Claims Made vs. Occurrence*, MED. WORLD NEWS, Vol. 16, No. 15, July 14, 1975, at 77.

Perhaps the most serious criticism of this type of insurance is the situation created when the practitioner retires, changes associations, or dies, leaving his estate with liability. Since claims-made insurance covers only the premium year, the doctor is liable for actions arising during his practice against which he must insure himself. An equitable plan has been offered by one insurance company in which the retiring physician purchases claims-made policies for three years after retirement or cessation of practice, at a decreasing sum as the probable liability decreases.

The opposition to claims-made insurance is based on the premise that claims-made insurance causes confusion rather than alleviating the medical malpractice insurance problem. It is argued that the small gains are not worth the considerable changes in the present system of providing liability insurance for medical professionals. It is also noted that the alleged decreases in premiums would only be temporary.<sup>523</sup>

### CONCLUSION

The forces behind the medical malpractice problem are of a multifarious nature. Proposed solutions must be examined in light of their effect on all parties involved. The medical liability situation is predicated upon two assumptions: that the present tort system of compensation is retained and that private insurers continue to spread most of the medical malpractice risk. Given these premises, a balance must be struck between protecting the medical professional and compensating the injured patient. It is submitted that private insurers should continue to provide at least partial coverage of medical liability. By means of a Patient Compensation Board, or some variation of self-insurance the medical profession itself should take a more active role in providing liability coverage. This would lead to a more efficient and less radical change than many other proposals. Emphasis should be placed upon deterrence and correction of medical malpractice incidents. Finally, the public must share in overcoming the medical malpractice problem by accepting less cash benefits in the form of compensation to injured patients. This reduction should be balanced by increased rehabilitative efforts and better health care.

An intrinsic part of the medical malpractice problem is the medical liability crisis. Modification of the one affects the other. While a solution to malpractice problems is demanded, it must be recognized that the peculiar insurance problems must also be corrected. Carriers should be subject to closer scrutiny by an appropriate agency equipped with the means to obtain full information concerning the coverage of medical professionals.

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523. Trout, *Malpractice Insurance: Claims-Made Policies Pose a New Dilemma*, J. LEGAL MED., Vol. 3, No. 6, June 1975, at 33, 34.