

A Report for the Federation of Independent
Practitioner Organisations
(FIPO)

On The Market for Medical Malpractice Indemnity

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Executive Summary

Key Findings

- 1 The provision of medical malpractice indemnity is offered principally through three medical defence organisations in the United Kingdom: the Medical Defence Union, Medical Protection Society and the Medical Dental and Defence Union of Scotland, collectively known as the Medical Defence Organisations (MDOs). Between them, the MDOs control approximately 97% + of the consultancy market; the remaining 3% is controlled by commercial insurers.
- 2 The MDOs took approximately £540 million in subscriptions (2010 – including overseas members) across all specialities. This market has attracted commercial insurers who wish to offer an alternative product. However, the commercial insurance market offers indemnity on very different terms and conditions to the MPS and the MDDUS, while the indemnity provided by the MDU combines features from both insurance and discretionary models.
- 3 Whereas the MDOs are subject to the Companies Act 2006 and other company legislation they are not subject to supervision by the Financial Services Authority and do not submit to regulatory scrutiny in respect of the discretionary indemnity they offer. The MDU differs from the other two MDOs as it also provides its members with a professional indemnity insurance policy, the MDU's subsidiary MDU services Ltd is regulated as an insurance intermediary. There is a liability that exists where an incident has happened but not yet notified to them, this is known as incurred but not reported (IBNR). Where they offer discretionary indemnity they make reference to this liability but do not quantify this considerable exposure other than to say in their funds are more than sufficient to cover this risk.
- 4 There are three business models for medical malpractice indemnity provision, all significantly different; The FIPO survey revealed 70% of consultants do not understand the difference between these models.
- 5 The FIPO survey revealed that 76% of consultants do not understand the important difference between claims-made and losses occurring indemnity. A total of 65% of consultants do not understand the difference between discretionary and contractual indemnity.
- 6 Despite producing a significant amount of quality literature the MDOs and from the statistics in points 4 & 5 around 70% of consultants do not understand the information provided by their MDO. Consultants have little knowledge of the complexities of medical malpractice indemnity and do not understand the structure of the market that provides it. Also, from discussion with consultants, there is evidence that where only

discretionary indemnity is offered, advice on specific questions about cover is sometimes inconsistent and contradictory.

- 7 The FIPO survey showed that a total of 76% of consultants do not know the limit of the indemnity that they have under their current arrangement.
- 8 Limits of indemnity and risk exposure are not understood by most consultants. Many consultants who change indemnifiers purchase on price and practising privilege requirements rather than their actual risk exposure. There are trends emerging that hospitals are reviewing the indemnity held by consultants and will not renew admission rights where they believe the limit of indemnity to be inadequate. It is predicted this will become common practice.
- 9 The decision by consultants to change indemnity providers is almost solely based on price with no appreciation of the implications of points 4, 5, 7 and 8. Some consultants are misguided into changing to a cheaper insurance policy, not realising that the new cover offered is inferior.
- 10 When a consultant changes to an inferior product there is evidence that they then recommend this cheaper cover to colleagues who then go on to repeat the same error.
- 11 Inflation in medical malpractice claims is currently running at approximately 10% per annum; subscriptions and insurance premiums will have to rise significantly in the future. Under discretionary indemnity, if there is a shortfall in funding in a particular sector (and there is no suggestion that the MDOs are underfunded), the next generation of consultants will be subsidising the current generation. The FIPO survey tells us that some consultants have reported a 100% increase in subscriptions.
- 12 There is a healthy, financially secure and experienced commercial insurance market that will offer alternatives to the MDOs discretionary indemnity and the insurance policy the MDU provides to its members, usually at a lower cost *but* on different terms and conditions.
- 13 The commercial market claims it is capable of providing consultants with good advisory and claims handling services as the MDOs but at lower cost, it is important to ensure the lower cost is not achieved by inadequate cover and service.
- 14 There are consultant indemnity schemes being created and new agents have entered the marketplace, all with specific products and agendas. They have concentrated on specific specialities, creating small schemes with only a few hundred members. In insurance terms, these schemes are tiny and it is possible that their continuance would be threatened by large claims. It is important any provider offers a sustainable product.
- 15 Many consultants do not understand the difference between an insurance agent, insurance broker or insurance company.
- 16 The MDOs have dominated the provision of medical malpractice indemnity; this has restricted the development of an alternative market. There are a negligible number of

truly independent brokers or insurance consultants in existence to give consultants unbiased advice. What expertise does exist is fragmented or assigned to particular schemes. Every indemnity provision available differs in some way and I have tried to outline the key differentials and expert guidance should be sought. However, there is a major void in the indemnity market for professional firms giving independent advice to consultants.

- 17 Insurance companies have few established distribution channels. That is to say, consultants have no clear access to insurance companies, which is limiting the growth of the commercial insurance market. It is important that insurers start to write volumes of business to continue to expand their offerings to consultants and be competitive; otherwise they will be a market for distressed risk.
- 18 There is a perception amongst consultants that their MDO subscriptions are subsidising other more risky specialities or general practitioners who use the advisory services more heavily. This can neither be proved nor disproved, as the MDOs will not disclose the relevant data. However, it is likely that underwriting by MDOs is not as analytical compared to commercial insurers.
- 19 Consultants should also be aware of important issues that arise should they create a separate legal entity, such as a Limited Liability Partnership through which they manage their independent practice. This is a complex area and consultants should seek advice from their insurance broker or MDO as it is probable that such an entity will need insurance protection in its own right.

Introduction

Tens of thousands¹ of consultants are being left to make complex decisions about their medical malpractice indemnity without access to professional and independent advice. Concerns have been raised following the emergence of new providers that are not part of the Medical Defence Organisations (MDOs) offering cut-price indemnity insurance. In response to this, the Federation of Independent Practitioner Organisations (FIPO) commissioned this report which sets out to give consultants additional information to make informed choices about how they select their medical malpractice indemnifier and dispel many erroneous perceptions that may be held. This report is written for consultants who work in the independent/private sector both as employees and on a self-employed basis.

There are no statutory requirements for consultants to make provision to compensate patients from harm caused by negligence, although the General Medical Council (GMC) has a regulatory requirement to ensure registered practitioners are licensed where they treat patients, and this includes that adequate indemnity be in place. The GMC does not issue any clear guidelines on what is meant by 'adequate' in this context. However, there are well-advanced plans to link registration to the need to have adequate and appropriate indemnity, by whatever means, discretionary or insurance.

This report will consider a number of important issues including:

- why medical malpractice indemnity is needed,
- the problems and trends facing indemnity suppliers and the rising cost of claims. The unwillingness to provide insurance cover for some specialities,
- who the alternative indemnity suppliers are and how they offer cover ,
- where this cover can be obtained and
- the pitfalls and implications of switching from one indemnifier to another

All those involved in providing medical malpractice indemnity in the United Kingdom (UK) have been interviewed, or invited to be interviewed, in person, in the writing of this report. This includes the MDOs, all the commercial insurance companies, insurance brokers and agents, specialised scheme providers, legal experts in this field and the National Health Service Litigation Authority (NHSLA). Most organisations and individuals provided full co-operation as far as it was commercially viable to do so and the author would like to thank them all. It must be recognised that there is confidential data held by organisations that remains their property and, although claims are made from this confidential data, it is not possible to check its accuracy. Also, many comments were made 'off the record' on the understanding that they would not be attributed to a specific source. **The reliability of**

interview material has been established as far as practically possible, but it is not possible to make any representation or warranty of any kind as to the accuracy and completeness of this report. Furthermore, the author does not accept liability of any kind and disclaims all responsibility for the consequences of any person acting or refraining to act in reliance or for any decisions made or not made based on this report.

In addition, with FIPO's assistance, the author has undertaken a survey of consultants to find out the general extent of their knowledge regarding medical malpractice indemnity, the subtleties of the differing types of cover available and their feelings around the costs and the issues that are important to them when making the final choice when purchasing indemnity.

The report deals with some complex issues, which have been summarised, and often expanded in the appendix notes. To some readers the content of this report may be surprising, while to other readers it may appear simplistic. The author accepts that some of the issues raised in this report are open to debate and further in-depth discussion; if this report is the catalyst for those debates then the author would welcome that outcome.

Should you wish to discuss any aspect of this report please contact Kevin McCluskie at

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Section 1.

The Essential Background

What is Medical Malpractice?

Medical malpractice can be split into three key areas

- (1) **Clinical Negligence** - this is professional negligence by a healthcare professional and it arises where the care provided to a patient by a healthcare professional deviates from standard acceptable medical practices at the time. It is an act or omission that causes actual bodily injury or death to the patient. For a patient to succeed in a claim it is not enough to prove that the standards of treatment were poor, they will have to prove that the lack of care resulted in an avoidable injury; this is called 'causation'. Proving that injury or death to a patient was a result of the action of a healthcare professional is one of the most difficult and contested areas in medical malpractice claims.

For a patient to be successful in a clinical negligence claim in the UK, four fundamental questions must be answered positively:

1. Was the patient owed a legal duty of care?
2. Was that duty of care breached?
3. Did that breach cause the injury?
4. Did damage result?

Modern medical negligence law is defined by two legal cases: the 1957 Bolam² case and the Bolitho³ decision in 1997 which later modified it. Bolam established the test 'Did the standard of care reach that of a reasonable doctor?' The problem with this test is that it becomes a matter of opinion amongst medical professionals as to what is 'reasonable'; it also allows doctors to judge themselves rather than the courts. Bolitho modified the principle to say that the opinion must be logical and that it is for the court and not the medical profession to decide what is meant by 'logical'.

- (2) **Defence of Rights to Practice** – Consultants are subject to external supervision by the GMC who are charged with protecting the public by ensuring proper standards in the practice of medicine. When either of these is challenged funding for legal expenses incurred in the defence is necessary.
- (3) **Medico – Legal** – This is legal liability arising from giving opinions in a legal context where others rely on this expert testimony and the consequences thereof. The new appraisal and revalidation responsibilities add new questions regarding a duty of care to colleagues and the issue of conflict of interest.

A History of the Development of Medical Negligence

We have come a long way from the original practice of medicine delivered from the barber shops in the 18th and 19th Century. Originally, patient illnesses were self-diagnosed and patients decided what interventional procedures would be used. Medicine was steeped in superstition and expectations of outcome were fatalistic. From the mid-19th century, doctors became more skilful and started to implement a scientific approach. Although the accuracy of their diagnoses improved, the law lagged behind; it saw the relationship between doctor and patient as a trade contract for services and applied fitting remedies. This was effectively the case until the beginning of the 20th century, when the law started to recognise the professionalism of doctors and no longer treated medicine as a trade liaison. By the middle of the 20th century, doctors were embraced by the State with the advent of the UK's National Health Service (NHS) and, with the Bolam ruling, they assumed complete power of diagnosis. Culturally, the public often treated doctors with awe and their skill and expertise was rarely questioned.

Bringing privatisation into the NHS started to change the picture; the knowledge and expectations of NHS patients started to increase and an element of competition was introduced into medicine. By 1990 patient rights and ethical issues gained momentum and an increasing rise in medical litigation claiming malpractice and the rising cost of compensation resulted in the creation of the National Health Litigation Authority (NHSLA)⁴ a few years later.

We enter a period now where there is an increased awareness around patient rights, fuelled by an aggressive litigious legal profession that is buoyed by 'no win no fee' funding. Since the introduction of After the Event Insurance (ATE)⁵ and Conditional Fee Arrangements (CFAs)⁶ there has been a steady rise in clinical negligence claims. Some types of legal funding do not merely offer an indemnity to the legal profession for costs and expenses incurred, but also allow additional amounts to be awarded for success fees, up to 100%; this has created a hugely disproportionate discrepancy between the legal costs and the actual award to the claimant.

The Compensation Culture

Establishing blame is the only redress between an aggrieved patient and a doctor, and the legal profession has been zealous in exploiting a culture of compensation. Specialist solicitors use their experience to spot 'winners', seeking independent expert advice to apply the Bolam test. If a case goes to trial, the judge must decide on the evidence presented. The degree of proof that needs to be established is not 'beyond any reasonable doubt', but merely that the doctor was probably negligent. John de Bono⁷, a specialist clinical negligence barrister, says: 'It is not surprising that claimants recover damages in many cases where those treating believe, with good reason, that they have done nothing wrong.' Some consultants feel aggrieved that a claim was settled where they were not negligent.

Patient consent, although useful, is not a defence against negligence. From the position earlier in history, where the original relationship between a doctor and patient was considered to be a contract for services, the relationship has now evolved into one in which a doctor may stab a patient in the operating theatre without it being deemed assault. The courts have made it clear that obtaining inadequate consent constitutes negligence by a doctor, i.e. it is a tort (a civil wrong) rather than a criminal act of assault. It is negligent for a doctor not to give enough information about a procedure, but what is enough information? Here the Bolam test is applied: the greater the risk of complication, the stronger the argument is that the risk must be communicated to the patient.

This lack of clarity sets the stage for an adversarial legal contest between a patient and doctor that will be very expensive with an uncertain outcome. Less than 1% of cases go to trial, since the fear of huge costs makes it seem more economical to reach an out-of-court compromise. There is conclusive evidence that delays in negotiation or taking a realistic position can hugely inflate the final cost of a claim. Claimants and their advisors are persistent. In situations where the claimants' legal bills are effectively being paid for them, it makes sense for them to pursue a claim that their legal team think is a 'winner'.

Legal Costs

Legal costs are so high that they frequently exceed the damages paid to the claimant by a considerable margin. These costs influence the decision-making process on whether or not to settle, where it is not a question of 'Was the doctor negligent?' but 'Is it cheaper to settle the claim than to contest it?' Sometimes the bemused doctor can only look on from the sidelines as they feel their reputation is taken out of the equation. In practice, doctors are consulted at all times throughout the process but our survey shows this is not their perception. The MDU insurers have a clause in their insurance 'We will not admit liability for, or settle, any claim against you without your prior consent'.

It is worth considering how these high costs arise. Since 1998, the principle of access to justice has manifested itself in Conditional Fee Arrangements (CFAs). The principle here is that a solicitor does not charge the claimant up-front; rather they consider the merit of the case and determine if it is a 'winner'. The solicitor must declare this arrangement to the defendant and they are paid on the outcome of the success of the litigation. They are allowed to charge their normal hourly rate, and a success fee up to 100% of their normal rate plus disbursements. Part of that disbursement may be an item called After the Event Insurance (ATE); there is always a danger the claimant will lose the case and this risk is insurable. However, the CFA requires an expensive premium to be paid (normally in stages as the litigation progresses), which is added to the final bill. The claimant has no interest in the level of costs and this lack of interest leads to disproportionate prices being applied.

The Medical Defence Organisations (MDOs) and the commercial insurance sector are reluctant to disclose confidential claim data; however, some admit that up to 70% of their total costs with a claim are legal fees. Where public data is available from the NHS (NHSLA Fact sheet⁸), CNST fund, state that, in 2010, of £863,398,000 paid out in claims a total of £235,258,700 was paid out in legal fees. As of 31st March 2011, the NHSLA estimated that it had potential liabilities of £16.8 billion, of which £16.6 billion represented negligence claims. This includes an estimate for incidents which have happened but are not yet reported to the Authority (known as incurred but not reported –IBNR). The claims experience in the independent sector differs from NHS statistics because of the skew, for example, created by obstetrics claims, however the message is clear.

Obviously, as the amount of a claim increases, the legal costs as a proportion of the total bill will diminish. However, it is the frequency and volume of the smaller claims that is putting a strain on claim funding. These costs are endemic throughout the insurance sector. The Ministry of Justice⁹ reviewed all personal injury claims and reported that in 1999 claimants' costs were equivalent to 56% of damages agreed or awarded. By 2004 average claimants' costs were 103% of the damages/awards and, by 2010, the average cost had risen to 142% of the sums received by injured victims.

In 2009 the government undertook a review of civil litigation costs, headed by Lord Jackson and published in 2010 as the Jackson Report¹⁰. The recommendations, to be implemented by the Legal Aid, Sentencing and Punishment of Offenders Bill, include that 'no win no fee' should be abolished; the report also suggested an end to referral fees, which are blamed for adding unnecessarily to claimant costs.

Damages

The barrister John De Bono is eloquent on the subject of damages and, with his permission; this report includes an excerpt from his article from the *BMJ* 23 April 2011:

“When you read in the press of awards of more than £5m to children with cerebral palsy you are entitled to wonder how that sum is calculated. Two types of damages exist. The first type is general damages for pain, suffering and loss of amenity. For a person injured in a minor road crash who has a sore neck for a year, the current rate is £2,500. For someone with total blindness the appropriate figure is £175,000. A child with severe cerebral palsy will recover about £225,000 for severe brain damage.

Then there are special damages. These are damages for financial losses that can be calculated. The bulk of an award in a cerebral palsy case will be to pay for full time care. Suppose for paying for 1 or 2 carers at all times, 24 hours a day, is £100,000. If the child life expectancy was a further 60 years then the annual cost of £100,000 would be multiplied by 31.29 to give an award of damages for future care of £3.129m. The figure of 31.29 is the factor by which an annual loss needs to be multiplied to provide the equivalent £100,000 for 60 years at an assumed rate of return of 2.5% (the discount rate¹¹) a year. Other damages would be awarded in respect of loss of earnings, the provision of an adapted vehicle, specialist equipment, physiotherapy, private medical and so on.

The principle behind an award of damages is to put the victim of negligence in the same position as if the negligence had not happened (the principle of Indemnity¹²). This means that the brain-damaged children are entitled to damages to enable them to live as independently as possible in their own home, to go on holiday, and to have any adaptation that improves their quality of life.

An old adage is that it is cheaper to kill than to maim. This is usually true. If a child dies as a result of a lethal overdose the parents are entitled to a statutory award for bereavement damages of £11,800 together with funeral expenses, say £15,000 in total. Compare that to the likely costs if a child survives but with brain damage. If an unmarried adult dies with no dependents then there is not even a bereavement award and the defendant must pay only the funeral expenses.

In the UK damages for personal injury bear no relation to the degree of fault. In cases where the common bile duct is transacted during laparoscopic cholecystectomy the damages are the same when the surgeon has made an honest mistake of anatomy as when he or she was “cavalier, gung-ho or not properly trained”

The size of claims awards are defined by the cost of the long term care. Consider also who is being operated on: the same negligence suffered by an office worker will result in a vastly different settlement than that suffered by a top professional sportsman. It is clear, therefore, that it is not what mistake is made but whom it is made on; this has profound implications in selecting what level of indemnity is purchased when medical malpractice indemnity cover is sought. A recent example of this was the case of the plastic surgeon, Mr Le Roux Fourie¹³, who was sued by his patient Penny Johnson, originally for £50 million. It was finally settled for £6,190,884, of which £80,000 was for the disfigurement, pain and psychological consequences, and the remainder for loss of earnings.

Size and Frequency of Medical Negligence Claims

MDOs and insurance companies are not willing to release confidential and commercially sensitive claims data; however, the NHSLA⁸ does publish data for the NHS hospitals. While NHS practice and claims experience differ from that of the independent sector, it offer some indication of areas of highest risk. This data captures the speciality under which care was being delivered at the time of the occurrence of a negligent event, reflecting the fact that several professionals from different disciplines may have been working together to deliver the care.

Figure 1

Total number of reported CNST claims by specialty as at 31/03/11

(since the scheme began in April 1995, excluding "below excess" claims handled by trusts)

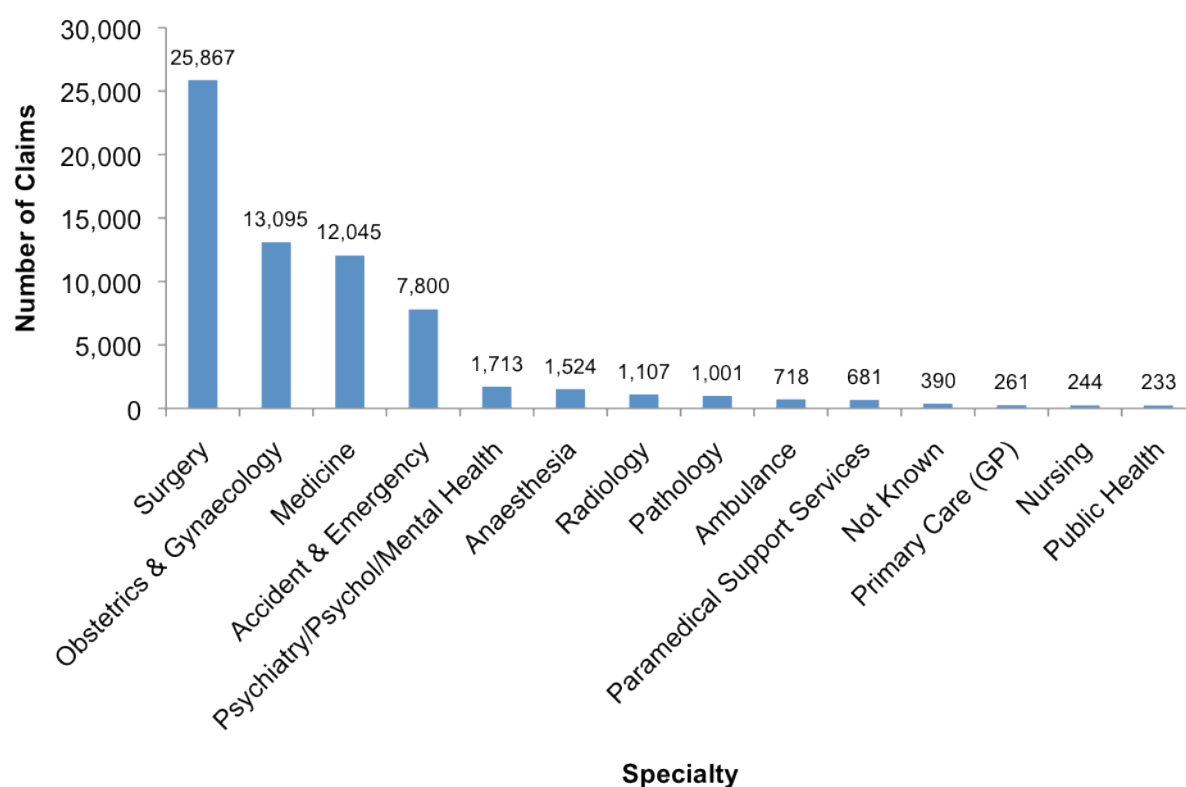


Figure 2

Total value of reported CNST claims by specialty as at 31/03/11

(since the scheme began in April 1995, excluding "below excess" claims handled by trusts)

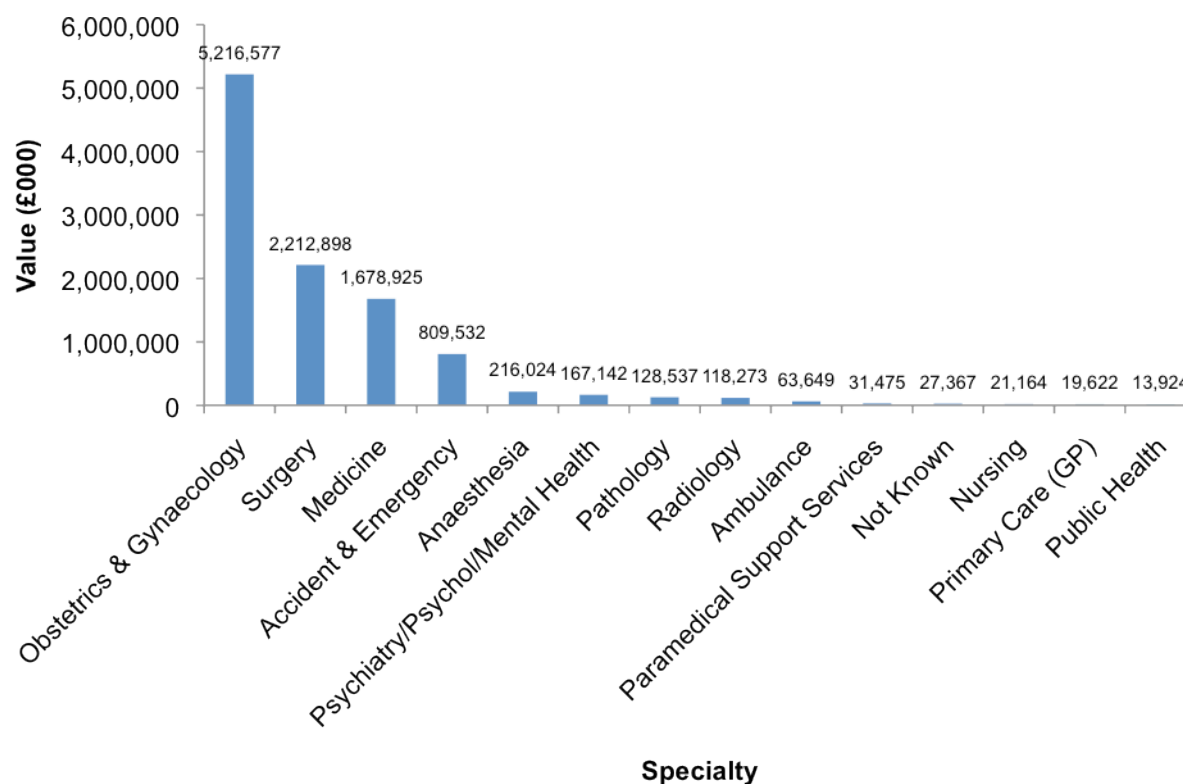


Figure 3 Useful Data extrapolated from the above charts showing frequency and severity by selected specialisations

Total Number and value of claims reported to the National Health Service Clinical Negligence Scheme for Trusts, by speciality, since 1995 as at 31/3/11 excluding 'below excess' claims (Red show highest category value)			
Speciality	No. Claims	Value (000's)	Av Cost per claim
Obstetrics & Gynaecology	13,095	5,216,577	398,364
Anaesthesia	1,524	216,024	141,748
Medicine	12,045	1,678,925	139,387
Pathology	1,001	128,537	128,408
Radiology	1,107	118,273	106,841
Surgery	25,867	2,212,898	85,549
Primary Care (GP)	261	19,622	75,180

Without doubt, the claims trend is worsening in the UK. The high-risk areas, from an underwriting perspective, are obstetrics (probably now uninsurable for new entrants in the private sector), orthopaedics (spinal), neuro-surgery, paediatrics, anaesthesia and cardiology. Another area for concern over the past few years, that is not highlighted by these statistics, is the increase in claims brought against general practitioners (GPs) especially out-of-hours, where the Medical Protection Society (MPS) report a 39% increase in claims over the past three years, though it is a differentiated part of general practice, with its own risk profile, compared with the average increase of 22%.

How Indemnity is Provided for in Medical Malpractice

The MDU, the MPS and the Medical and Dental Defence Union of Scotland (MDDUS) are collectively known as the Medical Defence Organisations (MDOs) and they account for 97% (by subscription/premium) of total member medical indemnity spend for individuals in the UK, estimated at £450-500m per annum¹⁴ (excluding overseas). They are mutual organisations based on membership subscriptions which provide discretionary indemnity. The MDU provides its members with an insurance policy for professional indemnity claims, in addition to a discretionary indemnity. The remaining 3% is covered within the commercial insurance market by approximately eight different insurance companies. Numerically, consultants form only a small part of the total membership.

The first medical defence organisation was the MDU, established in 1885 when Dr David Bradley was imprisoned for eight months after being wrongly convicted of assault on a woman in his surgery. Medical professionals came together to provide financial support for doctors to defend cases and, by 1924, this was extended to include indemnity for compensation to patients. After forays into providing indemnity in other countries, the MDU retrenched in 1998 to concentrate its activities in the UK and Ireland. The MDU membership is over 200,000.

The MPS was formed in 1892 to provide a similar service to the MDU. Today the MPS has a much wider membership base than the MDU, providing services in 40 countries worldwide, as far apart as Ireland, New Zealand, Hong Kong and Jamaica, accounting for 100,000 members from its total of 270,000.

The MDDUS was founded in 1902 and, contrary to popular perception, operates throughout the UK and has a membership of 30,000.

Finally, there is the growing commercial insurance market in the UK, which has been expanding steadily over the past ten years. This is an expanding sector that claims to have the necessary skill, financial muscle and capability, as well as an appetite to compete against the MDOs; this sector will likely have a significant impact if it gains market share in the future. They support these claims by allocating considerable capital to them.

How Indemnity Providers are Structured

There are essentially three business models of indemnity provider in the UK and it is vitally important to understand the difference between them in order to reach an informed decision on where to purchase medical indemnity cover. However, it is important first that two fundamental principles be understood; these principles are so important that an indemnity provider should not be changed unless they are fully appreciated.

Principle No 1. The difference between claims-made and losses-occurring indemnity.

Principle No 2. The difference between contractual indemnity and discretionary indemnity.

Note : For the purpose of explaining these principles I use the terms policy, cover and indemnity. The MDDUS, MPS who offer discretionary indemnity (as does the MDU in part) and do not issue insurance policies refer to themselves as indemnifiers. In its original meaning indemnity means ‘to make whole again’, a concept that is difficult to convey to someone with brain damage. When these expressions are used in this context it means ‘cover for compensation’. What systems are used by each MDO is explained later.

Principle 1: Losses Occurring vs. Claims-Made

Indemnifiers will offer indemnity based on either of the following terms:

Losses Occurring Indemnity

Under a losses occurring indemnity, cover is triggered based upon the date *of the event giving rise to the claim, and not when the claim was first notified*. Occurrence membership does not provide cover for events or acts that occur prior to the effective date of the membership. Because assistance may be provided based upon when damage occurs, membership on the date of the treatment is necessary for the indemnifier to respond to the claim *regardless of when the claim was presented to the indemnifier*. A claim may arise many years after the treatment (in insurance/indemnity parlance known as the tail.)

For example, if a patient was treated in 1995 but associated claim was presented in 2010, so long as the doctor was a member in 1995, if assistance is provided, the claim can be paid even if the doctor is no longer a member, or has retired in 2010.

Claims-Made Insurance Policies

Under a claims-made policy, cover is triggered by the date the insured person first became aware of the possibility of a claim and notified their insurer of such knowledge. The insurance policy in force on the date that *the insured gained such awareness and reported it to the insurer* is the one which responds to the claim. The policy period for a claims-made policy will extend backwards in time to a 'retroactive date'¹⁵ that may be some years before the policy was purchased. Therefore, the policy will provide cover for claims made today stemming from actions or events all the way back to that retroactive date. A claims-made policy requires the claim be made during the policy period or an extended reporting period ('ERP' or 'run-off'). The policy provides coverage only for losses which: (a) occurred after the retroactive date and (b) were reported during the policy period or the run-off.

Therefore, in the above example of a claims-made policy, if a patient was treated in 1995 but the claim was made in 2010 then the policy that was purchased in 2010 is the one that responds. If there was no active policy in 2010 then there is *no cover in force* unless extended claims reporting cover is purchased, the so-called 'run-off' cover.

Switching between types of indemnity:

- (i) If indemnity is changed from a losses occurring membership to a claims-made policy then the retroactive date will be the date the switch was made. The losses occurring membership can respond to all claims made before the retroactive date and the claims-made policy will respond to all claims made after the retroactive date.
- (ii) If a policy is changed from one claims-made policy to another claims-made policy, from insurer A to insurer B, the retroactive date will be from the commencement date of insurer A's policy, so that insurer B's policy, by negotiation, extends back in time to cover all past incidents, such that insurer A no longer has any liability.
- (iii) If indemnity is changed from a losses occurring membership to a claims-made policy and is then switched back to losses occurring, say after three years, the three year period in which the claims-made policy was active will not be covered by the occurrence membership for new incidents that happened in the three year period but that were not notified during that period. Unless there is a specific agreement in force there is *no insurance cover for that period*. Therefore one should never change from a claims-made policy back to a losses occurring membership.

Principle 2: Contractual and Discretionary Indemnity

Contractual Indemnity

Contractual indemnity is where a proposal is submitted, accepted, a premium is paid and a document (a contract) is issued (an insurance policy in this context) that sets out the terms and conditions that apply between the parties. It will set out what incidents are insured for, what incidents are not insured for, and the obligations and entitlements of the policyholder. ***Such a policy is legally enforceable in a court of law*** if there is a dispute as to the terms and conditions. An insurance contract will normally state a maximum limit of the compensation that will be paid, and any compensation that is awarded to a claimant in excess of this limit must therefore be paid from the policyholder's own funds. This limit is known as the 'limit of indemnity'.

Discretionary Indemnity

Discretionary indemnity is provided under a membership agreement. A membership application is submitted and accepted, a subscription is paid, which sets out the objectives of the organisation or what it will offer in terms of indemnity, the MDDUS say 'circumstances that arise from the *bona fide* practice of medicine'. The Company Act applies and the MDOs set out their objectives in a Memorandum of Association. A person who has been accepted as a member and paid a subscription is entitled to request the benefits of membership, including indemnity ***which is granted at the absolute discretion of the Board or Council***. There is no right that this is automatically granted.

Discretionary cover is the ultimate test of 'utmost good faith'¹⁶; there is no contract and there is no limit of indemnity.

In theory, a discretionary indemnity can pay whatever compensation it decides, subject to Board or Council approval, subject to any stated membership exclusions. However, these are similar to the exclusions that would be imposed under a medical malpractice insurance policy and would include items such as defamation, employment related issues (not related to professional practise), debt recovery, criminal acts, fines and penalties etc.

There are advantages and disadvantages, with cost implications, to each, and the proponents of each system mount vigorous defences of their offering. Below are the advantages and disadvantages of contractual indemnity vs. discretionary.

The Advantages of a Contract

- 1 It offers a legal guarantee that can be enforced in a court of law.
2. The terms and conditions of the policy clearly state what is and what is not insured.
3. It is regulated by a third party with legal powers, currently The Financial Services Authority (FSA)¹⁷. The safeguards of FSA regulation include:
 - The need to treat customers fairly in the sales process.
 - The need for insurers to have adequate funds to meet liabilities.
 - A formal complaints service.
- 4 There is access to the Financial Ombudsmen Service in the event of a dispute with the insurer.
5. The Financial Services Authority (FSA) requires ring fencing of funds subscribed by UK doctors to pay UK claims, so there can be no subsidy of overseas customers.
6. There is access to the Financial Services Compensation Scheme in the event of a failure of an insurer.
- 7 There are protections for claimants *via* the Third Party Rights Against Insurer legislation, where the claimant can claim directly against the insurer in the event of a doctor's absence/death; this is not possible with discretionary indemnity.

The Disadvantages of a Claims-Made Contractual Indemnity

- 1 There is a need to ensure that adequate 'run-off' cover is provided to cover claims arising after insured persons retire or leave the scheme.
- 2 The cost of 'run-off' cover can be high and can serve as a 'lock-in' to a scheme.
- 3 There is a history of an insurer, the St. Paul¹⁸, leaving the market and leaving doctors with no run-off cover from them for the period they were with the St. Paul. This had to be bought back elsewhere.
- 4 Expert guidance is needed to explain the exclusions which apply to the contract and their implications.
- 5 There is a limit to the amount the policy will pay for successful claims.
- 6 Insurance policies are subject to 6% Insurance Premium Tax.

The Advantages of a Discretionary/Losses Occurring Subscription

- 1 A membership agreement or the Memorandum and Articles of Association set out the benefits of the indemnity, and these can be as open as the indemnifier decides.
- 2 There is no limit to the indemnity offered or the expenses that may be paid.
- 3 It allows maximum flexibility and the indemnifier can fight a principle, not necessarily the legal argument, especially if it is in the interest of the profession.
- 4 Provided that a customer was a member at the time of an incident, they can still ask for, and be granted, assistance after they leave.

The Disadvantages of a Discretionary/Losses Occurring Subscription

- 1 There is no guarantee that a claim will be paid. There are examples of this where 15 patients who have been denied justice or whose access to justice has been severely affected by the withdrawal of discretionary cover.^{19a}
- 2 There is no upfront certainty as to what incidents will and will not be covered.
- 3 There is no regulatory supervision of the adequacy of the funds that are held to meet future discretionary liabilities.
- 4 There is no access to an external ombudsman service in the event of a dispute with the provider.
- 5 Even if assistance is provided, discretion can be exercised at any time in order to limit or withdraw assistance.

The Business Models

Business Model 1: The Mutual Organisation, as Operated by MPS and MDDUS

A mutual organisation is based on the principle of mutuality. Members do not contribute to the capital of the business by direct investment but instead obtain their rights through the subscription they pay to their membership organisation. These funds are used to provide common services to all its members according to its Memorandum and Articles of Association. There are no shareholders to service and no dividends to pay; the profits (surplus of income over liabilities/costs) are re-invested into the business for the benefit of the members. A mutual organisation can only raise capital from its members, and therefore, if it requires more money for any reason, it must undertake a cash call on its membership.

The MDOs are mutual organisations and also limited companies; these mutuals are *not* insurance companies. They have funds that are administered by their Councils or Board of Directors, as elected by the members. They are not regulated* by the Financial Services Authority but do publish their accounts and comply with company law. Where there are discretionary funds it would be of benefit if they complied voluntarily with solvency regulations and submit to the new Solvency II²⁰ requirements to be introduced in 2013 in order to put them on the same transparency as insurance companies. They currently adhere to good accountancy practices regarding income declaration, expenditure and known liabilities, but are not definitive regarding the valuation of their unknown obligations, which could adversely affect their balance sheet at some point in the future (see IBNR p 26). The accounts show a residue after provision of known liabilities and the claim is that these funds are far in excess of their IBNR provision.

The MPS and the MDDUS offer indemnity on a *discretionary basis on a losses occurring* wording.

This model does not say how much it will pay in the event of a successful claim; in theory payment is limited only by the available resources.

* Some MDOs have subsidiary companies which are separate legal entities which are regulated; e.g. the MDU Services Ltd is authorised and regulated by the FSA in respect of insurance mediation activities only. MDUSL is an agent for the MDU Ltd.

Business Model 2: Commercial Insurers

The insurance companies that deal with medical malpractice are Limited Companies²¹. Their model is one of a legally binding contract which is a promise to pay on the occurrence of certain, specified, happenings. Therefore, the contract sets out clearly what it will pay and what it will not pay. It also says up to how much it will pay, known as the indemnity limit.

Such companies offer indemnity on a *contractual and claims-made* basis.

Business Model 3: The Hybrid – The Medical Defence Union

A hybrid model is the Medical Defence Union. The MDU is a mutual organisation but offsets claims liability from its balance sheet by provides a *claims-made contract* for clinical negligence claims up to £10 million for each individual member. However, this is underpinned by a *discretionary promise* on a losses occurring basis for anything that falls outside that contract. All non-clinical indemnity (advice lines etc.), run-off and amounts above £10 million are discretionary.

General Financial Objective of the MDOs and Insurers

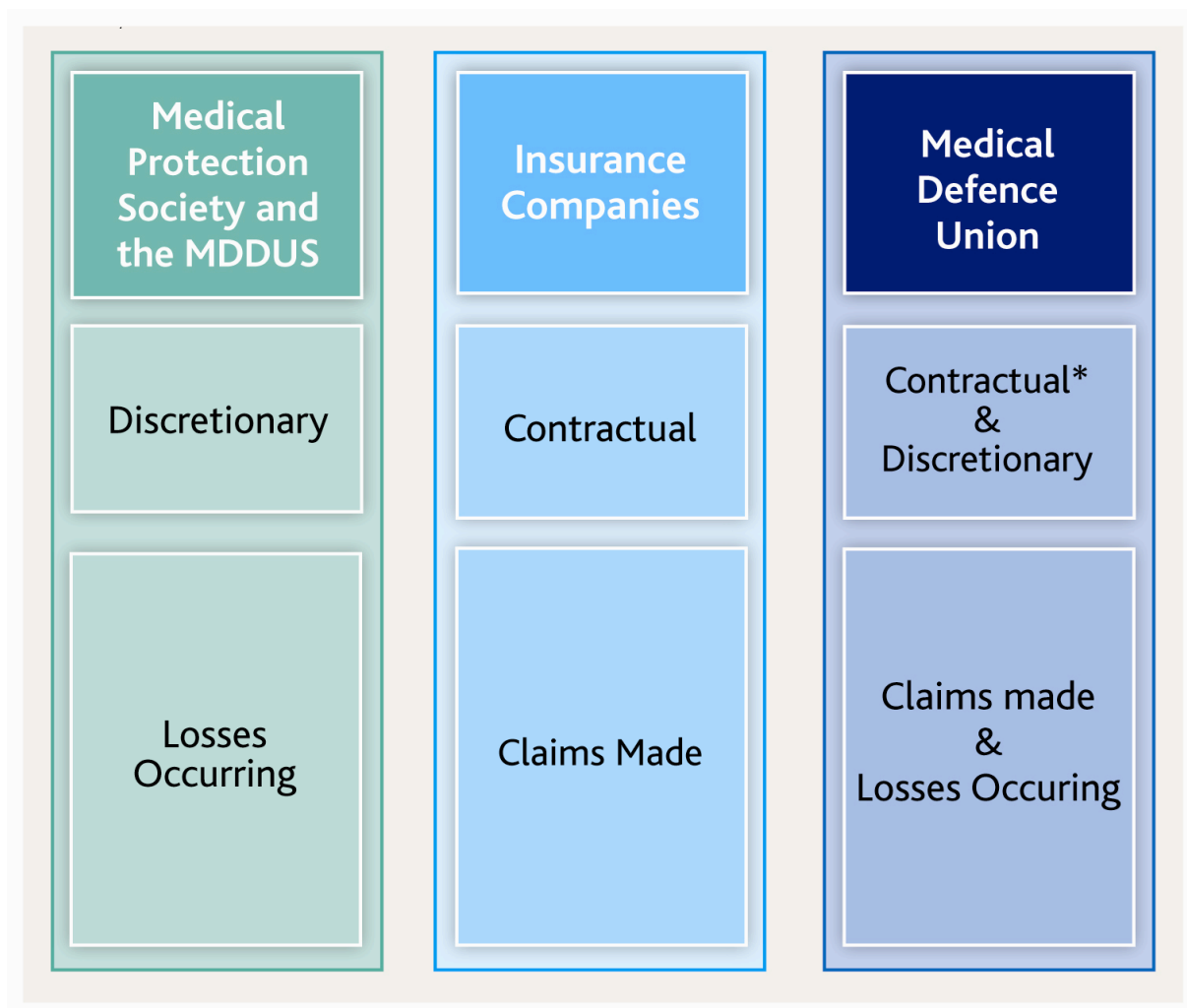
The objective of both the mutual and the insurance company is to collect more in premium/subscriptions (the terms are interchangeable in this context; it is the payment of money for indemnity) and investment income than is paid out in losses. A mutual will term such an excess a 'surplus' whereas an insurance company will term it a 'profit'.

Profit/Surplus (loss/deficit) can be reduced to a simple equation:

Profit/Surplus = earned premium + investment income **minus** incurred loss (adjusted for the annual movement of provision for liabilities) + admin expenses.

At the termination of the policy/subscription year, the profit for an insurance company is usually distributed to its shareholders and for a mutual it is placed into reserves for the benefit of their members.

Figure 4 – The Systems used by Indemnifiers



*The MDU provides its members with an insurance policy underwritten by SCOR UK Company Ltd and International Insurance Company of Hannover Ltd which provides indemnity up to £10 million per claim and in the annual aggregate for claims of clinical negligence. This is supported by discretionary losses occurring benefits for claims reported after a member retires, dies or leaves the organisation, and for claims exceeding the £10 million policy limit.

All other benefits of MDU membership such as defence of the rights to practise are provided on a discretionary losses occurring basis.

How indemnifiers Set the Price of a Subscription or Premium. Why Can There be Such a Big Difference Between Prices?

An important skill for both the mutual and the insurance company is price setting. This is based on actuarial science which uses statistics and probability to calculate and quantify future claims. Future claims will depend on the frequency and the severity of clinical negligence events and the legal costs associated with them. Having established the business model the next important decision is (i) who will and will not be indemnified, (ii) what services will be offered and (iii) the length of time indemnity will be offered for. Here is where the principles of the mutual and the insurance company diverge significantly

(i) Who indemnity is and is not offered to

The process of selecting a risk, in insurance terminology, is underwriting.

When buying motor insurance, why does one insurance company offer a low cost premium and another company offer a very high cost premium for the same risk? The answer is specialisation by the underwriter. The same is the case for the medical profession. Insurers specialise in certain specialist sectors and they feel that their knowledge in one particular sector gives them a market advantage when it comes to pricing and cover; specialist companies believe (evidenced by experience) that they have an insight into a particular sector which their competitors do not have.

The insurance company approach

An insurance company will request that a client completes a proposal form, which will ask specific and detailed questions about the individual who is proposing the insurance contract (the proposer). The underwriter will assess the risk and will make two key decisions. First, is the risk of the proposer acceptable? Secondly, what price will be charged? This process is one of balancing good risks against the bad risks.

This selection²² process is crucial. Insurers and the MDOs know that each year a small number of different doctors generate a significant amount of the claims by value. The key underwriting skill is to identify this element that will result in the big losses; this will benefit the other members by keeping premiums low. This is not to say this group are bad doctors, there are doctors who are truly excellent and simply find themselves making claims due to bad luck or adverse circumstances, but there are doctors who do fall below accepted standards. Although based on actuarial science (which sets the price), this selection process (which eliminates the poor risks) is more art than science; good and experienced underwriters who are able to identify poor risks accurately are a very valuable commodity.

There are a small number of underwriters currently trading in the market who have been successfully underwriting or have experience in this sector since the early 1990's.

Whilst insurers claim to use this selection process successfully, MDOs often claim that it is not possible to be this selective and both parties cite confidential data to support their position. Some insurers claim their loss ratio²³ to be as low as 20%; however the period over which this figure is quoted is unknown and it is, therefore, not possible to confirm or dispute the accuracy of this statistic. It is, however, fair to assume that it must be possible to make a profit and offer competitive terms in order for them to remain in the market.

Medical Defence Organisations

Originally MDOs applied the same subscription rate to all members but this changed in the late 1980's, and they now request a membership application form be completed by potential members, allowing them to assess risk by banding specialities into groups. The crucial point here is that pricing focuses on the speciality, *i.e.* the whole population of that group, and not the individual. In rare cases, where the risk is obvious, MDOs will refuse membership but our survey implies that less than 1.4% of applicants are rejected, compared to a typical insurer who reject 20%.

(ii) Services offered

Insurance companies

The services that are offered vary between insurers and are normally a subject of negotiation between the consultant and the company. Helplines are available on a 24 hour basis for matters associated with clinical negligence and some helplines also deal with legal matters not associated with clinical negligence indemnity, *e.g.* disciplinary hearings and so on. What a customer needs and what is offered will be reflected in the pricing, but a consultant must decide how a premium will be allocated. It is essential to negotiate what is needed at the time of purchase.

Some medical malpractice insurers subcontract out this legal element of the risk to another more specialist insurer. This is normally easy to identify, as there will be sub-limits of indemnity within a policy for these contingencies. For example, a policy may have a limit of indemnity of £10 million for clinical negligence and associated legal costs but have an inner limit of say, £250k for GMC hearings and the adequacy of this limit must be questioned. This is in order to provide a high level of service whilst at the same time minimising costs and the client will select to pay for their realistic needs. This is an internal arrangement between the insurers as only one policy is ever issued to the client.

The MDOs would argue that the support services offered by commercial insurers are a weak component of their package and do not meet the needs of the profession. Specialist insurers consider this view unfair and out of date. Most of the legal support services offered by

insurance companies are by first rate legal firms with specialist knowledge in the matter at hand.

Medical Defence Organisations

MDOs offer the widest range of ancillary services but at ever-increasing costs. They employ doctors who are legally trained to answer day-to-day queries regarding all kinds of medico-legal matters. In addition, MDOs run workshops, publish high quality magazines, offer on-line learning and much more. For example, in 2010, the MPS ran 1,500 workshops and published 33 editions of high quality magazines; they spent £52m on advisory and non-claim legal costs, an impressive 17.5% of their subscriptions. Simon Kayll (Finance Director of the MPS, soon to be CEO) commenting in the 2010 accounts summary on the 12.5% increase in these costs over the last year said “this cost element has been increasing quite rapidly for many years and shows no sign of abating.”

Commercial insurers are critical of such high expenditure and argue that a relatively small percentage of consultant members use these services, which are manned by over qualified and expensive staff.

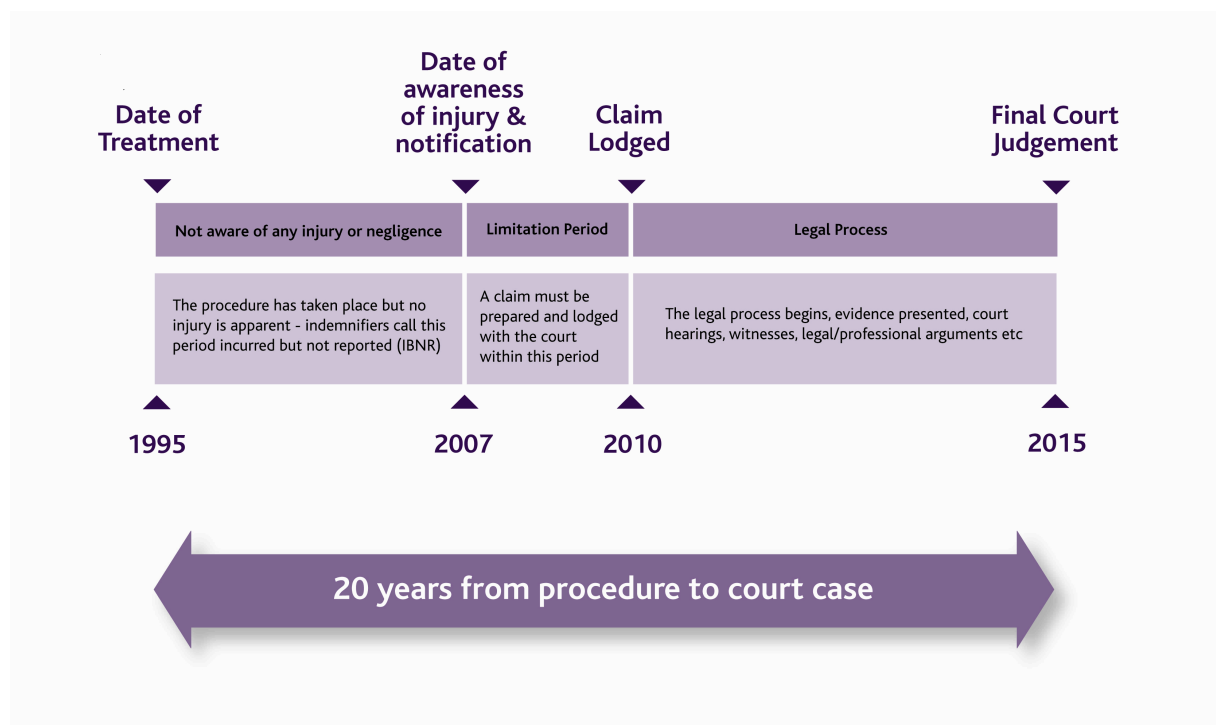
MDOs are active in political lobbying, where they attempt to influence government decisions to protect or enhance the interest of their members. One very important campaign that will influence future malpractice indemnity subscriptions/premiums is tort reform²⁴, where campaigners question how the principle of common law should apportion damages from medical injuries and what limits needs to be addressed or what are the alternatives? Common law is the principle of law being determined by custom and precedent, there are no statutory rules that apply. Tort reform suggests that new rules be introduced that either cap the amount that is paid to a claimant, redefine what is a reasonable level of care, restrict conditional fee arrangements, reform limitation periods or offer some alternative form of compensation arrangement such as a no-fault system that eliminates the adversarial nature of the current system. Many of these reforms have taken place in the United States and Australia and their experience on the whole has been beneficial, so there seems little reason not to undertake such reforms in the UK.

(iii) The length of time that indemnity is offered

UK law includes the principle of a 'limitation period', as set out in the Limitation Act of 1980²⁵. Simply stated, for personal injury, an action is struck out if it is not brought within three years after the damage became known or ought to have become known. For a minor, the clock starts to run from their 18th birthday. For a mentally disabled individual the period of limitation may not apply at all.

For example, if a procedure is performed in 1995 and the damage does not manifest itself until 2007, for the purposes of the limitation period, the clock starts to run from 2007. From 1995 to 2007 there was a claim that nobody knew about. Indemnifiers term this as 'incurred but not reported' (IBNR), and it has a significant impact on premiums and subscriptions and it is the main reason for the existence of the 'claims-made' wording.

Figure 5 Illustration of the Length of Time from Procedure to Settlement



For provisioning of claims reserving indemnifiers must make allowance for IBNR claims, for which actuarial methods are used whereby an attempt is made to predict the future development of existing claims and also unreported claims. These methods and the provision amounts are usually reviewed independently as well as being subject to actuarial professional standards.

FSA regulated insurance companies (including SCOR and Hannover who provide cover as previously described for MDU members) have a legal obligation to account for future claims to a degree of probability far greater than that required by the MDOs where such regulation does not apply.

FSA regulated insurance companies, under Solvency II, are required to assess, in broad terms, the capital required to survive up to a 1-in-200 year event which will lead them to consider extreme scenarios of exceptional severity and/or infrequency. With claims-made policies it is possible for the insurer to close their year of account within a short period of time as all claims that are obliged to be paid are known and thus reserve allocation becomes a very certain science.

Contrast this with an occurrence indemnity where MDOs who offer only discretionary cover never know for sure what their liabilities are because of the long length of time they are exposed to them. This means that over time they must build sufficient funds not only to cover the known liabilities but also the unknown, which can be substantial. Price uncertainty is further enhanced, as legal sentiments between the date the negligence occurred and the date claim was filed and the eventual date it was judged may be substantial; 10 years is not uncommon and in excess of 30 years in extreme cases is not unheard of. The problem is that the price is assessed at the indemnity level that applied when the negligence occurred rather than at the time the case is settled in court. For these reasons a mutual organisation will not return any surplus it has accrued to its membership. If there is a shortfall in funding then future generations must make good the gap with ever-increasing subscriptions. This 'pay as you go' approach, when unregulated, is a concern.

Provided the solvency of an indemnifier is certain, from the perspective of an individual doctor, losses-occurring is the best protection. However, it is also the most difficult to account for on the part of the indemnifier. The risk is that there may not be enough in the kitty to pay the claims.

Run-off (extended reporting period)

A claims-made policy requires that a claim be presented to an insurance company during the policy period. If a consultant learns of a situation that might lead to a claim, or receives a notice of a claim, then they must notify the insurance company immediately and before the

policy expires. This reporting provision could be difficult to comply with if the consultant receives notice of the claim near the policy's expiration date. It is essential to have procedures in place to report a likely claim or incident that may give rise to a claim immediately; a delay in reporting can invalidate cover. Some insurance companies provide a 30-day extension beyond the policy expiration to report claims for incidents that occurred during the policy period, this is the run off.

Several situations necessitate the purchase of an extended reporting period (ERP) beyond the run off . An ERP extends the claims-reporting provisions for a specific time period beyond the policy expiration date. A consultant should purchase the extended reporting period when:

1. The consultant ceases practising, usually through retirement or death and cancels or does not renew the claims-made policy.
2. The insurance company cancels or does not renew a claims-made policy and the consultant is unable to obtain new insurance coverage.
3. The consultant replaces a claims-made policy with a losses occurring indemnity.

In all three of these situations, the consultant would not have insurance cover for any losses that occurred after the retroactive date and were not reported to the insurance company prior to the expiration date of the last policy. The run off/ERP extends the reporting provisions so that the consultant can report any claims received during this period to the insurance company. The purchased ERP can be agreed, by negotiation, with the insurer and its cost depends upon the nature of the risk. Each policy has very specific requirements for activating and purchasing the ERP. The insured usually needs to notify the insurance company (in writing) of the desire to purchase ERP, request the cover within 30 days of the expiration date and pay the premium in full before the cover comes into force.

Therefore, after a subscription or policy year has expired, for incidents that have occurred in that period (known or unknown) the following apply:

- (a) A losses-occurring indemnity gives run-off cover for the risk for an indefinite time period.
- (b) A claims-made wording gives cover for the length of the negotiated ERP period, usually up to six years, but this can be higher or lower subject to negotiation and cost. Some insurers now offer indefinite (in terms of time) ERP cover.

Limits of Indemnity

A limit of indemnity is the maximum amount of indemnity provided by an insurance policy and it is determined by the sum insured and constitutes the maximum liability in respect of

any one event or series of events. It includes all legal costs and expenses and is expressed as a monetary amount, e.g. £10 million.

When a limit of indemnity is expressed as ‘any one claim and in the aggregate’, this means that if the limit were £10 million then the policy would only pay that sum regardless of the frequency and severity of claims. If you had three x £10 million (total loss) claims from three separate incidents the policy would still only pay a single £10 million sum.

When the limit of indemnity is expressed as ‘£10 million in any one claim, £20 million in the aggregate’, in the above example two (total loss) £10 million claims would be paid.

If the limit of indemnity has a re-instatement clause this means that if the original limit is exhausted the insured party has the right, by paying an additional premium, to reinstate the original limit.

How to Choose What Limit to Buy

MDOs do not have a limit of indemnity attached to their indemnity provision; it is, in theory, unlimited. This is not ‘free’ and must be accounted for somewhere.

The commercial insurance market can offer up to £25 million for any one claim and in the aggregate; by capping their risk exposure they are able to offer efficient and cost-effective products, avoiding situations where clients pay for cover they do not need. An important issue therefore, is how to identify precisely what limit is needed.

Poor advice that is sometimes given on this subject is to buy what is required to secure practising privileges, for example for a hospital to demand the purchase of only a £3 million limit, which is clearly not high enough. The limit that is purchased should bear a direct relation to the actual exposure to risk.

The law and the GMC are virtually silent on this point. The GMC say:

“Article 34. You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests as well as your own”²⁶.

The onus, therefore, is upon the doctor to select what they feel is adequate and, in the event of a large claim, if there is a shortfall in the limit of indemnity, the balance of any settlement will be from the doctor's own personal assets. It is unlikely that any insurer, governing body, regulator or broker will ever advise what limit should be purchased because that exposes them to a professional indemnity claim should they get this wrong.

The best approach is to look at the evidence and the facts and to understand what is going on in the real world. The following points should be considered:

1. It is apparent that it is not what is done to the victim that defines the size of the award but the cost of long term care and, in some cases, the loss of future earnings. Some insurers have been reluctant to provide indemnity for procedures on high earning professional sportspeople. The MDOs can indemnify a claim brought by a sportsperson himself, but may not assist with one bought by the sportsperson's club for consequential loss. It is essential the indemnity provider is advised of this type of work by the consultant before the commencement of treatment.

2. The length of time from the date of the claim to the date the case is heard before a judge; this is usually 7-10 years in contentious cases. Damages are set at the time of judgement, not the time of the incident; claims inflation (see point 3 below) means that a limit set at ten years in the past will be inadequate. Therefore, the indemnity provider should price their product today to take account of future awards.

3. A significant part of a claim is the provision of care, possibly over many decades. Medical malpractice claims inflation is currently running at a little over 10% p.a. At this rate it means that the limit of indemnity (and premiums) must be doubled every seven and a half years to keep pace.

4. Risks should be considered in relation to the speciality. All procedures can result in catastrophic damage and should have a limit of indemnity to reflect that eventuality.

5. What are the trends in the law and UK culture: is the tide in favour of the defendant or the claimant? One big landmark judgement has the effect of 'dragging up' all the other similar outstanding claims that have yet to be settled.

6. Contractual Obligations/Practising Privileges. Many independent hospitals are reviewing their own insurance arrangements since they are concerned that if a consultant has inadequate personal indemnity then any shortfall could be claimed against them and this action would need to be defended. The hospital insurers are aware that some of the new offerings are materially substandard, and might leave the consultant and the hospital exposed to significant financial risk in the event of a clinical claim.

One hospital group has identified that the largest category of non-MDO indemnities have a £1 million limit. By looking at current claim levels it has been concluded that this level of cover is inadequate and exposes the consultants and the hospital to an unacceptable financial risk. They have imposed a condition that consultants *will not have their practising privileges renewed* unless they have a certain minimum level of indemnity; the limit for average risk specialities is £3 million, rising to £5 million for cosmetic/plastic surgery. The full list is being compiled at the time of writing.

They do stress these are minimum guidelines and would prefer a much higher limit of £10 million. Their advice is that consultants should be advised to seek independent professional advice to work out the appropriate level of cover for them. It is almost a given that all

hospital groups will follow this practice in the very near future; they would be negligent if they did not.

Taking into account the above, current claim trends and the possibility of a catastrophic injury a £10 million limit is the minimum that should be considered.

Section 2.

What to Consider When Buying Malpractice Indemnity

The Risks That Should be Insured

This report is concerned with medical malpractice indemnity, but it is worth saying a few words on what fortuitous and insurable risks a consultant, as an individual (not a limited company), is exposed to on a daily basis.

There are three broad areas of general risk for a consultant

1. Clinical negligence to patients

This is and includes:

- (i) The consultant's personal (and those whom the consultant is responsible for) legal liability for negligent acts and omissions in the rendering, or failure to render, medical services.
- (ii) Liability for medical malpractice in the conduct of 'Good Samaritan Acts' at the scene of a medical emergency.
- (iii) Defence costs and expenses incurred in the defence and settlement of a claim.

A typical insuring clause would state something along the lines of: 'any bodily injury, mental illness, disease or death of any patient caused by any negligent act, error or omission committed by the assured in or about the assured occupation or business stated in the Proposal or Declaration, or Good Samaritan Acts (hereinafter referred to as "Malpractice"), and pay all Defence costs incurred with the Underwriter's consent'.

2. The risk the consultant is exposed to that could affect the ability to practise independently

- (i) Legal expenses incurred in the defence of a consultant for GMC hearings, disciplinary procedures, fitness to practice, inquests and fatal accident enquiries, criminal investigations arising from professional practice, breaches of confidentiality and loss of data.
- (ii) Liability arising from medico-legal work, i.e. giving opinions in a legal context where others rely on this as expert testimony and the consequences thereof.
- (iii) Liability arising from the new appraisal and revalidation responsibilities (see special note below).
- (iv) Loss of income following loss of reputation following an alleged incident.

- (v) Income protection following accident or injury that prevents undertaking usual business.
- (vi) Critical illness that prevents usual business.
- (vii) Directors and Officers (liability arising from wrongful acts whilst acting in your capacity as a Director or Officer of an organisation, e.g. a Director of a Trust).

3. Risks associated with a consultant running a business with an office and employees

- (i) Fixed assets (buildings/contents etc.) against loss for all risk of material damage.
- (ii) Increased cost of working following loss of fixed assets.
- (iii) General legal liabilities, legal liability to third parties and products supplied.
- (iv) Contingent liabilities and vicarious liabilities incurred by acts of employees or those persons which the doctor is responsible for.
- (v) Motor vehicle damage and legal liabilities from its use.
- (vi) Employment disputes and tribunals.

A medical indemnity policy issued by a commercial insurer will generally cover all of item 1 and items 2(i), (ii) and 3(iv) and all other listed risks require separate insurance policies following advice from a qualified insurance broker.

The MPS and MDDUS do not have an insurance policy and indemnity is provided on a discretionary basis along the lines of 'circumstances that arise from the bona fide practice of medicine'. In practice the boundaries of the core intent and cover/restrictions are very similar to those offered by insurance companies.

4. Additional Risks Associated with a consultant running a business that is a Limited Company or Limited Liability partnership

By creating a limited company or LLP, usually on the advice of an accountant, one creates a quite separate legal entity. In the event of a clinical negligence claim, the entity, as well as the consultant could be sued. It is essential that consultants who are directors of such entities obtain proper advice from their insurance broker or MDO in order to protect their company or LLP and themselves.

Entity cover does not normally form part of a consultant's medical malpractice indemnity but certain insurers will include the cover under certain circumstances and there are numerous insurers and MDOs willing and able to provide any separate cover that may be required

Special Note. Risk 2(iii) Liability arising from the new appraisals and revalidation system is an area raising new questions. MDOs and insurers take different views as to whether they do or do not offer this cover. Therefore, check specifically with the indemnifier if this is covered or not.

If the principle of utmost good faith²⁶ is not adhered to by a consultant the penalties from both the insurer and the MDOs are likely to be the same, ultimately leading to rejection of the claim.

Where to Buy Medical Malpractice Indemnity

In the UK, medical malpractice indemnity can be purchased from the following sources:

1. An MDO, specifically the MDU, MPS or the MDDUS (who operate throughout the UK).
2. An insurance company via a Broker.
3. An insurance company via a facility run by an agent (appointed representative).
4. An insurance company via an agent who has arranged a speciality specific scheme owned and governed by a consultant association.

An MDO will deal directly with their subscriber on a direct basis. There is no middleman but this means there is also no independent advice. They offer their own products as previously described.

The relationship looks like this:

Consultants → MDO

A Broker is an insurance agent (or limited company) who has been granted an agency status by a number of insurance companies, and will then source insurance contracts on behalf of its clients. Brokers will collect the risk data and submit this to numerous insurance companies inviting them all to offer quotations and to state on what terms and conditions the quotations are offered. These offers are then individually negotiated and fine-tuned and the best option presented to the client to decide whether or not to purchase the insurance contract. Any insurance agent can call himself or herself a broker, but the most professional will have an insurance qualification obtained through examination and experience. It is worth noting that a MDO or a scheme agent will not have to incur the cost of comparing available options (an expensive and time consuming process) as they will only offer their own product.

One major safeguard afforded by using a FSA broker (or regulated agent) is that they are themselves required to hold their own professional indemnity policy, which is to say, if they give negligent advice they are themselves insured for the consequences. It is perfectly reasonable to ask what limit they have as this can vary considerably.

The relationship chain involving a broker is as follows:

Consultant → Broker → Entire Insurance Company Market

Brokers are paid a commission by the insurance company (or alternatively receive a fee from the client) on every contract issued. Their absolute obligation, by law and FSA regulation, is to obtain the best deal for their client.

An agent, or appointed representative, is usually a company which has a tied relationship with an insurance broker. Sometimes, either because they cannot comply or choose not to, go through compliance registration in their own name, they seek assistance from a broker to arrange contracts with insurance companies on their behalf. The broker takes responsibility for the arrangement in the eyes of the FSA. They can only offer and sell what they have previously arranged with the insurance company.

The relationship chain involving a broker and agent is as follows::

Consultant → Agent → Broker → 1 or 2 insurance companies

An example of this is the company Premium Medical Protection (PMP) which is an agent that uses a broker (Integro) to arrange contracts for insurance companies, in this case, WR Berkeley Insurance (Europe) Ltd or ACE. They are paid a commission from the insurance company which is then split between PMP and Integro.

Speciality specific schemes are schemes in which a consultant association works with a speciality agent who sets up a not-for-profit company limited by guarantee (a mutual organisation). It will arrange, *via* a broker, a policy with a company that wishes to focus on a particular medical speciality.

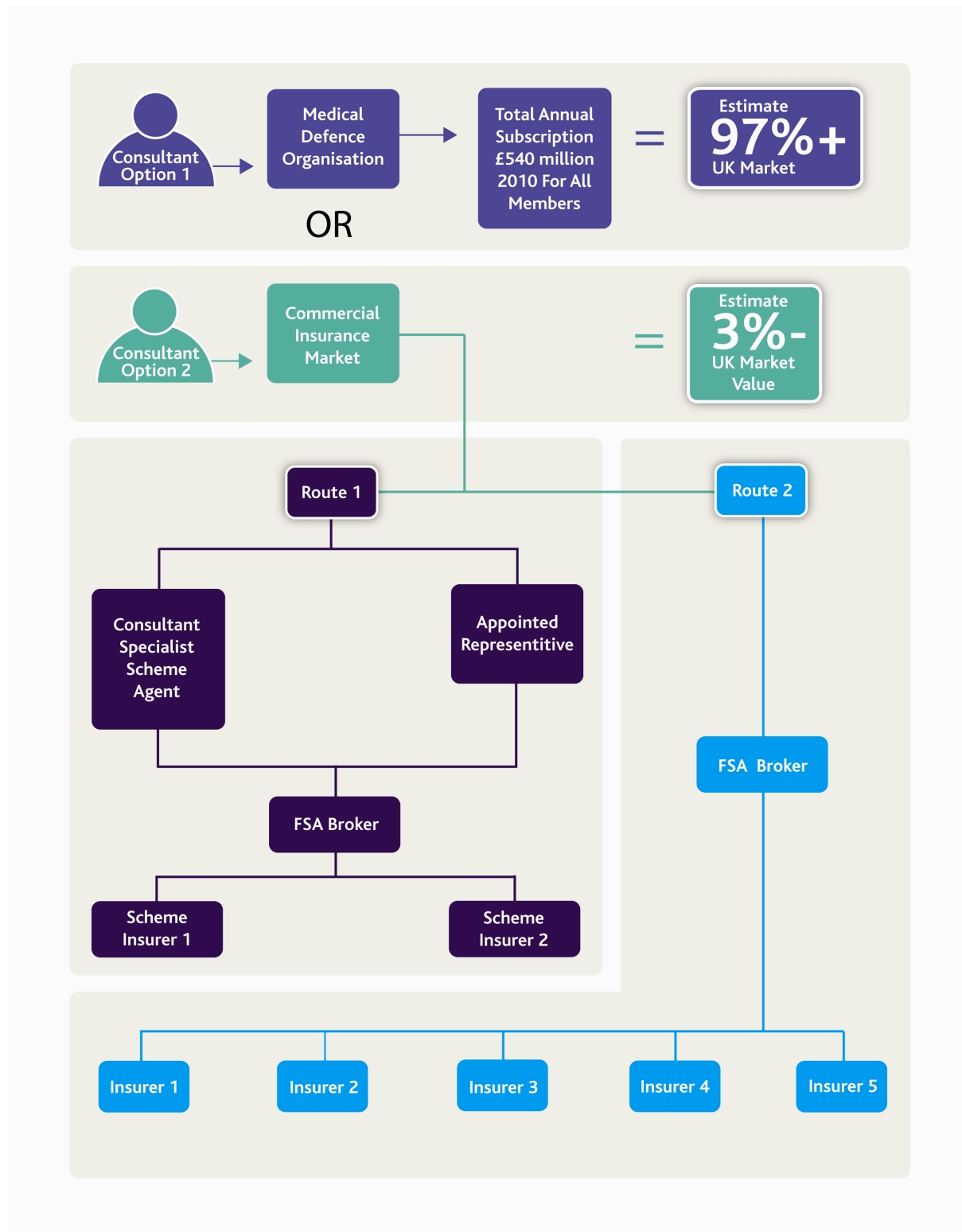
The relationship chain involving a mutual agent and a broker is as follows:

Consultants → Mutual agent → Broker → Single scheme Insurer

An example of this is the PRASIS scheme where the agent is TWG who are paid a retainer to cover administration expenses. TWG use a broker (Paragon, who receive normal commission) to arrange the contract with the company (Marketform). This scheme specialises in plastic, aesthetic and reconstructive surgery risks and any consultant who falls within that profile will generally be offered good terms.

A list of active brokers, agents and insurers is summarised in note 27 in the Appendix.

Figure 6 - A Graphic of the Market Structure.



Brokerage and Commission Fees

A consultant will deal directly with an MDO without the need for a middleman in the arrangement. An MDO will argue that this is a good thing as the entire membership subscription is being used for the benefit of consultants. A broker or an agent will be paid a commission, known as brokerage, by an insurance company, up to approximately 20% of the premium.

It is not possible, or advisable, to buy directly from an insurance company in the open commercial market. They can only be accessed by agents or brokers and, therefore, these middleman fees have to be met. Agents and brokers will claim that fees are essential to the process; it is their principle income stream that allows them to exist. The fee is paid to the agent or broker by the insurance company and pays for the experts within the brokerage to give sound independent advice, cover marketing, claims handling and general administration costs. Brokerage is a very efficient system to create quality products and keep costs down as evidenced by 300 years of business practice.

Administration costs, claims handling costs, rents, rates etc are incurred by MDOs as well. The big area of difference is that insurance companies (including SCOR and the International Insurance Company of Hannover, who provide the insurance policy for the MDU), brokers and agents need to make a profit from the business and have to deliver returns to shareholders. The MPS and MDDUS and the surplus above the premium paid by the MDU do not and all the income is focused on subscriber's benefits. However, it is undisputable that profit or surplus drives competition, innovation and efficiency.

Underwriting Factors That Influence Acceptance of a Risk and Cost in the Independent Sector

Each indemnifier will have its own criteria for accepting risk and at what price; underwriting is the process of assessing whether a customer meets these criteria. Effectively, by paying a subscription or premium the risk is being transferred from one party, the consultant, to another, the insurer. There are a number of areas that the indemnifier will consider when determining acceptance or price: these include, but are not limited to:

1. the speciality area of the consultant,
2. the frequency of treatment expressed as the number of procedures, fee income or both over a certain period of time,
3. the limit of indemnity being offered,
4. the scope and extent of the cover provided including 'run-off provision',
5. the quality of the record keeping systems,
6. the attitude and approach to medicine of the consultant,
7. the communication and rapport skills of the consultant,
8. the indemnity excess selected, and

9. the possible need for “retrospective” cover from inception.

1. Speciality area of the consultant

Evidence gathered from claims statistics shows that some areas of medical practice are vulnerable to more claims than others. Obstetrics and neurosurgery top the list and it is unlikely that cover for these will be available in the commercial market. It is estimated that if a consultant obstetrician working in the NHS had to purchase their own indemnity rather than being covered by the State, the cost would be in excess of £500,000 per annum.

Until April 2011, the MPS published their guide rates, but following a review they no longer do this and individual submissions now have to be made. The MDDUS continue to regularly publish their rates in a magazine called *Medieconomics*.

MDOs now apply ever-stricter acceptance criteria for new consultants. Insurance is about fortuitous risk, something that may or may not happen within a particular probability. When that probability becomes too high the risk becomes uninsurable.

2 Frequency of treatment and fee income

Earnings can be defined (and a breakdown is required) as fees, salary, benefits, profit dividends and bonuses for the year in question. A breakdown in income for various activities may also be required, for instance in the case of medico-legal work. This is helpful as some activities attract a greater risk (and premium) than others, and it would, therefore, be unfair to be charged across your entire income for a high risk but low frequency activity.

The rationale here is that the more work you undertake the greater is the probability of something going wrong. This is not a reflection on the skill of the consultant, since even the most professional of practitioners can have a series of unforeseen misfortunes. It is also not fair to assume that the more work you undertake then the more skilled you are and there is, therefore, a lower probability of something going wrong; such an assumption is unsupported by claims data.

The MPS and the MDDUS have published its rates or speciality groupings. The MPS ceased to do so in April 2011. The last published MPS data (now withdrawn) on speciality groupings and rates, reproduced here, provide an insight on the rationale behind pricing. There are effectively nine risk groups, Group 1 being of the highest risk.

The complaint with this banding structure is that a consultant with, say, a £7,501 income pays the same as one with a £15,000. Also, if the consultant is in a lower band on the cusp of a higher band a small increase takes them into the new band which could result in a proportionately massive increase in subscription.

Figure 8 – Possible Risk Groups

The Groups (Descending Risk/Price).	
Group 1	Obstetrics: the management of pregnancy after 24 weeks gestation.
Group 2	Neurosurgery, spinal surgery (spinal procedures performed on the spine) and/or meninges.
Group 3	Gynaecology and non-spinal trauma and orthopaedic surgery, bariatric surgery.
Group 4	Cardiac surgery; cardiothoracic surgery; colorectal surgery; general surgery; thoracic surgery; urology; vascular surgery.
Group 5	Ophthalmology (excluding refractive laser surgery) and otorhinolaryngology.
Group 6	Cardiology; paediatric surgery.
Group 7	Neurology; radiology; accident and emergency, sports and exercise medicine, forensic and medical examiners (police surgeon).
Group 8	Anaesthetics.
Group 9	Allergy; alternative medicine; audiology; community health; dermatology; endocrinology; gastroenterology; general medicine; genetics; genitourinary medicine; geriatric medicine; health screening; intensive care; internal medicine; neonatology; nephrology; nuclear medicine; occupational health; oncology; pathology; (including Home Office); paediatrics (excludes surgery); psychiatry; radiotherapy; rehabilitation medicine; rheumatology.

Group 1 and Plastic Surgeons are not quoted since both require a special referral to the MPS.

The Rates (for methodology and comparative guide only – these rates are no longer applicable)

Income £	Grade	2	3	4	5	6	7	8	9
0	BMC	590	590	590	590	590	590	590	590
0-7,500	CA	1,800	1,200	960	735	685	645	640	625
7,501-15,000	CB	11,715	7,720	4,690	3,595	2,155	1,875	1,630	930
15,501-25,000	CC	17,670	11,885	7,065	5,410	3,205	2,755	2,400	1,370
25,001-35,000	CD	21,805	14,755	8,720	6,680	3,910	3,355	2,952	1,710
35,001-50,000	CE	26,120	17,700	10,520	8,060	4,535	3,910	3,370	2,040
50,001-75,000	CF	30,660	20,670	12,370	9,475	5,375	4,650	4,075	2,355
75,001-100,000	CH	35,575	23,805	14,165	11,170	6,535	5,680	4,975	2,815
100,001-125,000	CI	39,075	25,890	15,940	12,570	7,350	6,320	5,530	3,140
125,001-175,000	CJ	42,135	27,795	17,645	13,920	8,510	7,545	6,600	3,475
175,001-225,000	CK	45,040	29,700	19,400	15,305	9,125	8,120	7,105	3,720
225,001-300,000	CL	48,110	31,730	20,385	16,080	9,590	8,530	7,470	3,910
300,001-400,000	CM	51,355	33,875	21,405	16,890	10,075	8,965	7,845	4,115
400,001-500,000	CN	55,225	36,495	22,700	17,915	10,680	9,505	8,320	4,360
Above 500,000	CQ	59,470	39,215	24,070	19,000	11,330	10,075	8,820	4,630

3 The limit of indemnity offered

The limit of indemnity has already been described briefly (p.28). However, it should be added that by doubling the limit of indemnity the premium will not necessarily double. A limit of indemnity is structured within an insurance policy; that is to say, although a single policy is issued the insurance company will 'layer' the limits internally and offset the risk by selling it on to someone else. The first layer of insurance is known as the primary layer and all other layers are known as the excess layers, or top-up. When a claim is made the primary layer will always have to pay but the top up layers are only called to account in the event of a very large pay-out, which is rare. Therefore, as a proportion of the premium, the primary layer takes by far the majority of the risk and the top-up a much smaller proportion. This is essentially why increasing the limit of indemnity does not cause the premium to increase at the same rate. However, as it is normally another underwriter pricing the top-up, they may consider the primary layer to be too cheap and unsustainable, which may explain some of the pricing anomalies that can be seen in the market at present.

4 The Scope of Cover Including Run-Off/ERP Provision

Everything within an indemnity provision needs to be charged for, *nothing* is free, the more cover that is required, the more the policy will cost. Run-off cover purchased at the wrong time (for example approaching retirement) with a new insurer can be very expensive.

Equally, if skilfully managed, the cost of indemnity can be spread out over many years. As has already been discussed, MDOs and insurers offer different packages with different levels of cover and insurers claim that their product is more tailored to the needs of an individual and not the population as a whole. It must also be considered how subscriptions are spent and whether a minority of members are benefiting disproportionately from the resources provided by the majority, and how fair this may be.

Whilst it is right that the patient is indemnified in the event of malpractice, a core consideration for the consultant is to look after his or her own interest. In the event of disciplinary action the insurance contract needs to be robust enough and supported by skilled professionals to provide appropriate protection to defend any action. The process must also be empathetic, communicative and consultative. By purchasing indemnity the customer is purchasing a promise from the indemnifier that they will do certain things in the event of certain circumstances. A good measure of the quality of the indemnifier is reputation, the opinion of colleagues and their own experiences.

5 The quality of record keeping

Record keeping quality is essential. Generally, in law, if there is no formal record of an event or an event cannot be evidenced in some way, then it is as though it did not happen. What happened in the consultation process must be recorded accurately in a legible and comprehensible manner with no room for ambiguity. Independent consultants must remember that they must behave as businessmen when it comes to their record keeping. Not only must the record keeping be performed, it must be demonstrated that it has been performed correctly to a third party.

6 Attitude of the proposer

Evidence of hubris, cognitive bias and tunnel vision will all help the underwriter to reject a proposal. Consultants should be prepared to revisit the original diagnosis. Proposers often feel aggrieved when an indemnifier rejects them even when they have an unblemished claims record; a rejection is not always about an assessment of capability and skill.

7 The communication and rapport skill of the doctor

Studies have shown that up to 70% of litigation can be attributed to poor communication. Linguistic research²⁸ says that communication is 55% body language, 38% verbal tone and only 7% spoken words; poor communication is likely to result in adverse patient outcomes; a patient is less likely to pursue a claim against a doctor they like and respect. The GMC states that 26% of complaints received are communication related. Dialogue between doctors is an important part of the communication process and facts are often assumed without explicit communication having taken place. Doctors making the transition from the NHS into the independent sector should be mindful to build a good rapport with their patients, since patient expectations are often much higher in the independent sector, where the patient is paying not only for the skill of the doctor but also for a special relationship. When a good rapport is achieved, not only is the risk of a claim by the patient reduced but also there will be a significant increase in the number of referrals; it is simply sound business sense.

If these skills can be positively demonstrated then this increases the likelihood of a doctor obtaining good insurance terms. This area is considered so important that the MDOs run courses specifically on this subject.

8 The excess

Simply put, if a predetermined amount of any claim is to be met automatically by the proposer (the excess), then this will attract a reduction in premium; the higher the excess that is selected the greater the discount. The excess is also known as the 'self-insured' retention and a doctor may choose to accept a certain excess but keep the cost saving in a separate account to fund any future pay-outs; the excess should pay for itself in about 4/5 years. However, it should be noted that a doctor would lose out with this arrangement if he or she suffers multiple claims over a short time period.

Sometimes an excess is imposed on the proposer on a compulsory basis; this is rare in medical malpractice as the underwriter is more likely to decline a risk than impose stricter terms.

9 The possible need for 'retrospective cover' from inception

When a claims-made policy is purchased, the underwriter will need to consider the period of the 'tail' they are being asked to cover. For example, if a policy is purchased in 2010 with a retroactive date of 2004, the insurer is effectively picking up all IBNR risks in the six-year period between 2004 and 2009. Therefore the shorter the period of retrospective cover the less risk exposure and the cheaper the premium.

Useful Questions to Ask When Considering Changing Malpractice Indemnifier:

1. Is the cover offered losses occurring or claims-made, do I understand the difference and am I happy with my decision?
2. Is the cover contractual or discretionary, do I understand the difference and am I happy with that decision?
3. Do I understand the implications of switching my indemnity from a claims made cover to losses occurring (including switching from the MDU to either the MPS or MDDUS)
4. What is the limit of indemnity being offered, have I rationally assessed my risk exposure to claims and to matters such as GMC, disciplinary and criminal investigations?
5. Is a price reduction being offered merely a reduction in cover or a reduction in the indemnity limit? If there is an inner limit for legal expenses ensure this is sufficient.
6. Does the indemnity have any exclusions that apply to me now or likely to apply in the future?
7. If I change my indemnity carrier, will they cover changes in my work in the future? (Pay particular attention to any overseas work you are doing or considering, check with your indemnifier that it will be covered).
8. Is the advice I am getting independent? Is it from qualified professionals, or from a source that has a vested interest to push a particular product to generate sales?
9. Is the cover I already have the most appropriate and will my professional advisor confirm that?
10. Is the advisor FSA regulated and what is the limit of indemnity under their own professional indemnity insurance?
11. Am I being treated fairly, are my skill, work practices and communication ability being assessed on my merits?
12. Are advisory services being offered and are they fit for purpose?
13. Am I close to retirement, have I considered the run-off exposure and can the carrier offer a satisfactory solution?
14. Is the indemnity provider financially secure?
15. Does the indemnity satisfy all obligations required by the hospital where I practice?

If the answer is 'no' to any of the above, then a change of indemnifier may be a costly mistake.

Conclusions

Consultants working in the independent sector must take out medical malpractice indemnity, not only to provide indemnity to their patients should the worst happen, but also to safeguard their right to continue to practise medicine.

Traditionally, the only realistic option was to sign up to an MDO; students were captured at medical school and induced into joining a MDO by a nominal subscription rate which continued to climb as the years passed and their career matured. In times of low claims frequency and modest settlements these MDO business models worked well and provided affordable subscription rates that were barely noticed at renewal. Indeed, the decision to renew hardly reached the consciousness and decisions to renew were made automatically; inertia prevailed.

Times are changing and it can be seen that increases in claim frequency, award amounts and higher patient expectations have resulted in large claims payments. MDOs have adjusted their business strategies, but ultimately if claim awards cannot be controlled then the only possible solution is to raise subscriptions, and this is what has happened. With claims inflation running at 10% p.a. subscriptions and premiums can only go up. Efforts have been made to educate doctors about risk and risk awareness and there has been a stream of quality publications and events to support this aim. Unfortunately, there is little evidence that these measures work. The survey shows frustration is rife concerning price increases and many feel that they are subsidising other more risky activities or substandard doctors.

MDOs who do not offer insurance cover say that new claims-made contracts are unrealistically cheap, new providers are not burdened with a heavy claims legacy and that the prices offered are not the 'mature rates' and will only go up at renewal. Insurers deny this and say the mistakes of the past have been learnt and they are open to provide first-class security at affordable terms.

The peril is that with a malpractice indemnity spend in the UK in excess of £500 million per annum this will attract short-term opportunists to challenge the MDOs. The St Paul experience¹⁷ has left doubts in the minds of the informed buyer and the expectation is that the current batch of commercial insurers will follow the same pattern. One must be realistic and accept that financial products are always exposed to adverse circumstances and this applies equally to the MDOs as it does the commercial insurers. Mutual organisations have failed in the past (e.g. Solicitor Indemnity Fund) and there are a few examples in the public domain in the UK of MDOs exercising their discretion not to assist with clinical negligence claims^{19a}.

The benevolent view that being within an MDO and paying, despite rising cost, to support members who do not pay any subscriptions, quality literature and underwriting campaigns on tort reform etc. is giving way to the commercial reality and necessity of paying an affordable rate. Rates and premiums must be proportionate to the fee incomes generated

and if they are not then consultants' withdrawal from the independent sector is the ultimate outcome.

The types of indemnity on offer are offered under very different terms and conditions and it is crucial these differences are understood before any switch is made from one indemnifier to another. The answer is to understand the risks, the issues involved and the implications of the decisions made, in other words, to have enough information to allow an informed choice. The MDOs and commercial insurers work within the same risk population and under the same legal system, but they adopt very different approaches in providing solutions. All three systems have their merits and both have their issues and each will be exaggerated by the vested interest of those who are arguing the point. It is in everybody's interest that healthy competition exists and it should be encouraged, provided it is done ethically and professionally.

The best guidance is to seek independent advice and assistance from professionally qualified people, balance the arguments and make a choice not based primarily on cost but more importantly, on exposure to risk and the consequences of purchasing inadequate cover.

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Supporting Notes

1. www.gmc-uk.org/doctors/medical_register.asp. The top 20 specialities show 60,000 consultants registered; there is an equal number of GPs.

2. ***Bolam vs. Friern Hospital Management Committee*** [1957] 1 WLR 582 is an English Tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. consultants): the "Bolam test". Where the defendant has represented him or herself as having more than average skills and abilities, this test expects standards which must be in accordance with a responsible body of opinion, even if others differ in opinion. In other words, the Bolam test states that ***"If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent"***

3. ***Bolitho vs. City and Hackney Health Authority*** [1997] 4 All ER 771 The House of Lords held that there would have to be a logical basis for the medical opinion. This would involve a weighing of risks against benefit in order to achieve a defensible conclusion. This means that a judge will be entitled to choose between two bodies of expert opinion and to reject an opinion which is 'logically indefensible'. This has been interpreted as being a situation where the law is set by a court and not the profession. However, Lord Browne-Wilkinson held that the court would hold a practice that was in conformity with a sound body of expert opinion to be negligent only in "a rare case."

4. **The NHS Litigation Authority (NHS LA)** was established on 20 November 1995 to indemnify English NHS bodies against claims for clinical negligence. They are not an insurance company. Initially, their sole function was to administer the Clinical Negligence Scheme for Trusts (CNST), a risk-pooling scheme in respect of clinical claims arising from incidents on or after 1 April 1995.

Who is covered under this scheme? Clinical negligence is defined as 'breach of duty of care by members of the health care professionals employed by the NHS bodies or others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of their employment and which are admitted as negligent by the employer or are determined as such through the legal process'. This definition includes NHS hospital doctors, dentists and midwives. It applies where the professional was working under a contract of employment, contracted to the NHS to provide services (to whom the NHS owed a duty of care; this extends to include locums, medical academic staff, students, clinical trials, volunteers).

Who is not covered? *Inter alia*, family health service practitioners working under a contract for services, GPs (including fund-holders) general dental practitioners and other self-employed professionals.

In 2010/11, the NHSLA received 8,655 claims (including potential claims) under its clinical negligence schemes and 4,346 claims (including potential claims) in respect of its non-clinical schemes. The figures for 2009/10 were 6,652 and 4,074 respectively. The Authority had 21,339 “live” claims as at 31 March 2011, and CNST claims are now settled in an average of 1.28 years, counting from the date of notification to the NHSLA to the date when compensation is agreed or the claimant discontinues their claim.

See Note 8.

The function of the NHSLA is explained in greater detail in their *Framework Document* (website www.nhsla.com).

5. ‘After the Event’ Insurance. Solicitors only tend to back the ‘winners’ but litigation is always a doubtful process; the gamble may backfire and the claimant might lose. If this happens the claimant will, in all probability, be ordered to pay the defendant’s costs on a standard or on an indemnity basis. In addition, even if the claimant is successful, they may have to fund their own disbursements such as fees of counsel and expert witnesses which will not be covered by the CFA. As a result of that risk and to provide a further safeguard to litigants, a number of insurers provide ‘after the event’ cover to claimants (and, in a smaller number of cases, to defendants) to provide protection against that risk.

6. A Conditional Fee (in England and Wales) is any fee for services provided where the fee is only payable if there is a favourable result. In law it is defined as “[a] fee charged for a lawyer’s services only if the lawsuit is successful or is favourably settled out of court”. In the USA this is known as a ‘contingent fee’ where the payment to the lawyer is expressed as a percentage of the claimant’s winnings. This is not allowed in the UK, instead a solicitor is allowed to charge a ‘success’ fee over and above their normal hourly billing rate. The success fee in England must be as a percentage no greater than 100% of the normal fee.

In the English legal system this is generally referred to as **no-win-no-fee**, this being a conditional fee agreement between a law firm and a client. The usual form of such an agreement is that the solicitor will take a law case on the understanding that if lost, no payment is made.

7. John de Bono, barrister, London, UK, jdebono@3sarjeantsinn.com. Extracts from ‘When patients sue’, *BMJ* 23 April 2011.

8. National Health Service Litigation Authority Fact Sheet 3 June 2010. The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) and Primary Care Trusts (PCTs) in England currently belong to the scheme. When a claim is made against a member of CNST, the NHS body remains the legal defendant. However, the NHSLA takes over full responsibility for handling the claim and meeting the associated costs.

9. Ministry of Justice www.justice.gov.uk

10. The Review of Civil Litigation Costs, or Jackson Review, is a review of civil litigation costs in England and Wales conducted by Lord Justice Jackson in 2009, the final report, known as the **Jackson Report**, being presented in January 2010¹

The main findings and recommendations of the review include that:

- the cost system should be based on legal expenses that reflect the nature/complexity of the case;
- success fees and after the event insurance premiums should not be recoverable in no win, no fee cases;
- general damages awards for personal injuries and other civil wrongs should be increased by 10%;
- referral fees should be scrapped;
- claimants should only make a small contribution to defendant costs if a claim is unsuccessful (as long as they have behaved reasonably);
- there should be fixed costs for "fast track" cases (with a claim up to £25,000);
- a Costs Council should be established to annually review fixed costs and lawyers' hourly rates;
- lawyers should be allowed to enter into Contingency Fee Agreements; and
- 'before the event' legal insurance should be promoted.

The findings have resulted in the Legal Aid and Sentencing and Punishment of Offenders Bill introduced to the commons in June 2011 and going through its third reading at the time of writing.

11. The discount rate is a rate of interest set down by the Lord Chancellor. It is a rate that is to be used when predicting the likely investment returns so as to derive the lump sum needed today to yield the desired sums for future annual payments. It is of great importance, as any variation on it will have a significant impact on how an indemnifier reserves funds to pay future incidents. Some claimants argue that 2.5% in times of low inflation is too high and should be reduced; this would mean that an even larger sum of money would be needed today to pay future payments with the knock-on effect of higher premiums/subscriptions.

12. Indemnity is the act of making someone 'whole' (give equal to what they have lost) or protected from (insured against) any losses which have occurred or will occur. The principle puts the indemnified person in the same position that they were in before the accident or loss occurred. Often it is not possible to do this and, therefore, a monetary compensation is paid for the loss or injury. The principle extends to loss or potential loss of earnings. In the UK we do not have punitive damages (a civil fine for negligence); the purpose is to redress the balance.

It should be noted that courts in the UK do not take into account the ability to pay an award. The award is made and the defendant has to find the resources to pay, if they have adequate insurance all well and good, if not then personal assets will have to be liquidated

13. Mrs Penny Johnson vs. Mr Le Roux Fourie, judgement 23/5/11 Royal Court of Justice. Penny Johnson underwent a facelift in 2003 but was left with severe nerve damage around her right cheek. She was a 49-year-old director of an IT company and claimed the “experimental work” by Le Roux Fourie destroyed her career and business. It was accepted that her injuries restricted her ability to work but, besides the physical disfigurement and constant facial twitching, there were also profound psychological consequences. The judge, Mr Justice Owen said “She was formerly a confident, happy and outstandingly successful woman with a full and rewarding social life.” In May 2011 he awarded Mrs Johnson £80,000 damages for disfigurement, pain and psychological consequences, and more than £6 million loss of earnings. It is not what you do but who you do it to that determines the size of the claim.

14. 2010 accounts for MDO show following Statistics after unrealised gains

MDO	Subscriptions	Surplus on year	Total Reserves (Excluding IBNR
MDU	£188,828,000+	£ 37,604,000	£ 100,985,000++
MPS	£296,644,000*	£105,638,000	£1,019,000,000
MDDUS	£ 52,133,000	£ 45,521,000	£ 179,400,000

+ MDU – includes £5.5m for overseas members in Ireland

++ Total reserves are fixed assets and net current assets of £236,532,000 less provisions of £135,547,000, net reserves of £100,985,000

*MPS – Includes 100,000 overseas members, split not known.

15. The retroactive date. Claims-made policies did not become common until the 1980s and were issued for entities that previously had occurrence coverage. Any losses that occurred prior to the first claims-made policy were insured under occurrence policies. The insurer, to avoid redundant coverage and prior exposures, added a retroactive date to the policy. Claims-made policies do not insure any incidents that occur before the retroactive date, which is usually the inception or start date of the first claims-made policy. For example, if the insured person purchased the first claims-made policy on 1st January 2000, with that as its retroactive date, the policy would not cover any claims arising from an accident occurring prior to 1st January 2000, even if the claim was presented during the current policy term. The prior occurrence policy would cover the loss.

The rule is never to change the retroactive date. Often when an insured person changes insurance companies, the new insurer wants to advance the retroactive date to the inception date of its policy. If the insurer does this, the insured has no coverage for any losses that occur between the date of the first claims-made policy and the inception date of the new policy. This creates a huge gap in coverage and is expensive to address.

16. Utmost good faith is the name of a legal doctrine which governs insurance. This means that all parties to an insurance contract must deal in good faith, making a full declaration of all material in the insurance proposal. A material fact is a fact that would be, to a reasonable

person, essential to the decision to be made, as distinguished from an insignificant, trivial or unimportant detail. In other words, it is a fact for which concealment would reasonably result in a different decision.

17. The Financial Services Authority (FSA) is an independent *quasi*-judicial body and a company limited by guarantee responsible for the financial regulation of the financial services industry (including insurance) in the UK. The Treasury appoints its Board.

On June 16, 2010, the Chancellor of the Exchequer, George Osborne, announced plans to abolish the FSA and separate its responsibilities between a number of new agencies and the Bank of England

18. St Paul experience. St Paul was the 2nd largest medical malpractice insurer in the US. In the late 1990s they entered the UK medical malpractice market offering claims-made policies. They invested c £10 million and purchased a UK business, Medical Indemnity Association (MIA), to launch a product as an alternative to the MDOs. They experienced an increase in the severity in the US and the amount of medical malpractice claims and several years of losses, coupled with the trauma of 9/11 saw them withdraw from the medical malpractice market globally on 12th December 2001. They predicted they would generate a loss in 2001 on medical malpractice of \$910million.

They did not offer renewal to their UK policyholders who had little choice but to go back to the MDOs. Because of the claims-made nature of the St Paul policy there was the potential for gaps in cover for the years that an insured were with the St Paul (i.e. IBNR claims appearing from that period at a later date after the expiry of the St Paul contract). It was a mess and left a bitter taste in the mouths of those affected. Eventually this gap was plugged by both the St Paul offering a run-off cover and the MDOs stepping up to fill any shortfall.

This example is often cited by the MDOs as the reason why the commercial insurance market cannot be relied upon, yet on the other hand the commercial market will draw attention to the Australian experience around about the same time. In March 2001, the HIH Insurance Group, the reinsurer for many of the Australian MDOs, was placed into provisional liquidation. In 2002 United Medical Protection, which insured the majority of Australian doctors, went into provisional liquidation despite premiums doubling from 1997 to 2003. UMP was a discretionary mutual, like the MPS, MDU and MDDUS but unlike any UK MDOs transacted its business through an insurance company that it owned, AMIL. In the first half of the century litigation against doctors was low, infrequent claims meant that AMIL looked financially secure and did not attract the attention of government financial regulation. The 1960/70s saw a rise in litigation increasing 9-fold from 1979 to 1985, yet premiums remained artificially low, particularly not reserving for IBNR. They were operating a pay-as-you-go policy; claims from the current period were being met from subscriptions from the same period backed up by inadequate reserve. Changes to regulation exposed this artificial situation and AMIL and subsequently UMP collapsed in 2001 but was subsequently brought out of provisional liquidation and did not withdraw from the market.

So both an insurance company and a MDO can run into trouble.

19. MDU Ireland. There are issues with obstetricians in Ireland which the MDU has explained to its members in its Annual Reports. Information can be found on the following websites

www.the-mdu.com

www.ihca.ie

www.ncbi.nih.gov

or a Google search.

19 a An example where discretion has been declined can be found in 'Protecting patients versus the dentist's right to choose' published in Clinical Risk (2006) 12 58-60 by Greg Waldron a Partner in The Dental Law Partnership.

20. Solvency II is the updated set of regulatory requirements for insurance firms that will operate in the European Union once the Omnibus II directive is approved by the European Parliament; Solvency II will be scheduled to come into effect on 1 January 2013.

Solvency II will be based on economic principles for the measurement of assets and liabilities. It will also be a risk-based system as risk will be measured on consistent principles and capital requirements will depend directly on this. While the Solvency I directive was aimed at revising and updating the current EU Solvency regime, Solvency II has a much wider scope.

A solvency capital requirement may have the following purposes:

- to reduce the risk that an insurer would be unable to meet claims;
- to reduce the losses suffered by policyholders in the event that a firm is unable to meet all claims fully;
- to provide early warning to supervisors so that they can intervene promptly if capital falls below the required level; and
- to promote confidence in the financial stability of the insurance sector.

21. A limited company is a company in which the liability of the members or subscribers of the company is limited to what they have invested or guaranteed to the company. Limited companies may be limited by share or by guarantee, which effectively means if a company becomes bankrupt the only available funds are the realisation of its assets, which usually constitute a considerable shortfall against its obligations. It will appoint a Board of Directors who will in turn appoint an executive committee headed by a Chief Executive Officer or Managing Director. It can borrow money or raise capital by share issues. MDOs are limited companies by guarantee, but a limited company by guarantee cannot raise capital by share issue.

22. Risk selection. Selecting risk is not only about assessing skill, knowledge and capability. Evidence suggests that negligence claims generally arise from doctors' hubris, cognitive bias, bad patient skills, poor record keeping or just misfortune and circumstance. The underwriting will attempt to identify and eliminate the first four traits from the portfolio. Rejection, therefore, is not a reflection on skill but also on method and attitude.

23. The loss ratio is the ratio of total losses paid out in claims plus adjustment expenses divided by the total earned premiums. For example, if an insurance company pays out £60 in claims for every £100 in collected premiums, then its loss ratio is 60%. So, in this example, the contention is for every £100 collected £20 is paid out in claims.

24. Tort reform. Throughout the world different systems of medical liability operate. Australia and the US both suffered crisis under the system that operates in the UK and consequently made major reforms on how indemnity is offered. The argument runs that the UK will experience the same crisis if tort reform is not implemented. This is a complex case set out in Kessler, Summerton and Graham article in *The Lancet* vol. 368, July 15 2006. Also www.publications.parliament.uk/pa/cm/201012/cmselect/cmhealth

25. The Limitation Act 1980 (c. 58) is a British Act of Parliament. It is a statute of limitations which provides timescales inside which action may be taken (by issuing a claim form) for breaches of the law. For negligence resulting in personal injury the claim must be brought within a three year period from the date of accrual of the cause or the knowledge, *whichever is the later*.

The date of knowledge is where the claimant had knowledge and could reasonably have ascertained (with or without the help of expert advice) such facts so as to have knowledge: (S14)

- that the injury in question was significant; and
- that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty; and
- the identity of the defendant; and
- if it is alleged that the act or omission was that of a person other than the defendant, the identity of that person and the additional facts supporting the bringing of an action against the defendant.

26. Doctors are regulated by the GMC. It was established by the Medical Act of 1858 and which is governed by a range of legislation, principal among which is the Medical Act of 1983. The regulatory body for doctors a professional standard has been set out in *Good Medical Practice*: http://www.gmc-uk.org/guidance/good_medical_practice.asp where it is stated that doctors must take out insurance or indemnity cover.

‘ You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests as well as your own.’

Source: private GMC e-mail to K McCluskie, 11 February 2011.

Falsification of a material fact is falsification in such a manner that, had the insurance company known the truth, would not have insured the risk. Misrepresentation of a material fact gives an insurance company grounds to rescind a contract

27. Financial Standing and Web addresses of Agents and Insurers in the UK medical malpractice market

Important Note – An agent may show as not applicable (as they do not assume the risk) but the insurance companies they use are, nothing less than an A.

Provider	Web Address	Standard & Poor/AM Best Financial Rating
Medical Defence and Dental Union of Scotland	www.mddus.com	Not Rated
Medical Protection Society	www.medicalprotection.org.uk	Not Rated
Medical Defence Union	www.the-mdu.com	Not Rated
SCOR UK Co Ltd International In Co of Hannover	(MDU Clinical Negligence Insurers)	A
Plastic Reconstructive and Aesthetic Surgeons Indemnity Scheme	www.prasis.co.uk	Not Applicable
ISIS – ISIS scheme	Closed scheme, no known website	Not Applicable
AOOSIS is the AOO Specialists Indemnity Scheme	www.aosis.co.uk	Not Applicable
Sports and Exercise Medicine Professional Indemnity Scheme	www.sempris.co.uk	Not Applicable
OTIS should be OTSIS the Orthopaedic and Trauma Specialists Indemnity	www.otsis.co.uk	Not Applicable
SPIS - Specialist Professional Indemnity Services	www.spis.uk.net	Not applicable
Premiummedicalprotection	www.premiummedicalprotection.com	Not Applicable
TWG	www.twg.uk.net	Not applicable
Paragon	www.paragonbrokers.com	Not Applicable
W R Berkley (Europe) Ltd	www.wrberkley.com	A
Marketform (Lloyds)	www.marketform.com	A+
QBE	www.qbeeurope.com	A+
Medical Protection Liability Company	www.the-mplc.com	Not rated but Lloyds A+
CNA	www.cnaeurope.com	A-
ACE	www.acegroup.com	AA-
ARGO	www.argoinsurance.com	A
Newline	www.newlinegroup.com	A
Novae	www.novae.com	A+

28. Albert Mehrabian. The 7-38-55 rule is based on two studies reported in the 1967 papers "Decoding of Inconsistent Communications' and "Inference of Attitudes from Nonverbal Communication in Two Channels"