PROFESSIONAL INDEMNITY INSURANCE

– Is the Time Right for Tort Reform?

By A/Prof Chin Jing Jih

THE MEDICAL Protection Society (MPS), a UK-based medical defence organisation (MDO), recently announced changes to professional indemnity for doctors practising obstetrics in Singapore, producing quite a jolt in the local medical community. MPS is the largest provider of medical indemnity in Singapore, covering about 10,000 registered medical practitioners here. Tremors from their decision to switch obstetricians and gynaecologists (O&G) who manage pregnancies after 24 weeks' gestation from occurrence-based to claims-made cover, were felt beyond the O&G community. Many doctors from other specialties wondered if they would be next in line for the axe. Many questions were asked as doctors sought to understand this sudden and drastic change.

History of medical indemnity

Perhaps the current changes can only make sense when we examine the history of medical indemnity, and have a better understanding of what the risk-pooling business is all about in the context of professional liability.

Professional indemnity began in 1885 in England, when the Medical Defence Union (MDU), the world's first MDO, was formed in response to the medical community's outrage over the case of Dr David Bradley. He had been wrongly sentenced to two years of hard labour in 1884 for sexually assaulting a woman who suffered erotic delusions during and after epileptic seizures. Dr Bradley served eight months in prison before he was eventually granted a pardon. The case raised awareness among medical practitioners then on the risks involved in medical practice, and the need to pool resources together in order to defend doctors' reputation and livelihood against a rising tide of patient-initiated medical litigation. In addition to offering legal advice and defence, MDU was also established to promote honourable practice, to prosecute unauthorised practitioners, and to take positions for or against legislative measures that might benefit or adversely affect medical practice, respectively.

Over the next century, more MDOs like MDU came on board in England and other Commonwealth countries, each with a large membership base. These MDOs were formed as not-for-profit mutual organisations with member-owned assets, offering legal advice and assistance for doctors in response to complaints or claims after adverse events.

From my recent conversations with fellow doctors, I realised that many have only a superficial understanding of the different types of medical indemnity, including the particular type of coverage that they themselves have. A key fact to appreciate is that in many of these adverse incidents leading to complaints or claims, there is usually a lag time between the event occurrence and subsequent discovery and claim against the doctor. Whether a doctor is covered for an event depends on the type of coverage his plan provides – whether it is one based on when the incident occurred or one which depends on when the claim or complaint was made.

Traditionally, many MDOs are mutual organisations which offer "occurrence-based discretionary cover". Such coverage is "occurrence-based" because the MDO will assist the doctor in any complaint or claim against him, as long as the adverse event happened during the period of paid membership or premiums. This is regardless of when or how long later the discovery and therefore the claim for the incident are made (this can be years after the doctor has ceased practice and stopped paying premiums). Therefore, doctors on occurrence-based plans do not need to make any further arrangements for long term protection ("run-off protection" or "tail cover") after contract cessation. Many such plans are "discretionary", because in contrast to cover under an insurance contract, the MDO may exercise discretion on whether or not to grant assistance to a doctor member; this assistance, once granted, may not have a limit to the cover offered.

Claims-made cover, however, provides indemnity coverage only for claims made during the period of cover

paid for. This is not unlike an insurance-based cover which ends when the contract ends. In such schemes, doctors would have to purchase run-off (or tail) cover to remain protected for any claims made after the period of cover has ended. Run-off cover can be purchased from another provider, though it is probably more practical to do so from the same one. In general, the annual premiums for claims-made cover are lower than occurrence-based ones, but the difference is offset by the additional amount needed to purchase tail cover.

MPS announced that it will no longer cover obstetricians under an occurrence-based scheme, but will instead provide only claims-made cover, with an option for tail cover purchase, in blocks of five years. If one were familiar with the recent turbulent history of medical indemnity, particularly the 2001 collapse of United Medical Protection (UMP), then the largest MDO in Australia, it would not be surprising that the obstetricians were the first to be hit.

The first case that accelerated the medical indemnity storm was an obstetrics one in Australia. In November 2001, after a nine-year legal battle, the New South Wales (NSW) Supreme Court awarded Calandre Simpson, then 22, A$14 million (reduced on appeal to A$11 million). Ms Simpson was born in 1979 with severe athetoid cerebral palsy, and as a result became severely disabled. Her mother was given Syntocinon as part of labour induction, and five attempts at forceps delivery were made before she was finally delivered by caesarean section. The court ruled that her brain injury was caused by negligence by the obstetrician Dr Robert Diamond during the delivery.

This large payout was instrumental in catalysing UMP's demise. What was significant about this case was firstly, the quantum was twice that of the next highest payout, as it dfactored in the costs of future care for the disabled claimant. Secondly, and perhaps more importantly, the claim was allowed 22 years after the incident had occurred, because it was held that the true impact of an obstetric case on brain injury might not be clear or discoverable until the age of maturity. This resulted in a hyperinflation of the estimated sum of incurred but not reported (IBNR) claims (about A$455 million) which UMP would be expected to pay over the subsequent 20 years. UMP was then already under severe financial stress from increasing claims and progressively huge payouts awarded by the Australian courts.

With its reinsurer's collapse and a spike in claims in anticipation of tort reforms to cap payouts, the worst finally happened when in April 2002, UMP applied to the Australian court to appoint a provisional liquidator. As UMP was one of the two MDOs serving Singapore doctors, doctors under its cover were not spared the impact of this indemnity tsunami from Australia. To make matters worse, the guarantee of cover provided by the Australian federal government was not extended to UMP members in Singapore, who had to scramble for tail cover provided by both MPS and NTUC.

Challenges in providing cover for obstetrics

In its announcement, MPS stated that the main reason behind its change in its professional protection for O&G specialists was due to the "challenges and risks associated with obstetric claims and obstetric litigation globally". Key to this is the length of time between a birth injury and the settlement of an obstetric claim, which can be 20 years or more, compared with an average of five years for non-obstetric claims. MPS cited uncertainty in legislation and claims environment as reasons why it would be difficult to estimate the value of future obstetric claims, and hence the accurate pricing of obstetric risk now.

It is important in this discussion to appreciate that mutual insurance is an instrument of equitable risk distribution, where a group of doctors come together and agree to share their total estimated risk based on historical claims data, and then redistributing this risk among members. In contract insurance, a doctor hedges against the risk of loss from a professional liability claim by purchasing insurance coverage from an insurer through premium payments. Both forms of risk management use an actuarial science model which applies mathematical and statistical methods to assess risk. Basically, to sustain such a model, payouts should not exceed the sum of all paid-up premiums, and the premium quanta can be reasonably estimated from known claims data.

It is easy then to see the challenges faced in providing occurrence-based cover for a specialty like obstetrics. The specialty has an intrinsically long run-off period, and a tendency to face high (and still rising) quanta of claim payouts, resulting in a potentially large sum of IBNR claims that is risky and unmanageable. With such a profile, occurrence-based cover will be unsustainable due to high premiums needed to sustain the system. And more importantly, in such an environment, the difficulty in estimating the quanta of future payouts many years later during the run-off period makes it almost impossible to predict, with reasonable accuracy, the appropriate premiums to be paid now. This probably explains why MPS, in offering tail cover ("extended reporting benefits"), has indicated that its tail cover is available in five-year blocks, thereby enabling it to price coverage more accurately with five-yearly adjustments. Above all, the risk of insurer collapse in providing occurrence-based cover to such doctors becomes more than just a theoretical possibility. With hindsight from the Australian indemnity crisis, MPS explained on its website that "as a responsible organisation", it "must make changes in order to … continue providing affordable and sustainable professional protection to obstetricians".

For the same arguments above, it would be fair and logical to expect the same changes to soon affect other specialties that treat or operate on young children. Besides the inevitable contact in neonatology and general

paediatrics, specialties that are involved in providing high risk interventions in young children, particularly paediatric neurosurgery, may be next. The only reason why that has yet to happen is probably because payouts for claims in these specialties have yet to reach untenable quanta. But given the increasingly litigious climate in first world countries, this day may not be far away.

Solutions for this crisis

Is there a concrete solution to this? Some have advocated that having more insurers may help by providing choice and competition, thereby reducing monopoly by one major provider. However, no matter how many providers we have, none can run away from the realities of actuarial science mentioned above. In fact, the reduction of doctors covered by each insurer works negatively for the economies of risk pooling, and may again make the calculated premiums unbearably high.

Increasing premiums is possible but only a temporising measure, as they will soon reach a prohibitive sum. As one Australian obstetrician told the Australian Broadcasting Corporation in 2002 – he used to only need to deliver one baby to pay his premiums in 1982, but by 2002, he had to deliver 100 babies to pay for his insurance. In some countries, this has resulted in doctors relocating to states with more affordable premiums. In Singapore, I suspect while a few may do this, some may decide to retire, while many may consider practising only gynaecology.

This indemnity crisis cannot therefore be a problem of only the medical profession, but also of wider society, because any O&G specialist can decide to practice only gynaecology, where the risks of litigation are more manageable with a lower risk of IBNR. Now if most local O&G specialists decide to abandon obstetric practice, then obstetric care costs will escalate to a prohibitive level by a simple demand-supply principle. Even those who intend to retire from practice completely may be discouraged from quitting by the staggering tail cover that they need to pay to cover IBNR cases in their careers. Society may have no choice but to regress to less costly options like nurses and midwifes. In complicated pregnancies, the lack of specialist medical management can potentially result in higher risks to mother and fetus. Some citizens may even find the obstetric care costs so prohibitive that they decide to not have any children altogether. In the worst case situation, if obstetric practice is unable to obtain insurance cover, many will likely stop practice. While these are presently just speculative scenarios, their likelihood is not insignificant. For a country that is trying very hard to improve its birth rates, this can be a serious setback.

Obstetric practice is also being influenced where caesarean sections are known to be popular among obstetricians despite the absence of clear contraindication to normal delivery, as a way of lowering professional risk related to brain injury and other problems associated with a complicated vaginal delivery, particularly when instrumentation is needed. But caesarean delivery is not a problem-proof alternative either, as it has its own risks not usually present in normal vaginal delivery. Another way of defensively managing risk would be to cherry-pick straightforward cases, with few keen to take on complicated pregnancies. Doctors are not trained to evade challenging cases, but if the blame-and-sue culture leads one day to the prevalence of an unforgiving and harsh practice environment, then defensive medicine will unfortunately rear its ugly head.

The most likely solution that will bend the curve can possibly be found in tort reform. In 2002, Australia tackled its medical indemnity crisis by subsidising doctors subjected to high premiums and introducing a number of tort reform measures. For example, NSW law was amended to require doctors and others defending personal injury claims to show only that they took reasonable care, to set upper limits to damages, to hold lawyers personally liable for costs if they instigate "unmeritorious" public liability insurance claims and to limit access to courts. Then NSW Chief Justice James Spigelman pleaded to his fellow judges to adopt a principle-driven reform, which includes rationally moderating the scale of their damages awarded. While the Singapore judiciary has thus far been very reasonable and balanced, one cannot be certain that the same crisis in Australia and the USA in the last decade will not happen here. Now may be an opportune time for us to consider similar tort reforms that will provide more definitive and durable solutions, ultimately benefiting patients and Singaporean society.

While local healthcare services are generally safe and well regarded, adverse incidents can still arise from medical care despite the best of efforts, especially with complex cases or frail patients. In these cases, there is no denying that medical indemnity plays a vital role in protecting both doctors and patients. Therefore, it is also time for the regulators to consider making medical indemnity cover mandatory for all medical practitioners. It takes away unnecessary anxiety in both patients and doctors, leaving no one in a lurch when adverse events occur.

The soaring cost of medical indemnity cover today is certainly a national problem. It is time, perhaps, for us to consider tort reform as a more definitive and long-lasting solution that will benefit both doctors and patients. ■

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