Medicolegal Intelligence

Professional Liability Insurance

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FEW, if indeed any, present-day anesthesiologists would question the need for professional liability insurance. Many do wonder why the cost of such insurance is reaching such astronomical levels, and why it is becoming increasingly difficult to purchase it at all in a few, but increasing number of, areas. This article attempts to answer these questions. In doing so, the article will discuss the legal basis for insurance, the mechanics of underwriting, and the possible causes of many of the insurance problems which face the anesthesiologist today, and offer suggestions for ameliorating these problems.

Professional liability (malpractice) coverage is a type of casualty insurance. It represents a small portion of the total dollar volume of insurance in effect in this country (table 1).[1] Casualty insurance differs from most types of life insurance (term excepted) since the life policyholder builds up equity in the assets of the company. Non-term life insurance acquires a cash surrender value as those portions of the premium not devoted to overhead or to underwriting premature death of the insured are reinvested by the company. In contrast to life insurance, the entire premium paid by the casualty policyholder is absorbed by administrative costs, protection against loss, and profit for the carrier.

Mechanics of Underwriting

Sometime prior to making contact with the physician, the broker who is selling professional liability insurance has entered into an agency agreement with one or more companies willing to write such coverage. The broker agrees to act as an agent in soliciting business, in executing the insurance contracts with the physicians, and in transmitting premium payments to the company. For his services the broker receives a commission of approximately 20 per cent of the premiums. The company agrees to provide for the costs of defense, and pay any judgments up to the limits of the policy, should the insured be accused of negligence in his professional practice. These duties of the carrier also are conditional upon the insured's complying with all of the provisions of the insurance agreement set forth in the policy, as noted below.

The carrier may, in turn, distribute the risk by obtaining reinsurance with a number of large companies which offer diverse coverage. This practice, known as "Quota Share Reinsurance"[2] is common in the casualty insurance business when dealing with substantial risks. Reinsurance with Lloyd's of London has been a common practice in the past.

That portion of the premium dollar retained by the principal carrier also retains with it a commensurate risk of loss. The carrier must allocate these monies to cover underwriting, overhead and expenses involved in investigating, defending, and settling claims, with a small fund set aside for future claims and (hopefully) a small profit. The amount to be charged as a premium is based upon projected future costs—for investigation, defense, and settlement—which projections are based upon past experience.

The Insurance Contract

The contract for any insurance is embodied in the policy. The application, containing in the case of malpractice insurance a statement of insured's type of practice, prior loss experience, and whether he has any partners or employees, becomes a part of the contract. Casualty insurance embodies a *conditional*,

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unilateral contract. The contract is *unilateral* because performance is unilateral unless the casualty occurs; that is, the performance of the insured in paying the premium results in only a *promise* of the insurer to pay on the policy if a casualty occurs. If no casualty occurs by the end of the policy period, the contract expires, bilateral performance never having occurred. If, on the other hand, a casualty occurs (*i.e.,* the physician is threatened or sued for alleged professional negligence), performance will become bilateral. The insurer will investigate, settle or defend, and pay any judgment, provided that the insured adheres to the provisions of the policy.

The casualty—suit for malpractice or threat of one—is one of sereval events which must occur before the contract becomes bilateral. These events are conditions, hence the name *conditional* contract. In the case of professional liability insurance, the following conditions must be met:

1) The act which initiates the allegations of malpractice must have occurred within the scope of practice underwritten by the policy. It is obvious that the policy cannot cover risks not taken into consideration when the policy is issued. Particularly hazardous specialties must be charged higher premiums than specialty practices which carry low malpractice risks. House staff who "moonlight" may not be covered by the policy they purchase to indemnify themselves for negligent acts during their training.
2) All statements made in the application must be true to the best of the applicant's knowledge. The reasons for questions concerning employees and prior lawsuits are obvious.
3) The act for which the patient sues must be the result of alleged negligent conduct, and the plaintiff must so allege in his petition. Generally, intentional torts are not covered by the usual professional liability policy.†
4) The insured must notify the insurer promptly of any allegations of negligence leveled against him by a patient or former patient, irrespective of whether the suit is actual or only threatened. Insurance carriers insist on investigating potential problems promptly. The memories of parties and witnesses fade with time. Very often, prophylactic steps may be taken to preclude the filing of a suit or to effect early settlement if the injured patient has a meritorious claim.
5) The insured must cooperate with the insurer in other ways, as outlined in the policy. Included in this requirement is making available to the investigator and lawyer for the carrier hospital and office records and other memoranda, including correspondence with the patient, and mutually convenient time so that the case may be reviewed in depth.

Consequences of Breach of a Condition

If the insured breaches any of the conditions embodied in the insurance contract and the breach is considered to be a material one, the carrier may be able to avoid its duty to defend the physician and pay any judgment. Failure to notify the carrier promptly has been considered a material breach. An early Mississippi case[3] epitomizes this point. The insured was apprised in March of the possibility of a lawsuit by the injured patient's lawyer. Eight months elapsed before the suit was filed. One month later, the physician, who claimed he had forgotten from whom he had purchased a policy, started contacting insurance carriers. He finally learned which one had written his policy, and notified the carrier in February, when the jury was being empaneled. The Supreme Court of Mississippi held that the physician's failure to notify the carrier in a timely fashion constituted negligence on his

† The customary professional liability insurance policy protects the named insured only for his negligent acts. Negligence (malpractice) consists of the commission of a breach of a duty owing to a patient, with injury to the patient resulting from the breach. Negligence is a civil wrong which the courts recognize as such and for which damages will be awarded in compensation. There are, however, certain non-negligent wrongs. These are called intentional torts, and include battery (for example, operating without consent of the patient or parents); breach of contract (failing to produce a promised cosmetic effect or a cure); defamation (disseminating false information about a patient); false imprisonment (commitment of a patient without due cause); fraud (concealment of a negligent act); invasion of privacy (dissemination of true but private and objectionable information about a patient).

part, thereby releasing the carrier from any duty to indemnify the physician for the cost of legal defense or damages.

In another case,[4] the physician was well aware of the patient's pain following inguinal hernia repair. At a subsequent operation a suture was discovered in the substance of the femoral nerve. The physician received at least one telephone call from the patient's lawyer, threatening litigation. In spite of these notices the physician did not apprise his insurance carrier of the injury until after he received a letter from the patient's lawyer, more than seven months following the original negligent act. The court interpreted literally the provisions of the policy that the carrier be notified "as soon as practical" after "becoming aware of the alleged injury." The provision, said the court, did not mean that the physician could wait until he was sued.

A United States District Court, in a similar case[5] involving delay in notification of the insurance carrier, stated its reasoning this way: ". . . [A] provision in a liability insurance policy requiring that notice be given 'as soon as possible' is a condition precedent to the imposition of liability [on the company] and failure to comply with the condition releases the insurer. . . ." In effect, the court is saying that the physician by his delay materially breached the insurance contract.

If a lawsuit is filed and the case comes to trial, the defendant physician is required to attend the trial at no expense to the carrier, and to assist in his own defense. One court[6] held, however, that if the physician has moved out of the city and cannot afford to make the trip back at the time of the trial, it is the duty of the carrier to reimburse the physician for his expenses.

The Importance of Adequate Coverage

Another insurance problem which the physician may encounter is being sued for more than his policy limits provide. Accidents involving the administration of anesthesia often result in severe neurologic injuries. Damages may be large. The publicity being given large awards, and the heavy exposure of physicians in certain parts of the country, should place all on notice that each physician, and especially the anesthesiologist,[7] ‡ should carry adequate coverage. It has been reported that 70 per cent of all cases filed involve "incidents occurring in hospitals."[8] Yet as late as 1961 a study of the coverage of physicians practicing in two private hospitals in Los Angeles County revealed that approximately 10 per cent of surgical specialists carried policies with $50,000 limits or less, and some had purchased no insurance whatsoever!

The physician who does not have adequate insurance protection and against whom a large judgment is rendered faces certain involuntary bankruptcy unless his personal assets are sufficient to pay the judgment. Two cases, with

TABLE 1. Casualty and Life Insurance in Force in the United States in 1968*

	Total Premiums, Millions of Dollars	Percentage of Total Casualty Coverage
Casualty insurance		
Automobile, all types	9,255.8	37.2
Health and Accident	5,432.0	21.8
Workmen's Compensation	2,584.2	10.4
Fire and Extended Coverage	2,098.8	8.4
Homeowners'†	1,747.8	7.0
Commercial Multiperil, Burglary, Theft, Boiler and Machinery	1,084.5	4.4
Marine	929.0	3.7
Bodily Injury other than Auto and Malpractice†	911.9	3.7
Fidelity and Surety	442.8	1.8
Glass, Property Damage other than Automobile	337.7	1.4
Malpractice (medical)	75.0	0.3
TOTAL CASUALTY PREMIUMS	24,899.3	

	Insurance Coverage in Force, Billions of Dollars	Percentage of Total Coverage
Life insurance		
Ordinary	650	54.2
Group	450	37.5
Credit	80	6.7
Industrial	20	1.7
TOTAL	1,200	

* Sources: Insurance Rating Board; Institute of Life Insurance.

† Includes personal liability insurance other than Automobile.

‡ A Medical World News survey revealed that anesthesiologists rank fourth as targets of medical malpractice suits.

fortunately less disastrous results, are cited to further emphasize the desirability of purchasing enough liability insurance.

In one case[9] the physician was sued for $90,000. His policy limits were $5,000/10,000. Because of his personal exposure to a potential judgment of $85,000 he retained his own lawyer. Counsel for the insurance carrier felt that the case was defensible, but the physician, who would be required to pay any part of a judgment in excess of $5,000, was forced to settle for $4,000, which he had to pay from his own assets. The additional premium for higher limits would have been relatively insignificant compared with the $4,000 settlement.

The other case[10] involved two orthopedic residents who applied a cast to an upper extremity too tightly. The patient, a child, developed Volkmann's contracture. Later, when both men were in successful practices, and before the Statute of Limitations had begun to run, the parents consulted a lawyer. The insurance carrier was willing to settle for the limits of both policies, significantly less than the plaintiffs were asking. The plaintiffs' lawyer, who had once been threatened with a suit for malpractice himself, settled for a $2,500 contribution from each defendant, in addition to the $10,000 from the carrier. The accident had occurred in a city hospital which employed governmental immunity. But for the compassion of plaintiffs' lawyer for the defendants, the physicians undoubtedly would have had to pay a much larger amount from their own assets.

Considering the large awards which frequently result from anesthesia injury cases, it seems clear that $100,000/$300,000 policy limits should be *the very minimum* carried by the anesthesiologist at the present time, and the limit should be $1,000,000 or more if he practices in a high-risk area.

Insurance Protection for Residents

The real question of insurance for the resident is not whether he should be protected, but by whom and to what policy limits. Five generalizations may be made.

First, the resident in a city hospital should purchase his own insurance. Sovereign immunity § still exists in many states.[11] While the resident may not yet have acquired any assets, a judgment rendered against him can be levied against future earnings, for a number of years to come.

Second, if the resident purchases his own insurance, he should obtain it from the same carrier used by the surgical members of the operating team if at all possible. In a case of alleged negligence involving several members of the same operating team in which all are named codefendants, the defense of one member often is based upon the alleged negligence of another. When members of an operating team are insured by different carriers the mutually adverse defense efforts may help establish the plaintiff's case.

Third, if the resident plans to rely on the hospital to include him within its own policy, the resident should have the agreement reduced to writing. Failure to have such an agreement resulted in an ex-intern's being sued[12] for the $200,000 paid to settle a claim made by a patient who became paraplegic as a result of a negligent act of the intern. The hospital had been held vicariously liable for the negligence of its employee. Later, after the intern had commenced a residency in a different community, the hospital filed suit to recover its loss, an action any employer may take against an employee whose negligence is imputed to the employer, and for which the employer must respond in damages. Had the employment contract that the intern signed with the hospital contained a provision in which the hospital agreed to maintain malpractice protection for its house staff, the physician never would have been faced with paying a judgment of $190,000 from his personal assets (his own professional liability insurance carried a $10,000 limit).

Fourth, the amount of protection purchased by or otherwise afforded the house officer should be commensurate with his exposure. Because damages in cases of disability or death are based in part on loss of future earning capacity, the resident who treats patients with high earning capacities needs more pro-

§ Under the common law, an individual could not sue the sovereign without its consent. But the injured patient can sue an employee of the sovereign (resident in a city hospital) as an individual tortfeasor.

tection than the resident whose patients earn less.

Fifth, if the resident plans to "moonlight" he should purchase his own insurance with a carrier that is fully apprised of his "extracurricular" activities.

It is, of course, easy to advise residents to procure professional liability insurance, and to admonish all to "carry adequate coverage." But obtaining such coverage at a reasonable cost or at any price may be extremely difficult. The reasons stem from the adverse loss ratio experienced by practically all carriers writing professional liability insurance during the past ten years.

Adverse Loss Ratio

Insurance carriers, like other American businesses, attempt to operate at a profit. Underwriting professional liability insurance for physicians no longer is a profitable venture. The problem really is one of minimizing losses. It literally has reached crisis proportions.[13] One carrier cited[14] an average loss ratio in excess of 143 per cent ¶ for a five-year period, 1963 through 1967. Such loss ratios may be explained by an analysis,[15] partially projected, of the distribution of the 75 million dollars paid by physicians for professional liability insurance premium during 1968:

Awards retained by injured patients (after payment of counsel)	27 per cent
Fees to plaintiff's counsel and cost of prosecuting claims	29 per cent
Costs of investigation and defending cases	24 per cent
Solicitation of business	20 per cent
Overhead	13 per cent
TOTAL	113 per cent

Since these percentages total more than 100 per cent it is obvious that underwriting professional liability insurance in this country in 1968 was somewhat less than profitable. Further, not included in the above data is any reserve for future claims. Statutes of Limitations,** and the fact that many of the patients are minors and hence need not file claims until after they have reached their twenty-first birthdays, dictate the need for the establishment of a reserve fund for potential future claims. It is obvious that such a reserve fund must come from a source other than the premium dollar (*i.e.*, profit from the carriers' other types of insurance business).

Causes of the Insurance Problem

Simply stated, the malpractice insurance problem (or "crisis," if you will) is caused by losses far exceeding those expected when the costs of underwriting were predicted and premiums set. The problem thus is directly dependent upon the exposure of insured physicians to far more allegations of negligence and damages than were anticipated. Exact data on this incidence is impossible to obtain. Insurance carriers are understandably reluctant to divulge this information. Many claims are settled before lawsuits are even filed. Many more are settled before the cases are tried or submitted to the jury. Thus, those suits which do reach a verdict, of which an estimated 60 to 75 per cent are in favor of the defendant physicians,[14] represent only a small portion of the total number of claims for alleged malpractice. In 1964 the American Medical Association reported[16] that 18.6 per cent of physicians surveyed the previous year had had one or more claims for alleged professional negligence, an increase of one-third over a 1956 survey. Unquestionably the incidence is higher today. Richard P. Bergen, Director of Legal Research and member of the General Counsel of the American Medical Association, terms the incidence of claims ". . . a legal problem and an economic problem."[17] It is believed to be the culmination and interaction of a variety of social, economic and legal factors, as well as medical ones.[18] This interaction is diagrammed in figure 1.

The rising incidence of claims is said to stem from at least seven factors[15,18]: increasing complexity of medical practice; complications of medical and surgical treatment (iatrogenesis), with lack of informed consent; deterioration of interpersonal relationship in general; the growth of the "something-for-nothing" philosophy; awareness of the general

¶ Total costs of underwriting, taxes, claims investigation, settlement, and litigation amounted to 143 per cent of the total funds derived from premiums.

** In each state a claimant has a given time limitation within which to file a claim, which is delineated by statute. Depending on the state, the Statute of Limitations for malpractice actions varies between one and six years.

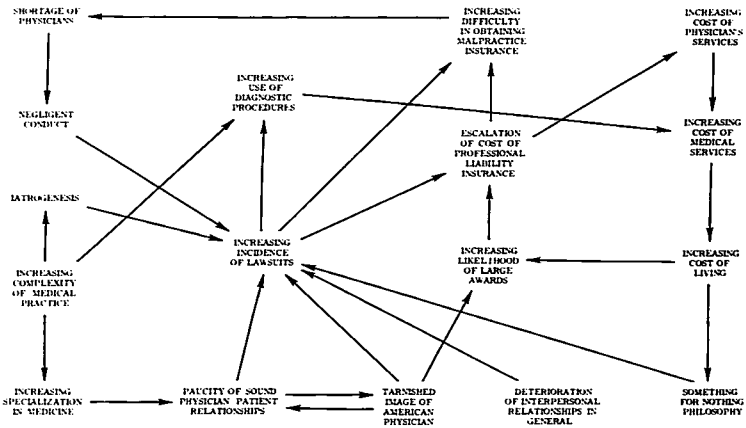

FIG. 1. Pathogenesis of the malpractice insurance problem.

public of other litigation; the sometimes tarnished image of the American physician; and specialization, with loss of the rapport between the patient and the physician. The increasing amounts of awards in negligence cases stem from some of these factors, plus two others[15]: the increasing skill of plaintiffs' counsel in both "diagnosing" and trying the case of negligence, and the greater availability of experts to testify for the plaintiff.

The interaction of these factors results in an increased incidence of threatened or actual litigation. This incidence, in turn, leads to an increase in total awards against physicians and to greater precautions taken by physicians, as epitomized by both the increased use of simpler diagnostic procedures and the hesitancy to employ more complex ones.[15, 19] The higher awards and more litigation, actual and threatened, of necessity force upward the cost of writing such insurance, and the premiums rise. Higher premiums raise the physicians' overhead, thus adding to the cost of physicians' services. Medical care costs also rise because of the added tests. These care costs raise the cost of living (increasing cost of living also increases cost of medical care), in turn raising the amount of damages in cases won or settled against physicians, escalating the inflationary spiral.[15]

The increase in litigation, real or threatened, and in amounts of awards and settlements make insurance more difficult to obtain. Ultimately this may lead to shortages of physicians,†† which would overburden those already practicing, causing further difficulties in building sound physician–patient relationships. Table 2[19] shows how malpractice insurance premiums have risen over the past ten years. In spite of these increases, premiums still have not kept abreast with costs.[12]

Efforts Being Directed Toward Ameliorating the Malpractice Insurance Problem

The problems of malpractice and malpractice insurance coverage have drawn the attention of a wide variety of organizations and agencies. The United States Senate Committee on Government Operations, through its Subcommittee on Executive Reorganization, held hearings early last year which culminated in the publications of a 1,060-page Committee Print.[15] One of the conclusions of the Report of the Subcommittee is that the federal government may well have a role in the resolution of this problem.

The American Trial Lawyer's Association,

†† Isolated cases of physicians retiring prematurely or entering federal service are reported.

which is comprised of lawyers who represent plaintiffs in personal injury actions, devoted the major portion of the February/March 1970 issue of its journal, *Trial*,[19] to the subject.

The Department of Health, Education and Welfare has established in the Public Health Service an Office of Malpractice Research and Prevention. The function of this office is to analyze the psychological, cultural, social and economic aspects of malpractice allegations, as well as the medical and legal ones.[20]

A variety of proposals have been made toward attenuating the problem. These proceed along four basic lines: attenuation of the exposure of the physician to malpractice litigation by state statute; adoption on a more widespread basis of arbitration or similar proceedings to settle disputes short of litigation; the development of "hospital stay" insurance, similar to airline "trip" insurance, which would indemnify the patient for expenses stemming from all iatrogenic disorders; and the procurement of a master plan for insurance coverage of all physicians (or all anesthesiologists). Each approach deserves some comment.

Legislative Suppression of Litigation

Such attempts to make it more difficult to sue the physician are exemplified by several bills which were introduced into and passed by the California Legislature during its 1969 session.[21] These included:

the requirement that a plaintiff post a $500.00 cost bond before a medical malpractice suit can be filed, bond to be forfeited if the case turns out to be frivolous;

the rendering privileged (*i.e.*, making them unavailable as evidence at a trial) reports of proceedings of hospital utilization and tissue committees unless the defendant physician was present at the committee meeting;

the granting of immunity of all attending physicians who respond to a call by a hospital for volunteers to perform resuscitations;

allowing insurers to make advance payments for medical care and other expenses prior to resolution of the issue of negligence, without thereby creating the inference of liability;

allowing either side to request preliminary trial on whether the Statute of Limitations has run out, prior to trial of the substance of the suit.

With the possible exception of the first statute, these new laws would seem to be both helpful in ameliorating the problem and legally sound. There is a real question in the mind of the author whether the cost bond will withstand constitutional scrutiny, *i.e.*, whether it is a violation of the Due Process Amendment of the United States Constitution.

Arbitration

Arbitration procedures commonly are employed in disputes arising from labor contracts. Parties draft into such a contract a provision that any dispute arising between the parties during the operation of the contract shall be settled by arbitration. A neutral arbitrator is agreed upon at the time the contract is signed. A dispute arising during the life of the contract is resolved by arbitration before a board of three arbitrators, two of whom are selected when needed, one by each party. Arbitration has been accepted practice in disputes involving patients of the Ross-Loos Medical Group, a prepaid health care plan in operation in Southern California.[22] When the patient enters into a contract for care by this group, he agrees to a provision for arbitration. The Supreme Court of California has upheld the validity of this provision, including the right of a parent to bind a minor child to its provisions.[23] Whether it would be feasible for the privately-practicing physician to ask his patients to enter into such an agreement is an interesting question. Clearly, all physicians involved in the care of that patient, plus the hospital, would have to be parties to the agreement. Such a plan is being tried in a limited area in California. The recentness of the adoption of this plan precludes any discussion of experiences thereunder.

As of March 1, 1970, the Medical Society and Bar Association of Franklin County (Columbus), Ohio, agreed upon a plan whereby members of the Bar will urge their clients in any future instances of alleged medical malpractice to seek arbitration as to the dual ques-

TABLE 2. Professional Liability Insurance Premiums for Anesthesiologists, $100/300 Thousand Limits*

State	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Alabama	169	169	169	208	208	208	208	278	531	775
Alaska	356	356	356	437	437	437	437	494	712	1040
Arizona	258	258	258	371	371	371	482	834	1580	2759
Arkansas	163	163	163	173	260	260	288	381	479	1399
California									2396	5254
S.F. and Alameda Co.	558	558	558	861	861	861	1001	1473		
Los Angeles Co.	558	558	558	727	727	727	525	1082		
San Diego Co.	420	420	420	861	861	861	1001	1473		
Rest of state	420	420	420	468	468	468	1001	1473		
Colorado	243	243	243	305	305	305	379	577	1088	1588
Connecticut	144	144	144	222	222	222	245	309	622	1588
Delaware	124	124	124	171	171	171	194	288	596	869
District of Columbia	346	348	348	482	482	556	630	752	945	1380
Florida										
Dade Co.	276	276	276	342	342	342	342	711	1425	3119
Rest of state	276	276	276	342	342	342	342	587	842	1546
Georgia	218	262	262	319	319	319	319	402	660	1247
Hawaii	187	187	187	187	187	431	474	762	816	1191
Idaho	237	237	237	282	282	282	311	391	738	1077
Illinois	237	237	237	288	288	319	348	402	609	1342
Indiana	187	208	208	311	311	311	356	412	536	1172
Iowa	258	222	222	288	288	288	371	494	803	1172
Kansas	148	194	194	290	290	290	342	443	557	813
Kentucky	311	220	220	282	282	282	282	282	531	1361
Louisiana	194	194	194	274	274	274	274	356	648	1266
Maine	243	243	243	325	325	325	325	371	518	832
Maryland	208	208	208	260	260	260	260	371	725	1058
Massachusetts	208	208	208	311	311	311	422	494	622	907
Michigan	222	203	203	363	363	363	437	608	1528	2892
Minnesota	268	268	268	325	325	325	325	325	549	1455
Mississippi	276	222	222	231	231	231	231	252	324	473
Missouri	212	233	233	260	260	260	297	402	660	964
Montana	258	258	258	342	342	342	342	474	1049	2060
Nebraska	124	124	124	163	163	163	214	214	376	964
Nevada	356	356	356	534	534	534	713	834	1580	2305
New Hampshire	138	177	177	266	266	266	266	288	324	473
New Jersey										
Bergen, Essex, Union, Passaic Co.	297	297	297	577	577	756	867	867	1347	2457
Rest of state	173	173	173	340	340	445	556	556	1101	2457
New Mexico	297	297	297	371	371	371	482	670	1127	1966
New York										
New York City	350	500	500	649	649	649	816	816	1554	3697
Nassau Co.	288	433	433	649	649	649	816	816	1554	3697
Suffolk Co.	288	433	433	571	571	571	682	682	1295	3402
Rockland, Sullivan, Ulster Co.	206	309	309	416	416	416	624	624	1295	3402
Westchester Co.	288	433	433	571	571	571	696	696	1165	2563
Orange Co.	206	309	309	416	416	416	624	624	1165	2563
Delaware Co.	206	309	309	416	416	416	556	556	721	1195
Rest of state	206	309	309	445	445	445	556	556	721	1996
North Carolina	140	140	140	177	177	177	177	268	337	491
North Dakota	227	227	227	274	274	274	318	371	466	680
Ohio	208	227	227	282	282	282	311	402	881	1928
Oklahoma	268	336	336	408	408	408	490	618	855	1247
Oregon	416	416	416	527	527	527	682	939	1023	1493
Pennsylvania	138	177	177	260	260	288	288	348	635	1304
Puerto Rico	194	194	194	245	245	245	268	268	492	869

TABLE 2. (*Continued*)

State	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969
Rhode Island	128	152	152	194	194	194	251	350	479	699
South Carolina	173	148	148	185	185	185	185	185	280	439
South Dakota	227	227	227	274	274	274	319	361	453	794
Tennessee	276	346	346	422	422	422	422	536	738	792
Texas	148	194	194	237	237	237	282	412	518	756
Utah	233	187	187	231	231	231	231	433	790	1731
Vermont	124	124	124	157	157	157	171	196	492	718
Virginia	268	214	214	245	245	245	245	350	660	964
Washington	202	241	241	297	297	297	356	670	842	1852
West Virginia	134	134	134	171	171	171	185	237	298	662
Wisconsin	393	297	297	325	325	325	325	325	952	1229
Wyoming	128	128	128	171	171	171	185	237	298	662
United States average	243	261	262	350	351	350	412	535	832	1571

* Source: Insurance Rating Board (premiums rounded off to nearest dollar).

tions of negligence and proximate cause.‡‡ This plan, which also is under active consideration by the Cincinnati Bar Association and Academy of Medicine,§§ has yet to be evaluated in practice. The courts have consistently held that arbitration may be applicable in resolving disputes arising out of noncontractual rights.[24]

It has been reported that one of the major objections to arbitration agreements and physician–lawyer screening panels has been raised by the insurance carriers themselves. They allegedly feel that with such an approach plaintiff's counsel are educated in what constitutes malpractice, and are guaranteed expert witnesses should the panel or arbitrators agree that the physician was negligent, and a subsequent settlement cannot be worked out. Conversely, if the panel held for the physician, the plaintiff still could file suit, in some instances after retaining a different lawyer.

While this argument may have some validity, it should be emphasized that other methods of resolving these disputes (*e.g.*, litigation) have not produced a leveling-off of the number of suits filed and/or awards. The use of arbitration by the Ross-Loos Group in California has kept settlement costs within reasonable limits. Clearly, panel plans or arbitration should be given wider evaluation and implementation.

‡‡ One of the elements to be established by a predominance of evidence in a medical malpractice case is whether the negligence of the physician was the proximate cause of the patient's injury, that is, whether it was more likely than not the causative factor.

§§ The author is a member of the pertinent committees of both the Bar Association and the Academy of Medicine.

MASTER-PLAN INSURANCE FOR ALL ANESTHESIOLOGISTS

It has been suggested from time to time[25] that the American Society of Anesthesiologists arrange with one or more carriers to provide professional liability insurance for all members of the Society. The Society was involved in such a plan in the 1950's. An agent in Chicago and A.S.A. headquarters handled the administrative details, and Interstate Fire and Casualty Company underwrote the program.[26] As of December 31, 1957, more than a thousand A.S.A. members (more than 17 per cent of the active membership) were insured under this plan.[27] The plan was not a true group plan, in the sense that hospitalization insurance is underwritten as a group plan. The carrier executed an individual contract with each insured anesthesiologist. The American Society of Anesthesiologists entered into an agreement with the agent on February 8, 1954. In effect, this agreement provided that the Society would apprise the membership of the availability of the coverage and accept and forward to the agent applications and premium checks. The agent in turn agreed to arrange with the carrier to provide the coverage.

The House of Delegates of the A.S.A. at its 1958 meeting voted to eliminate the Society's role in administering the program.[28] This action was taken because of the disporportionate

amount of executive office time consumed in correspondence and other administrative problems; the fact that the Society is strictly a scientific and educational one; and the possibility of legal action against the Society should a clerical error result in nonrenewal of a policy and subsequent exposure of an anesthesiologist to a suit for alleged malpractice in the absence of coverage.

Interstate Fire and Casualty continued to write individual policies. On February 15, 1961, underwriting in Pennsylvania and New York was terminated by the carrier, for reasons of adverse loss experience. The carrier cited total cumulative premiums of $326,256 "over the years," compared with losses of $506,000 during the same interval.[28] The carrier discontinued the entire program the following January.

It does not appear that an A.S.A.-sponsored master-plan type of professional liability insurance is the answer at the present time. Perhaps the foremost reason would be the difficulty or impossibility of obtaining a carrier which would write policies in all 50 states. A strong secondary reason undoubtedly would be the reluctance of a great many anesthesiologists to switch to a different carrier. Their argument could well be, "Why should I change from a company which now is giving me good service to one which may not remain in the field indefinitely, especially since the same company then would be insuring those whose insurance has been cancelled or who are now paying excessively high rates because of losses." Finally, the administrative problems and costs which would be incurred by A.S.A. sponsorship would preclude such sponsorship. Clearly, the answer to the malpractice insurance problem lies elsewhere.¶¶

"Hospital-stay" Insurance

Another recent suggestion for a solution to the problem [29] revolves about the establishment, on a statewide or nationwide basis, of insurance similar to that purchased for airline travel. For a nominal sum of, say, 25 cents per hospital day, the patient could indemnify himself for the added hospitalization and other medical expenses which might stem from an iatrogenic disorder.*** It is estimated [30] that during 1968, there were 450,965,802 days of patient care in the United States. If each patient paid only 25 cents per day for premiums for such insurance the aggregate of these premiums would amount to $112,741,450.00. Such a fund easily would have covered administrative costs in underwriting the insurance and still allowed sufficient funds for direct payment to injured patients. As reported by Bergen, of the Legal Department of the American Medical Association,[12] the total payment to injured patient-plaintiffs during 1968 was estimated to be 18 million dollars. Clearly, had each patient hospitalized in this country during 1968 taken out such coverage, the premiums would have been more than ample to satisfy the patients' claims. Insurance of this type certainly is worth considering seriously.

The author offers two additional suggestions, not necessarily original, namely, a more equitable premium-to-risk allocation and concerted educational efforts directed toward malpractice prevention.

More Equitable Premium-to-Risk Determination

It is now standard practice in certain types of casualty underwriting to assess all risks carefully and in some detail. The premiums charged then can be determined with mathematical precision. The greater the risk, the higher the premium. Conversely, and of importance to the skillful physician, the less the risk, the lower the premium. For example, in underwriting automobile liability insurance, a variety of factors are weighed, to wit: number of cars covered; number of miles driven annually; whether the car is used in business or profession; record of past accidents and traffic violations; age of drivers; in the case of male drivers less than 25 years old, scholastic records in high school or college. The rates charged male drivers less than 25 years old by certain carriers are reduced by 15 per cent if the applicant has passed a high school drivers' training course, and by 15 per cent if he passes an aptitude test administered by the carrier.

¶¶ The American Medical Association currently is negotiating with The Continental Casualty Company to undertake such a venture, however. See American Medical News, August 24, 1970, p. 1.

*** Would cover all diseases of medical progress, irrespective of whether professional negligence was involved.

It is proposed that a similar selective rating program be instituted as part of the procedure for underwriting insurance for high-risk medical specialists, such as anesthesiologists. The following questions might well be posed. The answers then could be used to rate the risk of that anesthesiologist-applicant for professional liability insurance, and the premium adjusted accordingly.

1) How many years have you been practicing anesthesiology?
2) Do you limit your practice to anesthesiology?
3) How many years of formal training have you had?
4) Was this training in a program accredited by the Council on Medical Education and Hospitals of the A.M.A.?
5) Are you certified by the American Board of Anesthesiology?
6) Are you a Fellow in the American College of Anesthesiologists?
7) If the answer to question 5 is "No" and the answer to question 6 is "Yes," are you participating in the self-evaluation program of the American College of Anesthesiologists?
8) Do you personally make preoperative rounds to see all of the patients you will anesthetize?
9) If the answer to question 8 is "No," does an anesthesiologist in your group or association make such rounds to see those patients you do not personally see preoperatively?
10) Do you inspect the mouth and teeth of every patient to whom you will give general anesthesia prior to starting the anesthetic?
11) Do you obtain informed consent from each patient for the agent/technique combination(s) you plan to use?
12) Please state the number of times you used each of the following as the principal anesthetic technique during the year preceding the present year (the total should equal the number of anesthetics administered during that year):

    a) inhalation anesthesia
    b) intravenous anesthesia
    c) spinal anesthesia
    d) epidural anesthesia
    e) other forms of regional anesthesia

13) Please estimate the percentages of the following agents which comprised the number of cases cited in 12a:

    Halothane
    Fluroxene
    Methoxyflurane
    Cyclopropane
    Diethyl ether
    Other

14) If you use spinal anesthesia in your practice, are the ampules used for that anesthesia sterilized with steam or ethylene oxide?
15) Do you use disposable spinal anesthesia sets?
16) If you use flammable agents in your practice, do your operating rooms meet the Code of the Use of Flammable Anesthetics, NFPA #56?
17) Do the practices of the hospital and operating room personnel meet the requirements of this code if flammable anesthetics are used?
18) Do you routinely practice electrocardiographic monitoring of patients who have cardiac or respiratory disease? Candidates for major operative procedures?
19) Do you determine and record at 5–10-minute intervals the blood pressures of all patients whom you anesthetize?
20) Do your professional activities include supervision of nurse anesthetists?
21) If "Yes," are all such nurses certified by the Association of Nurse-Anesthetists?
22) If nurse-anesthetists administer anesthesia to your patients, are the patients apprised of that fact before the anesthetic is administered?
23) How many patients anesthetized by you during the past five years died or suffered major neurologic, hepatic, vascular or respiratory problems postoperatively as a result of complications which developed during anesthesia?
24) Have you been sued for alleged professional negligence, or threatened with suit, during the past five years?

The anesthesiologist renewing his insurance would need only to bring up to date the data on the questionnaire at the time he applied for renewal. Thus, subsequent Board certification or College fellowship would be noted if the answers to questions 5–7 previously had been "No." Other data would be ignored, unless changes had occurred. On renewing his insurance the anesthesiologist would be furnished by the carrier with a copy of his prior answers, so that he would be able to verify their current correctness and/or note any changes in his practice.

In weighing risks and adjusting premiums, more weight would be given to unsafe practices than to length of training, in the absence of prior loss experience.

Four advantages would accrue to the use of such a system. First, each anesthesiologist would be placed on notice of hazardous practices when he applied for a policy and each time he applied for renewal. Second, those with training of less than two years would be charged a higher rate than those with two or more years of training, but the difference would be less for the individual who had been practicing for a number of years without any accidents. Third, the anesthesiologist who "cuts corners" would be charged a higher rate than the practitioner who pays attention to detail, irrespective of training. Fourth, false statements made as to practices would constitute a breach of the contract, relieving the carrier of liability and helping place the malpractice burden where it belongs.

Anesthesiologists may object strenuously to having to complete such a questionnaire. It should be stressed, however, that there is a sellers' market insofar as professional liability insurance is concerned. Physicians in general and anesthesiologists in particular are being subjected to soaring premium costs, and it is difficult or impossible to obtain insurance at any cost in some parts of the country. Clearly, the time has arrived for the high premiums to be leveled on those practitioners whose practices create the greatest risks and exposure to liability. The well-trained anesthesiologist who has never been sued, and who practices "heads-up" medicine, should not be forced to subsidize the "three-month wonder" who practices shoddy anesthesia, exposing his patients to medical hazards, himself to legal hazards, and his colleagues as well as himself to escalating malpractice insurance premiums.

Before more carriers withdraw from the professional liability coverage field, those who remain should give serious consideration to this proposal.

Education in Medical–Legal Problems

The second proposal of the author is education. This author believes that if the anesthesiologist has some understanding of anesthesiologic jurisprudence, that is, the impact of law upon his practice, he will be better able to practice preventive legal medicine, so to speak. Understanding the nature of the physician–patient relationship, and his duties to his patients as well as his rights, should contribute to better medical practice, fewer lawsuits against anesthesiologists, and peace of mind.

Unfortunately, relatively few medical schools offer instruction in law as a required course.††† Thus, exposure to legal matters must come either as part of residency training or in other postgraduate presentations, unless it develops in the preparation for the defense of a case of alleged professional negligence. Each anesthesiology resident should be given three or four hours of lectures or seminars in medical–legal problems. The American Society of Anesthesiologists should offer an annual refresher course on the subject, and consider implementing these educational endeavors with panel discussions at the annual meeting and, possibly, regional workshops. The Society, via its *Newsletter*, has initiated a monthly column dealing with professional liability insurance and related problems. It is essential that each anesthesiologist, as well as each anesthesiologist-to-be, obtain some formal or informal indoctrination in legal problems before he is compelled to do so in his own defense.

Conclusion

From the best evidence, the malpractice insurance problem will be with us for some

††† A recent survey conducted by the author revealed that only 47 of the 85 "approved" schools offered any instruction in law and medicine, and of these, only 27 offered the material as a required course.

time. The problem already has reached crisis proportions in some parts of the country. Everywhere premium charges are rising. Clearly, the problem will worsen before it levels off or begins to ameliorate. Clearly, too, it not only deserves but requires the best efforts of all in pursuing a variety of approaches toward at least a partial solution. These approaches are directed toward the protection of the anesthesiologist as an individual and as a member of the specialty.

Individual protection can be best achieved by the development of sound anesthesiologist–patient relationships, and by practicing "heads-up" anesthesia. Specialty-wide protection can be enhanced in a fourfold manner: education; the procurement of insurance which is better oriented toward the exact risks to which the individual practitioner is exposed; encouragement in the development and support of arbitration; and, should it become available, "hospital-stay" insurance.

All anesthesiologists have a stake in this problem. All should work hard toward finding solutions. If the prohibitive cost of insurance continues to force practitioners from the specialty, not only anesthesiology, but the entire practice of medicine, will suffer.

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