Your most frequently asked questions on malpractice insurance

In August, I spoke to CRNA's about malpractice insurance problems at the 42nd AANA Annual Meeting and Clinical Session held in Chicago. Following my talk was an in-depth question and answer session which I have compiled here, thinking that it might be of interest to Journal readers.

I am confused about the requirement in our policy to report an incident which "might" turn into a malpractice claim. Under what circumstances must we do this, and why?

You are asked to make this preliminary report about any "incident". What constitutes an "incident" is sometimes confusing, but you are in a position to know when something has obviously gone wrong or there is some damage done. If some injury or problem occurs, the matter should be reported, even if there is no recognizable "wrong doing" by you or your colleagues. We're not asking that mistakes be reported so much as circumstances in which the patient has some problem which he or she may consider actionable.

The reason for this early reporting is so that a claims expert in this field can evaluate the situation and its potential at the earliest possible time while details are still fresh and facts more likely complete. Also, in extreme cases, this allows the claims people to move swiftly to avert trouble—a procedure which is of benefit to all parties—including you.

Might not calling attention to a relatively minor "incident" tend to generate activity which could encourage legal action? Why don't we just keep accurate records ourselves of "incidents"?

No. Here, you must understand that the claims people who will review your report are experts at this. They know just how far to go, just whom to contact (if at all), and how. Remember, they are just as anxious to see that a situation does not develop into a claim as you are—perhaps even more so! And, be certain you understand that this entire matter is done with your knowledge and cooperation, so there aren't any unpleasant surprises. You merely help them to do a better job for you by reporting full information, on which they make seasoned judgments.

On the second question, we certainly would encourage you also to keep specific records of your own. But, as you are an expert at what you do, we are experts at what we do, and we
shouldn’t try to second-guess each other’s expertise.

Wouldn’t reportage of such “incidents” tend to damage my reputation with the insurance company?

Absolutely not. You must remember that the insurance company people and you are on the same “side”. They are your friends. Here. After all, remember that you’re not being asked to report your mistakes or the mistakes of others so much as a situation in which the patient might feel there is some problem. No prejudice will be leveled against you as a result of reporting. On the contrary, it might be just the opposite. The insurance company doesn’t like surprises, either!

Some state legislatures are considering providing malpractice insurance on some basis in excess of $200,000/$600,000. Since our base AANA Plan has only $100,000/$300,000, what is being done to supply that missing layer?

We are working on that right now, and are very confident that it will be possible to augment your basic coverage with this additional layer. In the absence of any “group” arrangements, though, this layer can be purchased individually—if at greater cost. We don’t think that will be necessary, and we will keep you informed as this matter progresses. But, rest assured we are very aware of your problems and continually seek solutions for you.

I work exclusively for a hospital which has an umbrella liability policy as regards medical malpractice. Is there any reason for me to purchase an individual professional liability policy?

So long as you work as an employee of the hospital and do not engage in any outside professional services, and provided you have a certificate from the hospital’s insurance company naming you as an insured person under that policy, you have no need for additional coverage. But, please be absolutely certain that you are included, as some hospitals with umbrella liability arrangements specifically exclude some types of practitioners.

How is the enormous increase this year in the cost of our insurance justified, and how can we be certain it will not simply increase to the point where we cannot afford it?

In the past, the premium for a “group” was established by estimating, based on experience statistics, what the group would cost in claims dollars. This is the so-called “pure premium”. To that is added the insurance company’s costs of doing business and their profit factor. The total is then shared by all insured people.

The problem is that the experience on which the rates are based is in the past, and recently the entire malpractice field has exploded to the point where past history is simply not credible. Enormous judgment figures (you’ve read about them in the papers), higher settlements, increased investigation and defense costs—all these have teamed to make even the present (let alone the future) absolutely unpredictable. What we see now is the insurance industry trying to establish and collect the sufficient premiums to pay for future experience; and in this volatile situation, they are naturally trying to judge the future and hedge against it.

What used to be a thoroughly predictable, rather commonplace matter of bookkeeping has now turned into speculation and daring. In the face of that, many companies simply do not underwrite malpractice anymore. We negotiated with 29 companies to get the current arrangement you have through the AANA group plan. We might even say we are lucky to have it at all, considering the alternative.

As to the future, there can be no certainty that premiums will remain stable, or even particularly reasonable. They will continue to reflect anticipated experience. The only guarantee we can give you is that we will continue to watchdog the company and make sure it doesn’t abuse the situation at your expense.

Why does our new policy no longer contain a personal liability feature?
Simple economy. Since personal liability is so readily and generally available through a variety of other sources—auto and homeowner’s insurance, for instance—we eliminated it here as a premium layer we felt you could do without.

Please explain the difference between a policy based on “losses occurring” and one based on “claims made”.

A “losses occurring” policy provides protection against claims which are made during or after the actual policy period for incidents occurring either before or during the actual policy period. This is the kind of policy you used to have. Because of the unpredictability of losses under such an arrangement, the insurance industry simply does not underwrite such a policy type any more—one cannot purchase it anywhere.

We were successful in replacing your insurance with a “claims made” type of coverage. It is distinguished by the necessity for both of the following to occur during the actual policy period: (a) the incident itself; (b) either an actual filed claim based on that incident, or your report of that incident to the insurance company (another important reason for you to report all potential claims). Unlike the “losses occurring” form, incidents occurring before the effective date of this coverage are not covered.

It is, however, possible to purchase provision for an “additional discovery period” which provides protection against a claim made anytime after the insurance has terminated for any reason. The incident, however, must have occurred during the actual policy period.

This combination of features was designed so there would be no holes in the protection you have.

If you have any additional questions, please feel free to call Marsh & McLennan, Inc., toll-free, at (800) 621-0366 (in Illinois: collect (312) 648-6435). We will be very happy to answer your questions in this important security matter.

Cancer hasn’t stopped 1,500,000 people from living.

They did it by not letting fear kill them. They did it by going to the doctor in time. They did it with the help of the effective methods of treatment today: surgery... radiation... chemotherapy.

They did it because of the advances made through research.

More than 1,500,000 Americans are living proof cancer can be cured. The American Cancer Society needs millions to save millions more.

Please, give more today.
We want to wipe out cancer in your lifetime.

American Cancer Society
The space contributed by the publisher.