

A Report for the Federation of Independent Practitioner Organisations

# ON THE MARKET FOR MEDICAL MALPRACTICE INDEMNITY

by Kevin McCluskie ACII  
November 2011



**“Excellent efficient response”**

Quote from FIPO Survey

## Introduction

Medical Malpractice subscriptions are rising at levels significantly above inflation, some specialities with rises up to 100%. The cost is forcing some consultants to cease independent practice.

The provision of medical malpractice indemnity is dominated by three not for profit mutual organisations, the Medical Defence Union, Medical Protection Society and the Medical Defence and Dental Union of Scotland, collectively known as the Medical Defence Organisations [MDOs].

The MDOs collected £540 million in 2010 from c 500,000 members. Not all members contribute and approximately 100,000 (mainly Medical Protection Society members) are from overseas. The MDOs are not insurance companies but member organisations where member benefits are given at the discretion of the organisation, overseen by a board of management or committee.

The MDU differs from the other two MDOs as it also provides its members with a medical malpractice indemnity insurance policy. Unlike the other two MDOs, which are not regulated by the Financial Services Authority in relation to the benefits provided to individual members, the MDU 's subsidiary MDU Services Limited is regulated as an insurance intermediary.

**FIPO undertook a consultant survey in 2011 with over 900 respondents from around the UK.**

**It found**

- 71% had experienced subscription increases in the past three years
- 75% of these have had increases of up to 30% in the past three years

There is a healthy, experienced and financially secure commercial insurance market willing to compete with the MDOs but its growth has been handicapped by the lack of professional brokers to access this market on behalf of consultants. Consultants are largely unaware of the differences between an insurance agent, insurance broker or scheme agent.

The commercial insurance market offers indemnity on very different terms and conditions to the Medical Protection Society and the Medical and Dental Defence Union of Scotland, while the indemnity provided by the Medical Defence Union combines features from both insurance and discretionary models. Consultants' knowledge of what they buy is limited on this complex issue and some are changing indemnifiers with price as the only criterion for change, ignoring certain risk factors.

**The level of satisfaction remains high amongst consultants surveyed with the services provided by the MDOs although there is a significant group who are not satisfied. The FIPO survey asked consultants how satisfied they were and**

- 54% were very satisfied
- 35% were fairly satisfied
- 11% were not satisfied

**When questioned on how many times they had contacted their indemnifier in the past five years**

- 43% said not at all
- 55% said between 1 and 5 times

**"No competition in the market, a need for comprehensive insurance tailored to risk stratification."**

Quote from FIPO Survey

New agents and specialist schemes have emerged in the past two years. These agents offer products from insurance companies with first class security as rated by independent rating agencies such as Standard and Poors; none of the insurance companies have less than an A listing. However, price reductions, in some cases, have been achieved by the agent by reducing the amount of cover to unsatisfactory levels. It is evident consultants do not know the status of the parties involved in negotiating with insurers, see the diagram on page 17 for a summary.

## What is Medical Malpractice?

There are three key areas

"I was forced out of my MDO by a subscription greater than 33% of my income"

Quote from FIPO Survey

### Clinical Negligence

- Arises when the standard of care provided to a patient (or as a result of a Good Samaritan Act) deviates from the standard acceptable practices at the time. The lack of care must result in an injury that could have been avoided.
- A duty of care must be owed to the patient, that duty breached, the breach caused injury and damage resulted.

### Defence of Right to Practice

- Legal expenses in the defence of 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.

### Medico-Legal

- 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 further questions regarding a duty of care to colleagues and conflicts of interest.

## Are Consultants and Doctors Getting a Fair Deal?

### The Compensation Culture and Legal Costs

Establishing blame is the only remedy for an aggrieved patient seeking compensation. Specialist solicitors funded not by the patient but by After the Event Insurance and Conditional Fee arrangements use their experience to 'spot winners'. Legal fees for general liability claims represent 142% of the sums received by injured victims. The degree of proof required is not 'beyond reasonable doubt' but merely the probability that negligence happened.

The issue of legal fees prompted the Government to commission a review (the Jackson Report) which recommended a comprehensive overhaul of how claims are funded. The recommendations of the report in respect of clinical negligence claims have been accepted and will be amended through legislation and changes to the claims procedure.

## Damages

In the financial year 2010/2011 alone, the NHS paid out over £257 million in lawyers' fees as a result of claims.

Currently the NHS has £16.8 billion of outstanding clinical negligence claims waiting to be settled, including those claims that have occurred but have not yet been reported (IBNR).

The principle behind an award is to put the victim of negligence in the same position as if the negligence had not happened.  
In the UK damages for personal injury bear no relation to the degree of fault.

### There are two aspects to any award

#### Pain and Suffering

- General Damages for pain and suffering and loss of amenity. The old adage it is cheaper to kill someone than to maim holds true. The current rate for total blindness is £175,000 and a child with cerebral palsy £225,000.



#### Special Damages

- These are damages for financial loss that can be calculated. For a cerebral palsy case it will be to pay for full time care 24 hours a day, say £100,000 per annum. Multiplying the annual cost by the life expectancy assuming a predetermined rate of interest for say 60 years (currently a multiple of 31.29) gives an award for damages of £3.129 million.

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 potential earnings. Some insurers have been reluctant to provide indemnity for procedures on high earning professional sportspeople. The MDOs can indemnify a claim brought by the sportsperson himself, but may not assist with one brought by the sportsperson's club for consequential loss. It is essential that the indemnity providers are advised of this type of work by the consultant before the commencement of treatment.

**"Expensive but good"**

Quote from FIPO Survey

**The plastic surgeon Mr Le Roux Fourie was sued by his patient Penny Johnson, originally for £50 million. It was settled in 2011 for £6,190,884 of which £80,000 was for pain and suffering and the remainder for special damages including loss of income. Legal costs were estimated at several million pounds in addition.**



## Size and Frequency of Medical Negligence Claims.

MDOs and insurers are not willing to release confidential and commercially sensitive claims data. However the NHS Litigation Authority does publish data for the NHS. While NHS practice and claims experience differ from that in the independent sector, it offers some indication of areas of high risk.

The chart below samples some specialities. It illustrates that the highest risk in terms of value per claim is obstetrics and gynaecology and in terms of frequency, surgery.

“It is far too expensive and I feel I am subsidising others with lower standards”

Quote from FIPO Survey

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

Claims trends are worsening in the UK. The high areas are, from an underwriting perspective, obstetrics (probably now not able to be covered outside the MDOs), spinal orthopaedics, neurosurgery, paediatrics, anaesthesia and cardiology. There has been an increase in out-of-hours claims against general practitioners, where the Medical Protection Society reported an increase of 39% over the past 3 years, though it is a 'differentiated part of general practice, with its own risk profile'.

"My only anxiety is the limit of Indemnity is too small at £1 million or £3 million pounds, is this enough? Can I be personally liable for this?"

Quote from FIPO Survey

From available statistics here is a possible rating group reflecting risk based on claims frequency and claims value per incident

#### 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.

## How Indemnity is Provided for Medical Malpractice in the UK

### Run Off

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 period.

It is important to ensure adequate run-off is in place upon permanent retirement and or death to protect the doctor or their estate against claims that may be made against them after they have ceased to practice.

**"Fee structure is increasingly difficult to ascertain."**

Quote from FIPO Survey

There are essentially three business models and indemnifiers will offer cover on different terms. The terms of business revolving around two key principles

### Key Principle No 1

## "Claims Made" v "Losses Occurring"

### Claims Made

- 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' 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.

### Losses Occurring

- 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**. 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 2006, but the associated claim was presented in 2011, so long as the person was a member in 2006, the claim should be dealt with. Occurrence indemnity does not provide cover for events or acts that occur prior to the effective date of the membership.



## Key Principle No 2

## “Discretionary” v “Contractual”

## Discretionary

“There is no contractual insurance and reverts to discretionary which is very unsatisfactory and causes significant anxiety.”

Quote from FIPO Survey

- Discretionary indemnity is provided under a membership agreement. Where a membership application has been accepted, and a subscription has been paid, a member is entitled to request the benefits of membership including indemnity, which may be granted at the absolute discretion of the Board or Council, pursuant to the organisation’s Memorandum and Articles of Association. There is no contract and no limit of indemnity. A discretionary indemnity can pay whatever compensation it decides, subject to Board or Council approval and to any membership exclusions. Typically such exclusions are similar to the exclusions that would be imposed under a medical malpractice insurance policy and would include items such as non-disclosure of a material fact, employment related issues not related to professional practice, debt recovery, criminal acts, fines and penalties etc.



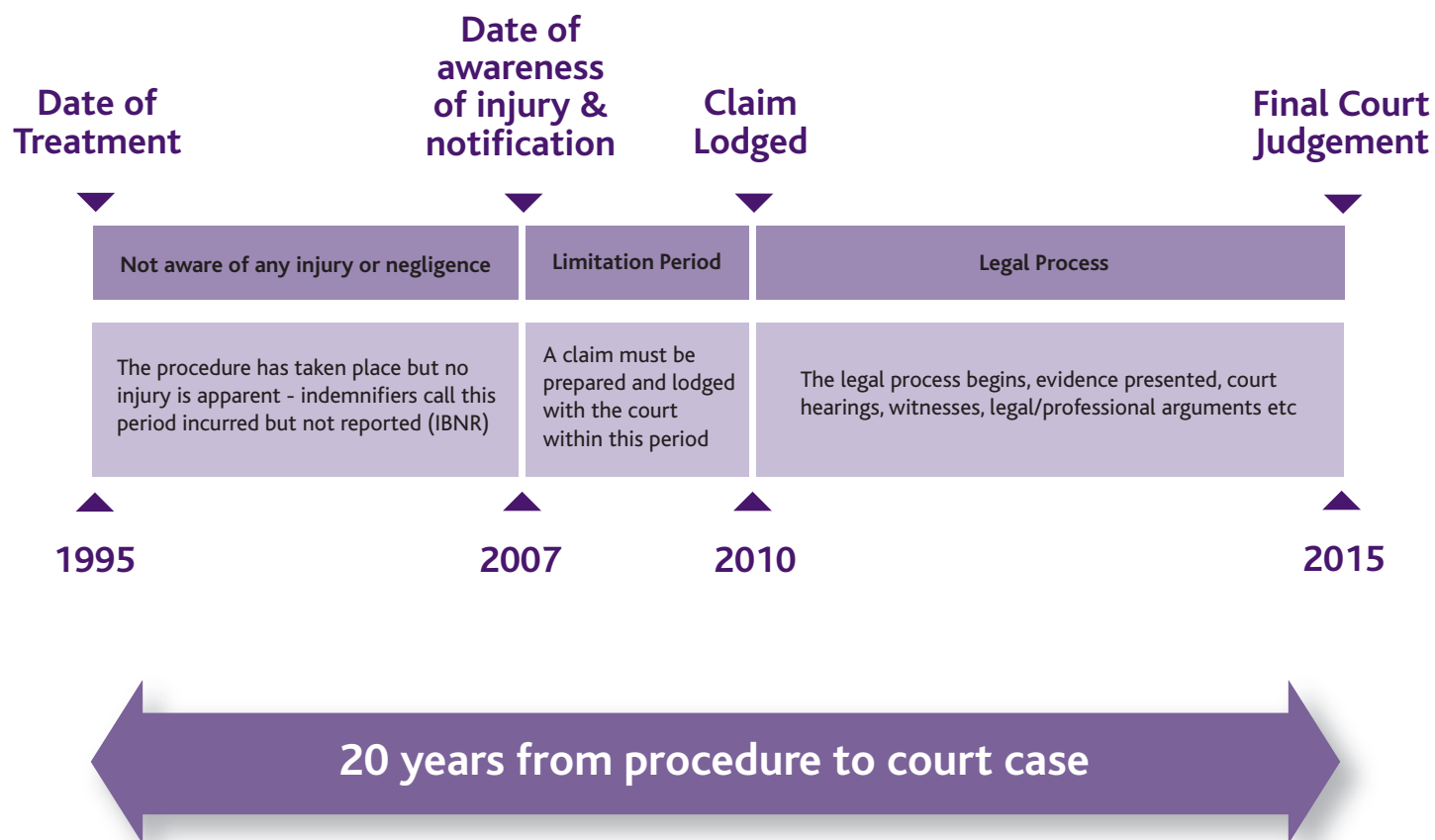
## Contractual

MDOs offer discretionary, losses occurring benefits – the granting of assistance with a claim being determined at the time the claim is reported.

Insurers offer contractual, claims made indemnity where cover is predetermined by the terms and conditions of a policy when it is taken out.

The MDU provides its members with a combination of a claims made professional indemnity policy and discretionary occurrence benefits.

- **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 is insured and what is not insured. ***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 policyholders own funds. This limit is known as the ‘limit of indemnity’.



"Much better to be individually assessed than lumped in with every other practitioner in my discipline."

Quote from FIPO Survey

### Retroactive Date

An insurance policy is an annual contract for 1 year and needs to be renewed. It is possible to 'buy back' cover into the past for IBNR to any chosen date. This is the retroactive date.

With a claims made indemnity the policy that was in force in 2007 when the claim was notified would be the one that paid. The limit selected in 2007 applies.

With a losses occurring indemnity the cover that was in force in 1995 would pay. The limit of indemnity selected in 1995 applies.

Special Note: MDOs are not insurance companies but operate under the principle of losses occurring. The advantage for the MDO subscriber is if they were an insurance company the limit of indemnity that applied in 1995 would be the amount available to settle the claim in 2015 which could well be inadequate. The MDOs, due to their discretionary cover do not have this limitation. However, in order to ensure they have funds to pay for such future claims they must have adequate reserves in place – financed from today's membership fees.



## Advantages and Disadvantages of Claims Made v Losses Occurring and Contractual v Discretionary Indemnity

“Over 19 years I have had 2 claims which settled for a total of £31,000, £21,000 to a solicitor £10,000 to patients. Over the same period I paid out £650,000 in premiums”

Quote from FIPO Survey

### The Advantages of a Claims Made 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). The safeguards of FSA regulation include:
  - The need to treat customers fairly.
  - 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 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 doctors 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, die 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 Paul, leaving the market resulting in doctors having no run-off cover from The St Paul for the period they were with them. The traditional market responded to this deficiency.
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. All insurance contracts are subject to 6% government tax

### The Advantages of a Discretionary/Losses Occuring Subscription

1. The benefits of membership are all available at the discretion of the Board or Council of the organisation.
2. There is no limit to the indemnity offered to the expenses that could be paid.
3. It allows maximum flexibility and can indemnify a claim for matters of principle where this is in the interest of the profession, even where an insurance policy may not respond to the claim.
4. Provided that a customer was a member at the time of an incident, they can still ask for, and can be granted, assistance after they leave/retire.

**"I hope the standard remains as good as it is"**

Quote from FIPO Survey

### The Disadvantages of a Discretionary/Losses Occuring Subscription

1. There is no guarantee that a claim will be paid.
2. There is no upfront certainty as to what incidents will and will not be covered. Cover is determined at the time of the loss.
3. There is no external 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.

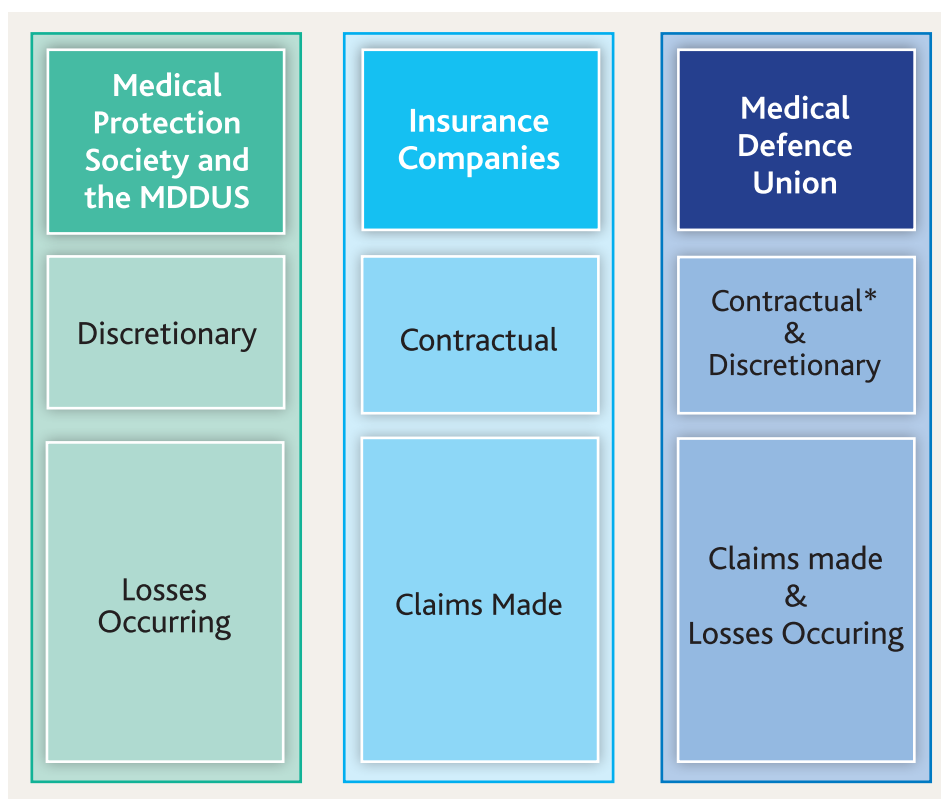
## The System Used by Indemnifiers

“Too expensive, indemnity should be related to claims history”

Quote from FIPO Survey

\* The MDU provides its members with an insurance policy underwritten by SCOR UK Company Limited and International Insurance Company of Hannover Limited 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 right to practise are provided on a discretionary losses occurring basis.



### The Indemnity Limit

Is the maximum annual aggregate amount an insurance policy will pay in any one year. Please note the limit includes the following features:-

- All legal costs and expenses.
- It is for any one claim or series of claims in the policy year.
- Once exhausted there is no more cover, the liability reverts back to the policyholder.
- It is possible to purchase further cover for potential new claims.

### When selecting a limit a consultant needs to consider

1. Who the patient is - damages are awarded for long term care costs and for loss of earnings as well as pain and suffering.
2. The length of time from the claim date to final judgment, possibly 10 years or more.
3. The level of medical claims inflation, currently c 10% p.a. At this level the indemnity limit should be doubled every 6 years.
4. Consultant speciality and the risk factors associated with it.
5. The trends in UK law and if there have there been any landmark rulings.
6. What the obligations are within the hospital group because some independent hospital groups are insisting on a minimum level of indemnity and may well refuse to allow practicing privileges if this limit is not met.



## How Indemnifiers Set the Price of a Subscription Premium.

### Why is There Such a Big Difference Between Prices?

"I think my MDO has lost its way, on the thankfully rare occasions when I have contacted them they have seemed less interested and less supportive"

Quote from FIPO Survey

#### The FIPO consultant survey showed:

- 55% do not know what their limit of indemnity is
- 65% do not know if their indemnity is 'contractual' or 'discretionary'.
- 76% do not know if their indemnity is 'claims made' or 'losses occurring'.

#### Of those who changed indemnifiers:

- 96% did so on price alone
- 53% were influenced by advice from a colleague

The indemnifiers incur different costs depending on what benefits and services they provide. In general, losses occurring benefits are more costly to provide due to their open-ended nature.

**Price setting** is determined using actuarial science to calculate the frequency and severity of future claims. Costs, expenses and profit/surplus are factored into the equation.

#### Risk selection is determined by

- **For MDOs** - by speciality groups – the whole population is banded into speciality groups.
- **For Insurers** - on individual merit by submission of a proposal form, they will take into account
  - The speciality of the consultant.
  - The quality of record keeping systems.
  - Past claims experience.
  - Attitude and approach to medicine.
  - Communication and rapport skills.

Insurers claim to reject 20% of risks proposed to them. The FIPO consultant survey shows that 1.4% have been refused indemnity but it was not possible to identify if this was an MDO or insurer.

#### Other factors that influence price are

- **For MDO**
  - Fee income from a banded scale.
- **For Insurers**
  - The number of procedures and fee income.
  - The limit of indemnity selected.
  - The length of the run off.
  - The amount of the excess, if any.
  - The period of retrospective cover.

Premiums for claims made policies may start low but then rise after the first few years as the likelihood of claims from incidents in earlier years being reported within the next policy year increases. This is less likely where retrospective cover has been purchased from the start of the relationship.

## Where to Buy Medical Malpractice Indemnity.

### Structure of the Market.

#### Professional fees

MDOs do not pay out any professional fees to agents as they deal directly with the consultants.

Insurance brokers and agents receive a commission from the insurance companies for their expertise and to cover expenses incurred and profit.

MDOs are not for profit organisations with surpluses being retained in reserves to meet future claims.

#### Limited Liability Partnerships

By creating a limited company or LLP, usually on the advice of accountants, 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 essential consultants obtain proper advice from their MDO or insurance broker to protect their limited company or LLP and themselves.

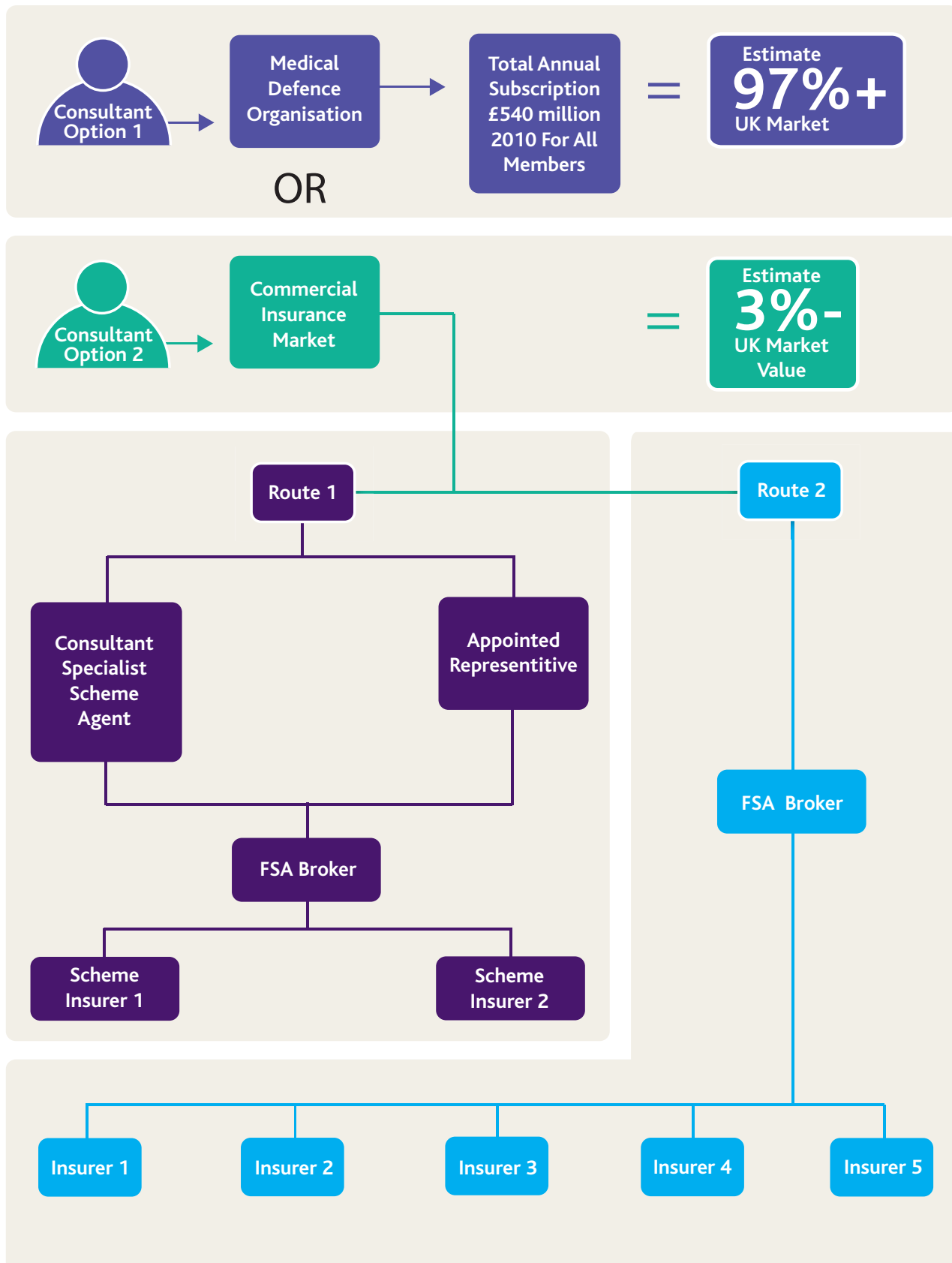
In the UK Medical Malpractice can be bought from four sources

- An MDO.
- An insurance company via a Broker.
- An insurance company via a speciality specific scheme owned and governed by a consultant organisation in association with an agent (appointed representative) and insurance broker.
- An insurance company via an appointed representative of an insurance broker.

#### The Parties Who Arrange Indemnity With an Insurer

- An insurance broker is an insurance specialist agent who has been granted an agency by an insurance company to transact business with them. They will individually negotiate terms and conditions with a number of companies and offer the best option to the consultant. They are regulated by the Financial Services Authority.
- An agent or appointed representative, is usually a company that has a tied relationship with an insurance Broker. They do not have an agency with the insurance company and must transact any business under the protection and guidance of an insurance broker.
- Consultant specialist scheme agent. Here a consultant organisation will work with an agent who acts as a risk manager to the scheme. They must engage the insurance company through an insurance broker. This type of agent will have specialist specific skills that add value to the transaction.

## The Structure and Size of the Consultant Market and How Doctors Gain Access to it.



## Useful Questions to Ask When Considering Changing Your Indemnifier

1. Is the cover contractual or discretionary? Do I understand the difference and am I happy with that decision?
2. Is the cover offered losses occurring or claims made? 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 basis to a losses occurring basis (including switching from the MDU to either the MPS or MDDUS)?
4. What is the limit of indemnity and what is the limit of legal expenses (both before and during a hearing) being offered? Are the legal expenses sufficient to cover more than one hearing, for example, both a GMC and an employer's disciplinary procedure? Have I rationally assessed my risk exposure to buy the appropriate limit?
5. Is any price reduction being offered merely a reduction in cover or a reduction of the indemnity limit?
6. Does the indemnity have any exclusions that are applicable to me now or likely to apply in the future?
7. If I am going to change my indemnity carrier, will they cover changes in my work in the future? (Pay particular attention to any overseas work being considered, check with the 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 close to retirement? If so, have I considered the run-off exposure and can the indemnifier offer a satisfactory solution?
12. Does the indemnity satisfy all obligations required by the hospitals where I practise?
13. Is the indemnity provider financially secure?

## Conclusions

1. Claims inflation is approximately 10% p.a. Subscriptions and premiums will inevitably rise for the foreseeable future.
2. Around 70% of consultants do not understand the information provided to them 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.
3. There is a healthy and secure alternative to the MDOs offered by the commercial insurance market but there are significant differences as to how this cover is provided – it is important these differences and the long tail nature of medical malpractice indemnity are understood before a change is made.
4. Discounted policies look attractive but often the discount is achieved at the expense of reduced cover. Consultants main criterion for change is price not exposure to risk.
5. MDOs risk stratification is generally based on population underwriting of a speciality group. Insurers assess each and every risk individually on its merits.
6. Insurers and brokers can compete with the MDOs on service, advice and price.
7. Commercial Insurers are keen to offer cover. However, they find it difficult to gain market share as there are no significant distribution channels for them, that is to say consultants have limited access to the insurance market. A void exists for a professional independent advisor to bridge that gap.
8. Hospitals are starting to review the cover held by consultants and will refuse a practising privileges where they believe the policy to be inadequate.

**The author does not accept liability of any kind and disclaims all responsibility for the consequences of any persons acting or refraining to act in reliance on information herein or for any decisions made or not made based on this report summary.**

**The author can be contacted at [kevinmcccluskie@msn.com](mailto:kevinmcccluskie@msn.com)**

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# FIPO

federation of independent  
practitioner organisations

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Federation of Independent Practitioner Organisations

14 Queen Anne's Gate, London SW1H 9AA

Tel. 020 7222 0975 Fax. 020 7222 4424

Email. [info@fipo.org.uk](mailto:info@fipo.org.uk)

[kevinmccluskie@msn.com](mailto:kevinmccluskie@msn.com)

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