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Professional Liability Insurance: The Doctor’s Dilemma

The well-documented surge of medical malpractice claims has shaken the foundation of the insurance system. Libraries of articles, reports and media accounts have examined the present crisis in an effort to discover causes and to generate solutions. The precipitating factors in the crisis are the concomitant elements of rising costs and the dwindling supply of malpractice insurance. As a result of the increased expenses and soaring volume of claims, insurance carriers across the nation have withdrawn from the market or substantially curtailed their underwriting. Simple economics teaches that in the market place when supply is decreased and demand remains constant or increases, the price of a commodity is driven upwards. The medical malpractice insurance market is no exception.

As a consumer of professional liability insurance, the physician today faces a situation not unlike the one he faces at the gas pump. Astronomical premium increases have resulted from the reduced availability and increased insurers’ costs. The legislatures of the

3. Hirsh, supra note 2.
4. In the 4-year period, from 1970 to 1974, claims have risen 120 percent. Two of the industry leaders have reported that their average claims payment has doubled in the last five years. AMA Source Document prepared by the Editors of PRISM, MALPRACTICE IN FOCUS 13, 14 (Aug. 1975) [hereinafter cited as MALPRACTICE IN FOCUS].
5. Id. at 22; Gibbs, supra note 1; Stewart, The Medical-Legal-Insurance Epidemic, 42 INS. CNSL. J., April 1975, at 249. The Secretary of Health, Education and Welfare has indicated that in seven states physicians are in jeopardy of losing their malpractice insurance. Wall St. J., Dec. 30, 1974 at 10, col. 4.
states have reacted in varying degrees to remedy the current exigency. The repercussions of the resulting legislation, including that in Illinois, have yet to be felt. In any case, the physician's best recourse is to inform himself of insurance alternatives and to be aware of the scope of his insurance coverage.

Medical malpractice insurance is a costly necessity to today's health care provider. By practicing without proper insurance protection, a doctor endangers his personal assets every time he treats a patient. In the current market the doctor is unable to barter for a better price. Therefore, the doctor must seek malpractice insurance that offers the broadest possible coverage for the least possible price. Before a physician can measure the coverage afforded by his insurance contract, he must be cognizant of the terms, conditions and exclusions contained in the insurance agreement. This article will attempt to examine these components in an effort to provide an insight to physicians and attorneys as to the workings of medical malpractice insurance in our legal system.

Categories of Malpractice Insurance

The Risk Covered

The physician should first be aware of the several forms or classifications of malpractice insurance. The predominant type of policy today is liability insurance. Professional liability insurance, generally termed malpractice insurance, takes the form of an errors and omissions policy. It provides a specialized and limited type of coverage as compared to general comprehensive liability insurance, which provides coverage for liability not arising from the performance of professional services. The policy is a contract designed to insure members of a professional group from liability originating from special risks inherent in the professional practice of medicine.

Sec'y's Comm'n on Medical Malpractice, Appendix, 494 (1973) [hereinafter cited as Sec'y's Report].

7. For a discussion of new Illinois legislation, see p. 480 infra. For a summary of proposed Federal Legislation in this area of insurance see Nelson, Mushrooming Malpractice: A Federal Rx, 11 Trial, May/June 1975, at 19. Although in United States v. South-Eastern Underwriters, 322 U.S. 533 (1944), the United States Supreme Court held that insurance, as interstate commerce, is subject to federal regulation, the federal government has not yet entered this area of regulation.

Such a policy is a contract by which the insurer promises, for a
consideration (the premium), to compensate or reimburse the in-
sured physician should he suffer loss from a specified cause, or to
secure him against loss from that cause.\textsuperscript{9} In this form of insurance,
the liability of the insured determines the enforceability of the pol-
icy. Once the insured's liability attaches, this contract requires the
insurer to pay sums which the insured has become legally obligated
to pay.

A second form of policy is indemnity insurance. In this type of
insurance, the physician is reimbursed when he has sustained actual
loss by, in fact, paying a judgment or settlement. The harshness of
requiring the insured to bear actual loss before being able to claim
under the policy has caused indemnity insurance to be disfavored
by the courts.\textsuperscript{10} As a result, indemnity insurance has all but disap-
peared from today's malpractice insurance market.

\textit{The Period Covered}

Perhaps the most significant distinction in medical malpractice
policies concerns the period in which liability of the insured is cov-
ered by the insurance contract. The traditional type of insurance is
the "occurrence" or "claims-incurred" policy. This type of policy
affords coverage for any acts or omissions in treatment occuring
during the policy period, regardless of when the claim is made.\textsuperscript{11} The
second form of insurance, the "claims-made" or "discovery" policy,
is a relative newcomer to the medical malpractice area. The
"claims-made" policy covers claims manifested within the policy
period regardless of when the act or omission occurred.\textsuperscript{12} The signifi-
cance of the difference between these two forms of coverage may not
be readily apparent, but closer examination reveals that this dis-
tinction may be crucial.\textsuperscript{13}

The recent introduction of the "claims-made" policy into the
medical malpractice insurance market is an effort by insurance

\textsuperscript{9} Fidelity General Ins. Co. v. Nelsen Steel & Wire Co., 132 Ill. App. 2d 635, 270 N.E.2d
616 (1971).

\textsuperscript{10} For example, today, most policies contain provisions requiring the insured to notify
the insurer of any claim, and requiring the company to assume the defense of any claim. Courts have generally construed policies containing these provisions to be liability and not
pure indemnity insurance. See, e.g. Ravenswood Hosp. v. Maryland Cas. Co., 280 Ill. 103,
117 N.E. 485 (1917). For a general discussion of the distinctions between liability and indemn-
ity insurance see LONG, \textit{1 THE LAW OF LIABILITY INSURANCE} 16 (1975).


\textsuperscript{12} Id.

\textsuperscript{13} For a detailed review of these two forms of coverage, see Comment, \textit{The "Claims
Made" Dilemma in Professional Liability Insurance}, 22 U.C.L.A. L. REV. 925 (1975); Trout,
\textit{Malpractice Insurance: Claims-Made Policies Pose a New Dilemma}, 3 J. OF LEGAL MEDICINE,
June 1975, at 33 [hereinafter cited as Trout]; SEC'Y'S REPORT, supra note 6, at 508.
companies to control the risk factor in underwriting. Policies containing such a provision boast lower premiums than those affording "occurrence" coverage. The reasons for the lower premiums are several. The effects of the much-maligned "discovery rule," and the statute of limitations, known as the "tail" in insurance terms, are minimized by the "claims-made" policy. Since the policy provides coverage only for claims arising during the policy period, the uncertainty of future claims resulting from current treatment is diminished. This allows for increased accuracy in the actuarial methods employed by the carriers in determining policy rates. Thus, the insurer may carry smaller reserves because the uncertainty of future claims and the effects of inflation are reduced to the normal one-year policy period.

Even the "claims-made" policy, however, is not without its shortcomings. For example, this form of insurance leaves the doctor who dies or retires somewhat financially insecure; once his "claims-made" policy has expired, the physician, or his estate, is exposed to the "long tail" of potential liability from treatments made in previous years. The doctor must therefore purchase insurance to cover his exposure to claims filed during the "tail" period. The length of the "tail" will vary according to the state's statute of limitations for tort or medical injury. Insurance for the "tail" period may be available on either a year-to-year or on a long term basis.

A further deficiency of the "claims-made" policy is manifested when a physician carrying such insurance moves to an area where

14. The "tail" is the period the doctor is exposed to potential liability before the statute of limitations has run. This occurs because the statute of limitations does not begin to run on a cause of action until the injury is discovered by the patient. The addition of § 22.1 to the Illinois statute of limitations by the new Illinois statute is an attempt to minimize the effect of the tail. A five-year absolute limitation is established in which an injured patient may bring suit. This five-year period begins to run from the moment of treatment. Additionally, if the injury is discovered by the patient, a two-year limitation is established. There are two significant exceptions to the five-year maximum period. If the injured party is a minor, mentally incompetent or incarcerated, the period does not begin to run until the injured is able to realize his injury. In the case of minors, this is not until he reaches the age of majority. The second exception relates to the type of injury. If a foreign object is left within the body of a patient, a ten-year maximum is established. Pub. Act No. 79-960 § 21.1 (Sept. 12, 1975).

15. Trout, supra note 13.

16. See note 14 supra. Under paragraph 22.1 of ch. 83 Ill. Rev. Stat. (1973) as amended by § 21.1, P.A. 79-960, September 12, 1975, this period will be at least five years. However, this is only the minimum period. If the insured is a pediatrician, for example, his exposure to liability may extend as far as twenty years into the future. A surgeon may face exposure to potential liability for a period of ten years if he has left a foreign substance in a patient's body.

17. Trout, supra note 13. The author indicates that estimates for a 3 year "tail" policy are triple the current annual premium.
only "occurrence" insurance is available. The doctor will face the risk of claims arising from his previous practice without proper protection. As such, he will be forced to bear the cost of carrying two insurance contracts. He will need insurance for claims made during the "tail" period but arising from occurrences in his former practice, and additional insurance to protect his new practice.

If the physician’s carrier withdraws from the market, a "claims-made" policy will afford no protection to the doctor. In today’s volatile market, the possibility of an insurer leaving the market is certainly a significant risk.  

The disadvantages of "claims-made" policies have been recognized by some courts and three jurisdictions have declared these policies void as against public policy. Nonetheless, several other courts considering "claims-made" insurance have upheld its validity. Therefore, the future of these policies is uncertain. Currently none of the major carriers in Illinois are offering this type of insurance.

Group and Individual Plans

Malpractice insurance is available in group plans or on an individual basis. Generally, group plans are issued to members of a professional association, normally at a lower premium rate than individual coverage. This reduced rate is made possible by spreading the risks of professional malpractice over a large group of practitioners.

Group plans often contain additional provisions for peer review of malpractice claims, and may require such review as a condition to settlement. Frequently, group plans also furnish optional coverage

18. A potential disadvantage to the public is also present in the "claims-made" policy. If a patient is treated by a foreign doctor carrying a "claims-made" policy and if that doctor returns to his native land, the injured patient may find no defendant (or insurance policy) available to compensate him for his injuries.

19. In three of six jurisdictions in which "claims made" policies have been subject to review, the courts have found these policies void as against public policy. See Jones v. Continental Cas. Co., 123 N.J. Super. 353, 303 A.2d 91 (1973); J.G. Link & Co. v. Continental Cas. Co., 470 F.2d 1133 (9th Cir. 1972); and Langva v. Texan Ranch Homes, Inc., Civil No. 198838-1970 (NY Sup. Ct. Feb. 2, 1972). For a detailed analysis of these cases and those upholding "claims made" insurance, see Comment, The 'Claims Made' Dilemma in Professional Liability Insurance, 22 U.C.L.A. L. Rev. 925 (1975).


21. SEC'y's REPORT; supra note 6, at 514. There are, however, exceptions to this. Often the doctor in a low-risk category subsidizes the high-risk members of the group. In Illinois, the Illinois State Medical Society and the American Association of Group Practice are just two examples of the group-endorsed plans available.

22. Id. at 508.
and deductibles that are usually either unavailable or very costly in individual plans. In several states, association-endorsed or sponsored insurance plans have a participation rate of over 75 percent.³

A recent progeny of group plans is the medical malpractice insurance trust in which physician ownership is the unique characteristic. The feasibility of this form of coverage varies greatly among jurisdictions and groups.⁴ An insurance trust is a type of limited self-insurance in which member physicians, through premium payments, establish their own financial reserves or fund from which malpractice claims are paid. Both individual policies and excess coverage⁵ can be made available to trust fund members.

Insurance companies are not necessarily excluded from these trust arrangements since excess insurance and reinsurance⁶ of the trust itself can be provided by a large carrier. Furthermore, an insurance company can supply the type of expert risk management that is necessary to ensure successful and efficient operation of the trust.

THE INSURANCE CONTRACT

There are three basic components of the malpractice insurance contract: the insuring agreement, the conditions, and the exclusions. These standard provisions are surprisingly short. The insurance policy, as a contract, requires the insured to pay consideration in the form of premiums.

Although the insurance policy is a contractual commitment, the physician faces a situation in which he has little bargaining power. The insurance contract is a standardized form that offers the insured little chance of altering the scope of its coverage. It is unlikely that the doctor seeking coverage will be able to bargain for a change in the basic provisions. The courts have recognized this disparity of

³ Id. at 510.
⁴ Gray, Florida's Medical Malpractice Insurance Trusts, 42 INS. CNSL. J., July 1975, at 399. This article notes that under Florida law these plans can be established, but only under rules and regulations promulgated by the state insurance department. Therefore, when considering this form of operation it is necessary to consult the state department of insurance regarding the legality of this type of organization. In Illinois, the state Insurance Code, ILL. REV. STAT. ch. 73, §§ 1 et seq., should also be examined.
⁵ The term “excess coverage” refers to a policy covering the doctor for an amount in excess of his normal malpractice policy. If the doctor is carrying an insurance policy with $100,000 worth of protection, excess insurance can be obtained from an excess carrier for liability above the $100,000 amount. If the doctor suffers a $101,000 loss, the excess insurance would only pay $1,000.
⁶ “Reinsurance” is the insuring of an insurance trust fund’s “loss reserves” fund. Since payments to the trust’s insureds are to be made out of the loss reserve fund, reinsurance is purchased to indemnify the fund if it pays a loss.
bargaining power between the parties, and at least one court has termed the insurance contract one of adhesion.\footnote{Gray v. Zurich Ins. Co., 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966).}

**Insuring Agreement**

The “heart” of the professional liability policy is the insuring agreement. This section delineates the dollar amount of coverage, the period for which the insured is protected, and the types of acts covered by the policy. In any analysis or comparison of malpractice insurance policies, these items should be threshold points of consideration for a prospective insured.

The standard policy affords coverage for “malpractice, omissions or errors” of the insured in the practice of his profession.\footnote{A variation of this coverage is the language employed in a sample policy of the Medical Protective Company which extends coverage “[i]n any claim for damages . . . . based on professional services rendered or which should have been rendered in the practice of the insured’s profession.”} In other words, the insurer agrees to pay damages incurred by the physician as a result of his malpractice in rendering or failing to render professional services. Additionally, the company contracts to defend the insured in any suit claiming such injury. Because the policy, by its language, covers “errors and omissions” of the insured, in addition to “malpractice,” the courts have construed professional liability insurance policies to protect the insured from more than merely malpractice. Malpractice is the failure of the one charged to exercise the diligence, care and skill ordinarily possessed by the members of his profession.\footnote{Burns v. American Cas. Co., 127 Cal. App. 2d 198, 273 P.2d 605 (1954).} The words “errors and omissions” cover negligent acts of the insured not necessarily related to medical skill, but still within the scope of his professional practice. Malpractice insurance, therefore, covers the physician for all negligence relating to his professional practice.

Thus, the coverage is not limited to particular types of injury. In addition to bodily injury, the policy’s coverage may include property damage, invasion of privacy, undue familiarity, and mental anguish. To fall within the policy limits, however, an injury must arise out of the insured’s practice of his profession.\footnote{An example of a case which did not arise from an insured’s practice of his medical profession is Crenshaw v. United States Fid. & Guar. Co., 193 S.W.2d 343 (Mo. App. 1946), where it was found that the malpractice insurance held by the physician did not cover a claim arising from an unlawful autopsy performed by the insured when acting as county coroner. Injuries resulting from equipment used by the physician are a frequent source of litigation. For example, where a patient being treated by a podiatrist was thrown out of a hydraulic chair which the physician had failed to lock, the court in American Policyholders Ins. Co. v. Michota, 156 Ohio St. 578, 103 N.E.2d 817 (1952), found this injury to be a covered risk.}
Generally, coverage is not exclusively limited to claims made by patients; there is no requirement in a policy that the person to whom the liability for damages runs be the same person directly injured by the malpractice. The insurance covers all persons who suffer injury that is proximately caused by the malpractice or negligence of the insured. For example, in *Squire v. Hayes,* the physician's insurance contract, which provided coverage for any injury arising from medical negligence, was construed by a Michigan court to cover the defendant physician's liability to an injured patient's husband. The court held that the term "injury" in the policy covered the mental and economic injury sustained by a husband arising from the doctor's improper treatment of his wife.

Another provision included in the insuring agreement is the period which the policy covers. Most medical malpractice policies specify a one-year period. Disputes involving the period of protection usually involve continuous treatment performed by the healthcare provider both prior to and after the effective date of coverage. Usually, where treatment is given both before and after the effective date of the policy, the carrier is liable under the contract only for injury arising from the latter treatment. The simple rule applied here by the courts is that the insurer is liable only for malpractice that occurs within the period of coverage.

court found that the physician owed a duty to his patients to maintain his equipment in safe condition. His failure to do so was "negligence, error or omission" within the meaning of the policy, and the resulting injury arose from the practice of the podistrist's profession. See also *Harris v. Fireman's Fund Indem. Co.*, 42 Wash. 2d 655, 257 P.2d 221 (1953) (malpractice policy of the insured covered an injury suffered by a patient when a doctor's treatment table collapsed).

34. See p. 461 supra for discussion of the difference between "claims made" and "occurrence" policies.

The duration of coverage is sometimes found in the conditions section of the policy rather than in the insuring agreement.

35. For example, in *Shaw v. United States Fidelity & Guar. Co.*, 101 F.2d 92 (3d Cir. 1938), a series of 55 treatments was administered to the patient by the doctor before inception of the insurance contract. After the effective date of the policy an additional 14 treatments occurred. The insurer denied coverage when the patient sued the doctor for malpractice. In the insured's action against the insurance company for breach of contract, the court found the company liable under the contract. The court held that if the evidence is reasonably susceptible to the inference that the last 14 treatments caused the injuries because of their added effect, or that the injury occurred during those treatments, the insurance company was bound to defend and indemnify the insured.

36. *Aetna Life Ins. Co. v. Maxwell*, 89 F.2d 988 (4th Cir. 1937); *In Waterman v. Fidelity & Cas. Co.*, 209 Ill. App. 284 (1917), the court held the insurance contract obligated the insurer to pay insured's costs of litigation.
The insuring agreement also contains the dollar amount of coverage afforded by the policy, although this provision may appear instead in the conditions section. The amount of coverage is usually denoted in a split-figure form. For example, a common amount of coverage today in an individual contract is $100,000/$300,000. The $100,000 figure denotes coverage per occurrence. The $300,000 figure represents the aggregate or total liability of the company during the policy period. This amount is subject to the $100,000 limit for each occurrence. The proper amount of coverage for a physician is dependent on a number of factors, including his specialty of practice, geographic location, history of previous claims, and such demographics as the type of community where the doctor resides.

There are several ways by which a physician can increase the dollar amount of his coverage. For instance, he may consider purchasing insurance with larger maximum amounts both per occurrence and in the aggregate. In fact, several carriers require policies in excess of the $100,000/$300,000 amount for practitioners in certain specialties. A physician may also procure excess coverage by purchasing a liability "floater" or rider to his policy. This will provide excess coverage for a duration less than the policy period. However, availability of this type of excess coverage is somewhat doubtful in today's squeeze. Another avenue by which to increase coverage is for the insured to purchase a policy with an "excess insurance carrier." This typically occurs where an agent is limited by the insurer in the monetary amount of coverage he can write in the basic policy. Again, the problem of availability is acute for this additional coverage. The most common way to procure excess coverage is to obtain its inclusion in an umbrella policy. This comprehensive liability insurance combines coverage for several kinds of risks at a premium rate that is often less expensive than purchasing individual policies covering these risks. An umbrella policy protects a physician from personal and premises liability claims as well as from claims relating to his practice of medicine.

A final method through which the physician can expand coverage is to buy two or more malpractice insurance policies, each from different carriers. Individual policies, however, normally provide in the conditions section that the carrier will only indemnify the in-

37. SEC's REPORT, supra note 6, at 505.
38. The per occurrence amount, rather than the aggregate, applies when there has been continuous treatment over several years. Such treatment gives rise to one cause of action. See Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1968). See also Ravenswood Hosp. v. Maryland Cas. Co., 280 Ill. 103, 117 N.E. 485 (1917).
39. SEC's REPORT, supra note 6, at 505.
40. Id. at 506.
sured in an amount that represents the percentage of the total malpractice insurance coverage carried by the insured. For example, if a physician carrying two policies of $100,000/$300,000, each from a different insurer, becomes liable for $50,000, then each company need only indemnify the insured for $25,000.

A final caveat is that an imprudent decision regarding a proper amount of insurance coverage exposes the doctor to the grave risk of being underinsured. In the period from 1974 to 1975 the number of medical professional negligence claims increased an estimated 57% in Illinois. In Chicago, until 1974, there had never been a judgment against a doctor that exceeded $250,000. However, during the past two years, two verdicts of $1 million-plus amounts, and one verdict for $2.5 million have been returned. In light of this trend, the careful doctor should constantly reassess the amount of his coverage.

The decision as to the amount of coverage that is necessary for today's physician may be affected in Illinois by the recently enacted medical malpractice legislation. The amendatory act establishes a $500,000 maximum on the amount of recovery in a suit alleging medical malpractice. The fixing of a maximum amount of recovery faces some major constitutional challenges. Until a determination of the constitutionality of these provisions is made, the doctor should be hesitant to rely on any maximum figure on recovery amount as affecting either a reduction of policy rates or a need for a lesser amount of insurance protection.

Insurance protection for the acts of the doctor's employees or assistants is another component of coverage afforded the insured. However, the insurance coverage in this area is not as broad as the potential liability of the physician. The doctor is generally liable for the acts of aides under the doctrine of respondeat superior when the acts are performed within the scope of the assistant's authority. An insurance agreement generally offers protection to the doctor for the acts of these agents only when the assistant performs services normally done by the insured physician or acts under the supervision of the insured.

42. Malpractice in Focus, supra note 4, at 12. The information was based on a survey of state medical associations in June, 1975.
43. Id. at 14.
46. Three of these provisions, including the $500,000 limit on judgments in suits alleging malpractice, were outlawed on constitutional grounds in a recent ruling by a Circuit Court of Cook County judge. Chicago Daily Law Bulletin, Sec. 3, 1975, at 1, col. 6.
47. For example, in Sevy v. Georgia Life Ins. Co., 132 Tenn. 673, 179 S.W. 312 (1915),
The insurer will not be obligated to indemnify or defend the insured against claims arising from the unauthorized acts of his agents. Furthermore, an assistant must be licensed in order for the insured to be covered for the aide's activities. Also, malpractice policies usually contain a proviso excepting from coverage any employee who is a physician or dentist, unless the employee is covered by a separate policy from the same company.

There is a growing use in medicine of assistants and para-medical personnel, therefore, it is important for the practitioner to be aware of the limitations in his insurance policy regarding the acts of aides. A physician who employs medical assistants increases his exposure to malpractice claims. He must exercise great care in defining the scope of his agents' duties and he should diligently supervise their activities.

**Exclusions**

A separate component of the malpractice insurance policy is the exclusion section, which limits the coverage afforded by the insurance agreement. The exclusion provisions enumerate both general and specific acts to which the policy does not apply.

Some common examples of general exceptions are provisions excluding from coverage liability of the insured arising from special contracts or guaranteed result agreements, from unlawful or criminal acts and from the effects of X-ray equipment used in therapy. The special exceptions vary according to the physician's specialty of practice, and the forms of treatment administered in his professional service.

the physician's assistant acted under general instructions and within the usual scope of his employment, but without the doctor's supervision. The court held the physician's insurer was not liable for injuries caused by the acts of the employee. The court held that the subordinate was unknown to the insurer; by the contract the insurer only undertook liability for assistants when they acted with the advice and supervision of the assured. See also O'Neil v. Glens Falls Indem. Co., 310 F.2d 165 (8th Cir. 1962).

50. Other common exceptions include the exclusion from coverage of partnership liability of the insured, liability for the acts of unauthorized or unlicensed employees of the insured, liability stemming from any business, hospital or clinic ownership or operation of the insured; any liability covered under a workmen's compensation, auto or fire insurance policy, and injury caused when the insured or his assistants act under the influence of intoxicants or narcotics.

Where the treatment by the physician exceeds the normal activity in his professional service, the insurer may properly deny insurance protection by reason of an exclusionary clause. Thus, in Kime v. Aetna Cas. & Sur. Co., 66 Ohio App. 277, 33 N.E.2d 1008 (1940), a malpractice claim resulting from an optometrist's improper removal of dirt from a patient's eye was held to be outside the usual practice of optometry. The insurer was not bound to defend the insured.
In an effort to avoid the harshness of a result that would leave the insured without the benefits of his policy, the courts will strictly construe the scope and effect of an exclusion provision. As a result, if the acts of the doctor seemingly fall into one of the enumerated exceptions of the policy, the courts will carefully consider these acts to ascertain whether they can be viewed in a way that is less culpable than one of the excluded acts. If such construction is possible, the insurer will be obligated to indemnify and defend the insured.

The exclusion of separate contracts guaranteeing results can pose problems for the physician. The duty of disclosure imposed on doctors may compound the problem. When the doctor knows that a hesitant patient needs a form of treatment, he may feel professionally or morally obligated to advise the patient to accept the treatment. A patient may view an overly-optimistic prognosis as a guarantee of a particular result. A legal safeguard provided in this situation is that the burden of proving the existence of a separate contract or guarantee is on the claiming party. In the absence of a special contract, the physician does not warrant a particular result by merely agreeing to treat a patient.

If a patient is successful in establishing the existence of a contractual guarantee, the physician may find himself faced with a liability specifically excluded by the insurance contract. The consequences of such a finding can be devastating to the physician. The insurance problem for the doctor arises from the fact that the carrier is not bound to defend or indemnify these actions. The legal consequence is that the party claiming injury need not prove the doctor's failure to exercise the requisite degree of skill, as would be the case in a malpractice claim. Instead, in an action based on contractual commitment, the issue is whether the doctor has breached his contractual obligation to the patient by failing to bring about a promised result.

Several courts have significantly narrowed the scope of the guar-
anteded result exclusion. These courts have recognized that malpractice actions may sound in both tort and contract. Consequently, when the insurance agreement covers claims arising from "malpractice, errors or omissions" made in the practice of the insured's profession, the physician's promise to cure, held by these courts to be within the scope of his professional practice, is thus within the coverage provision of the policy.

The exclusion from coverage of unlawful or criminal acts has generated a great deal of litigation. The issue here is often one of interpretation of contractual terminology. For example, allegations of battery are frequently employed by injured plaintiffs in formulating their claims. These forms of misfeasance carry both tortious and criminal connotations. As a result, the insurer may attempt to refuse coverage as being excluded by the criminal act provisions. The physician, however, will contend that these terms are within the protection afforded by the contractual language covering "malpractice, errors or omissions." In construing the policy's terms in a light most favorable to the insured, the exclusion of criminal acts from coverage has been read as excluding the insured's acts amounting to malfeasance, but to provide coverage where the doctor's acts have only been misfeasance.

Besides battery, other unlawful conduct has fallen within a liberal construction of coverage for malpractice, errors or omissions. For example, false imprisonment, libel and slander have been found

55. See, e.g., Kozan v. Comstock, 270 F.2d 839 (5th Cir. 1959); Manning v. Serrano, 97 So. 2d 688 (1957). See also Sutherland v. Fidelity & Cas. Co. of N.Y., 130 Wash. 583, 175 P. 187 (1918), where the court concluded that the insured's contract with the patient to remove all gallstones was made within the practice of the insured's profession. As such, the special contract was deemed to have been covered by the physician's insurance policy.

56. Actions based on charges of battery usually involve a claim that the physician operated without proper consent or beyond the consent given by the patient. See, e.g., Church v. Adler, 350 Ill. App. 471, 113 N.E.2d 327 (1953); Moos v. United States, 118 F. Supp. 275 (D. Minn. 1954). In Shehee v. Aetna Cas. & Sur. Co., 122 F. Supp. 1 (W.D. La. 1954), the failure of the insured to obtain consent before an operation did not constitute battery as that term was intended in the exclusionary clause of the contract of insurance. The court concluded that the coverage afforded the insured for claims stemming from "malpractice" was intended to protect the insured from lack of consent claims. Also, the mere allegation of battery by the insured does not justify the insurer's refusal to defend. Sommer v. New Amsterdam Cas. Co., 171 F. Supp. 84 (E.D. Mo. 1959).


58. See Big Town Nursing Home, Inc. v. Reserve Ins. Co., 492 F.2d 523 (5th Cir. 1974), where false imprisonment of the patient in the form of hospitalization against his will was covered by the insurance policy. The court held that the exclusion of criminal acts did not envision false imprisonment. See also Thoresen v. Roth, 351 F.2d 573 (7th Cir. 1965) (applying Illinois law).

59. See Geddes v. Tri-State Ins. Co., 264 Cal. App. 2d 181, 70 Cal. Rptr. 183 (1968). The Geddes court held that allegedly slanderous statements made by insured were within the
not to be excluded from coverage by the exclusions sections of the malpractice insurance contract.

Conditions

The conditions section of the insurance contract usually includes provisions concerning the duty of the insured to notify the insurer and to cooperate in the defense of any claim; cancellation procedures and nonassignability of the policy; the rights and duties of the parties in the settlement of any claim; apportionment provisions regarding other insurance; the right of the insured to recover a loss and maintain actions against the carrier; and the qualifications of the insured to practice under the laws of his state and profession. The amounts of coverage and the policy period may also appear in this section, as may provisions concerning waivers, deductibles, special exceptions and endorsements.

A most important section of the policy concerns the conditions and procedures regarding the filing, notification and defense of a claim. One component of these conditions is known as a "reservation of rights" or "non-waiver" agreement. This agreement allows the insurer to conditionally defend a claim against the insured, which it contends is outside the policy's coverage, without waiving its rights under the policy. The effect of this reservation is that the company can protect itself from a potential breach of contract suit by the physician, and at the same time investigate the validity of the claim under the insurance policy. By conditionally defending the insured, if a claim is later found to be outside the policy's coverage, the company maintains the right to disclaim liability. Additionally, in a breach of contract suit by the insured, the insurer will not be estopped from asserting its contractual defenses.

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60. The condition requiring the insured to be a qualified practitioner is a material provision of the contract. For example, in U.S. Fid. & Guar. Co. v. Fridrich, 123 N.J. Eq. 437, 198 A. 378 (1938), the insurer was allowed to cancel a malpractice policy because the insured had represented that he was a member of a state dental society, when he was not in good membership standing.


The requirement that the insured give notice to the insurer of a claim against him is closely related to the duty to cooperate. It imposes a contractual obligation upon the insured to immediately notify the company or its agent, and also mandates that the insured forward all papers relating to the claim. Finally, the insurer's duty to defend the insured is expressly conditioned on receipt of this notice. The question of the adequacy of the notice is generally one of reasonableness under the circumstances, which, as a question of fact, is to be decided by the trier of fact.

The notice requirement is generally construed liberally in favor of the insured. For example, in *Big Town Nursing Home, Inc. v. Reserve Ins. Co.*, the insured was held not to have breached the notice condition when it filed a false report with the carrier. The insured, however, did not knowingly falsify the report, nor had the insurer relied upon the false statements. The court stated that since the falsification resulted in no injury to the carrier, the report, although inaccurate, sufficiently notified the insurer of a potential claim against its insured.

The condition requiring the insured's cooperation in the investigation, preparation and defense of a claim also places a contractual duty on the insured. This duty includes attendance and assistance at any trial of a malpractice claim. The insured cannot condition his cooperation on the insurer's acceptance of his terms of settle-

against the insurer also applies to actions by the insurer that might cause the insured to justifiably rely on the insurer and materially alter his position. In *Kenilworth Ins. Co. v. McDougal*, 20 Ill. App. 3d 615, 313 N.E.2d 673 (1974), the court indicated that strong proof is not required to show a waiver by the insurer of a policy defense. The insured need only prove such facts as would make it unjust, inequitable or unconscionable to allow the defense to be interposed. Regardless of the stage of the proceedings, an insurer may waive its right to assert nonliability if its action has prejudiced the insured.

66. 492 F.2d 523 (5th Cir. 1974).
67. For example, a sample policy of the Medical Protective Company provides:
   The Insured shall at all times fully co-operate with the Company in any claim hereunder and shall attend and assist in the preparation and trial of any such claim without cost to the Company.
   Judge Cardozo summarized the duty of the insured to cooperate with the insurer as requiring a "fair and frank disclosure of information reasonably demanded by the insurer to enable it to determine whether there is a genuine defense." *Coleman v. New Amsterdam Cas. Co.*, 247 N.Y. 271, 273, 160 N.E. 367, 369 (1928).
68. Many insurance policies do not offer compensation to the insured for time spent fulfilling this duty, although a rider or extension may be used to extend this coverage. However, in *Medical Protective Co. v. Light*, 48 Ohio App. 508, 194 N.E. 446 (1934), an insurer was required to pay the insured's transportation costs from Texas to an Ohio trial site, but the insurer was not obligated to pay the insured a professional charge for his service as a witness.
The duty is contractual, and if the insured breaches the contract by failure to perform the duty, the insurer will be justified in electing to cancel the insurance policy. The burden, however, is on the insurer in proving a breach of the cooperation clause.70

Under the condition requiring cooperation, if the insured admits or assumes any liability or consents to any settlement without the prior approval of the company, the company is not liable to the insured.71 This independent action amounts to a breach of the clause and the insured must bear the cost of any such agreement or release without contribution from the insurer.

The provisions of the insurance contract require the insurer to defend the insured. Most policies provide that the carrier will assume its responsibility for the defense immediately upon receipt of notice of a claim. This provision also requires the insurer to retain legal counsel for the physician. Counsel is expected to defend in conjunction with the carrier’s legal department. The provisions regarding defense also mandate that the case be appealed until all remedies are exhausted. The cost of this process, including the furnishing of a bond required to appeal a judgment, is to be borne by the insurer. There is generally no limit in the policy as to the amount of money the insurer will expend in defense of a suit. However, if the bond required for appeal of a judgment is in excess of policy limits, the carrier will only provide the pro rata share necessary to secure the appeal. In the conditions section, the insurer will sometimes agree to defend the physician against claims which are outside the coverage of the malpractice policy.

The conditions regarding defense and settlement of a claim pose an area of potential conflict between competing interests of the insured and the insurer. After the physician notifies the carrier of a claim, the carrier will begin an investigation. The information gained from this inquiry will be used by the company to determine

70. In Chertock v. Santangelo, 6 Ill. App. 3d 201, 285 N.E.2d 209 (1972), the court held that not only must the insurer prove the insured’s breach, but the carrier must also establish that it exercised a reasonable degree of diligence in seeking the insured’s attendance at trial and that his failure to appear was due to a refusal to cooperate.
71. A sample policy of the Medical Protective Company states:
   The Insured shall not make or contract any expense in a claim hereunder nor voluntarily assume any liability nor make or contract any settlement thereof, except at his own cost, without the written authorization of the Company.
72. This is of special concern to those health-care providers who have adopted a policy of “waiving” an injured patient’s bills in exchange for his agreement not to press claim. This practice is dangerous in two respects. Not only does it amount to a breach of the cooperation clause allowing the insured to not indemnify, but it may act as an estoppel or admission of liability, if the patient decides later to sue.
the validity and disposal value of the claim. It is at this point that the potential conflict of interests may occur.

The insurance company’s interest will be one of cost. The carrier will contrast the relative costs of settlement with those of defense and trial to determine the most economical way to dispose of a reported claim. If the insurer’s approach is strictly a cost/benefit analysis, the carrier may find that the expense of defending the doctor from a seemingly unmeritorious charge may be far greater than settling the dispute for a nominal amount.

The doctor, while sharing a pecuniary interest with the company, will also be legitimately concerned with his professional reputation. When a doctor views a claim as unmeritorious, he will press the insurer not to settle the claim. Since malpractice policies usually include a condition that the insured consent to any settlement, the physician has some leverage in this regard.

From the physician’s standpoint, the policy’s settlement provision may be the most crucial. In the contract, the insured has bartered away the right to conduct his own defense. However, the settlement provision should, and most often does, give the insured a voice in the decision of whether to settle. A provision requiring the consent of the insured to any settlement offer is a necessity.

If a doctor refused a settlement offer that is within policy limits, he may expose himself to liability in several ways. If a judgment in excess of the policy limits results, the physician will be liable for the excess amount. If the judgment is within policy limits, the assured may still face an action by the insurer claiming breach of contract in the doctor’s failure to cooperate with the company. This is especially true if the insurer views the doctor’s refusal as unfounded or capricious.

The insurer’s duty in settlement negotiations results from its obligation to defend. Should a refusal by the carrier of a settlement within policy limits result in a judgment in excess of the liability amounts, the insurer may be liable for the entire judgment. The rationale for this outcome is that the insured has contracted away the right to conduct his own defense and relies on the insurer to

74. SEC’Y’s REPORT, supra note 6, at 508.
conduct an adequate defense. The company owes a duty of "paramount allegiance" to the insured. Therefore, where the possibility of a judgment in excess of policy limits exists, the company's duty to the insured is to consider his interests at least equally with its own. Where the insurer rejects a settlement within limits and a judgment occurs beyond the policy's coverage, the company will be liable for the entire judgment if it has acted in bad faith, or negligently, in refusing to settle.

While courts generally look to the bad faith or negligence of the insurer in assessing the costs of a judgment in excess of policy limits, the California Supreme Court in Crisci v. Security Insurance Company of New Haven, Conn., significantly expanded the duty of the insurer in settlement negotiations. The court imposed an almost absolute duty to settle within policy limits if the possibility of an excess judgment exists and the insured has consented to the settlement offer. Rather than a bad faith or negligence standard, the court articulated the proper test to be whether a prudent insurer without policy limits would have accepted the settlement offer. In Crisci, the insurer had refused a settlement of $9,000. The insured's policy was for $10,000 and the insured had consented to settlement. The case went to trial and resulted in a $100,000 judgment for the claimant. The court held that the insurer was obligated to pay the insured's entire loss.

The California Appellate court in Lysick v. Walcom held that the insured's attorney was also under a duty to act in good faith in settlement negotiations. The insured in that case had suffered a judgment in excess of policy limits when the attorney had waited more than a year after the insured's authorization to offer the policy limits.

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76. See American Mut. Liab. Ins. Co. of Boston, Mass. v. Cooper, 61 F.2d 446 (5th Cir. 1932).
limit in settlement.

Counsel representing both the insured and insurer is in a precarious position when their interests conflict. The suggestion has been made that counsel owes the insured a duty paramount to that owed the company. However, when the interests of the doctor and the carrier conflict, the insured's best recourse may be to seek independent counsel. If the retention of a separate lawyer is deemed necessary by the insured, the insurer may refuse to pay the expense of his services on the basis of the cooperation clause of the policy. One court, however, felt that the retention of counsel by the insured resulted in a benefit to the insurer and the carrier was therefore obligated to pay the attorney's fees. In light of the decisions imposing an almost absolute duty on the carrier to settle within policy limits where a possibility of an excess judgment exists and the insured has authorized settlement, the insurer's duty of good faith may obligate the carrier to bear the cost of the doctor's independent counsel. This is especially true where the physician's and company's interests conflict.

The insurer's obligation to the insured in settlement negotiations may not only include informing the insured of the possibility of a settlement in a figure beyond the policy limits, but may also require the carrier to advise the insured to contribute to the excess settlement amount. By recommending contribution from the insured, the carrier discharges its obligation to give the insured's interest paramount consideration. This position was taken by a federal court in Brockstein v. Nationwide Mutual Ins. Co., where the company failed to inform the insured of an excess settlement possibility, with only limited contribution necessary from the insured. The court reversed the finding of a lower court that the insurer had not acted in bad faith, and remanded the case for a determination of what information the insureds had received and whether they were willing to contribute to excess settlement.

The condition in many group policies requiring peer review of claims complicates the company's duty to the physician in settlement resolutions. For example, in Garner v. American Mutual Liability Ins., a California court found the insurer guilty of breach of contract for not giving full consideration to the insured's request to settle. The defendant company had a policy of refusing settlement where a peer review board found no malpractice, and the insured's

83. See Corboy, Can Two Masters Be Served, supra note 77.
85. 417 F.2d 703 (2d Cir. 1969).
request for settlement was refused after such a finding. In other words, this decision imposes a duty upon the insurer to evaluate a claim independently of any peer review. This view presents obvious problems for malpractice carriers. Similar difficulties may arise as a result of recent amendments to the Illinois Civil Practice Act requiring a determination by a medical injury review panel of the validity of all malpractice claims. This panel consists of three members: one circuit court judge, a practicing physician and one practicing attorney. When a cause of action is filed alleging injury from medical malpractice, the court will order the panel convened. The panel, acting as a judicial body, will hear and consider evidence to determine the merits of the claim. Its decision is not binding unless the parties so agree. Nor are its findings admissible in court if the case proceeds to trial. However, the effect of the panel and its decision on the duties of the insurer and the insured in settlement may be critical.

According to the view taken in Garner, the insurer has a duty of independent evaluation of the claim. If the Garner approach is adopted in Illinois, the insurer must make an independent good faith evaluation of the claim regardless of the findings on the question of malpractice by the medical review panel. However, assuming that Garner is not the law in Illinois, the existence of a review panel will still have an effect on claim settlements. Effective operation of the pre-trial panel may encourage the number of pre-trial settlements. Also, if the panel's decision is afforded great weight by the courts, the insurer's duty of evaluation may be limited. The carrier, in that case, need only rely on the determination of the panel in deciding whether or not settlement is appropriate.

Until a determination is made by the Illinois courts regarding the Garner decision and the authority of the medical review panel's evaluation, the duty of the insurer to the insured in the settlement decision will be confused. Regardless of the outcome, the voice of the doctor in a question of settlement may be diminished in favor of an evaluation by either the carrier or a state quasi-judicial board. Another condition usually contained in medical malpractice insurance concerns cancellation. Either party, generally upon written notice, can terminate the contract. Notice must be given within a period established by the policy. The availability crisis in the medical malpractice insurance market has prompted several states, including Illinois, to substantially limit the carrier's right to cancel or

87. Pub. Act No. 79-960 (Sept. 12, 1975). This provision was recently declared unconstitutional in its infringement upon judicial functions. See note 46 supra.
to raise rates. Some group policies also require that an insurer's request to cancel be submitted to a review panel for its determination.

Disputes in Coverage

As noted previously, the bulk of the cases concerning medical malpractice insurance involve disputed coverage: the insured claims that a particular form of injury is within the insuring agreement; the carrier asserts that the particular risk was excepted from coverage. The coverage of questionable items by a particular insurer is often dependent upon the underwriting intent or business philosophy of the company rather than upon strict construction of the policy obligations. This is because insurance, as a business, involves more than legal considerations. Because of this business factor, the construction of the insurance contract by the carrier may be less strict than one based upon wholly legal considerations.

When coverage of a claim is disputed, the physician has several options. He can accept the carrier's viewpoint and proceed to defend himself on his own. If a doctor chooses this alternative, he runs the risk of incurring personal liability. However, the insured may subsequently bring suit against the insurer for breach of the insurance contract. If successful, the doctor will then be indemnified for the amount of liability incurred and the cost of defending the suit, as well as for any other damages arising out of the breach by the carrier. It should be noted, however, that it may not be necessary for the physician to defend himself since the insurer can defend him without waiving its right to disclaim coverage.

To avoid the risk of personal liability by defending a suit without the aid of the insurer, the insured may seek judicial resolution of

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88. Recent legislation in Illinois requires insurance companies to receive approval of the state Director of Insurance before any increase in malpractice insurance rates in effect on June 10, 1975 is implemented. Pub. Act No. 79-960 § 401a (Sept. 12, 1975). This section was recently declared unconstitutional by a Circuit Court of Cook County judge. See note 46 supra.

89. SEC’Y's REPORT, supra note 6, at 508.

90. See Hirsh, Insuring Against Medical Professional Liability, supra note 8, where a set of hypothetical disputed coverage cases was sent as a survey to a sample of insurance carriers. Each company was asked to determine whether their insurance contract would afford coverage to an insured doctor in each hypothetical case. A disparity of answers, reflecting a great deal more than legal analysis of the question was revealed.

91. Certainly the first consideration of the insured should be to obtain competent legal counsel. The general alternatives listed here are intended only to familiarize the reader with possible modes of legal relief.

92. See p. 472 supra for discussion of waivers and reservation of rights available to the carrier.

93. See notes 68 through 71 supra and accompanying text.
the disputed coverage controversy prior to defending the malpractice claim. In an action for declaratory judgment, the rights of the parties under the contract can be determined by a court. Furthermore, it is possible to obtain an order staying proceedings in the malpractice case, pending the court's ruling in the declaratory judgment action.

Most professional malpractice insurance contracts provide that the insurer will defend, but not indemnify, the insured physician against certain specified actions which are admittedly outside the coverage of the policy. In disputed coverage matters, courts will look to the complaint of the injured party to determine if facts are alleged which potentially bring the suit within the area of coverage. In looking to the complaint, the facts alleged will be examined to determine if the insurer's duty to defend arises. If the pleadings give the insurer notice of a claim potentially within the insured's coverage, the carrier will be bound to defend. Unless the complaint alleges only facts which, if true, will exclude coverage, potentiality of coverage is asserted and the duty of the carrier is to defend.

**NEW ILLINOIS MEDICAL MALPRACTICE LEGISLATION**

On September 12, 1975 the State of Illinois enacted legislation significantly altering Illinois law regarding medical malpractice insurance and claims. Two Acts, originating as House Bill 1968 and Senate Bill 1024, add Article XXXVI to the Illinois Insurance Code, and amend the Illinois Civil Practice Act and the statute of limitations for medical malpractice injuries. The legislation is in direct response to the current crisis in medical malpractice insurance. The amendments are designed to provide immediate remedial effects, as well as to preserve the status quo pending further study of the current situation. Immediate changes which will affect malpractice insurance include the altering of the statute of limitations for medical injury claims, the fixing of a maximum recovery amount

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95. For example, while criminal acts of the insured physician are specifically excluded from protection by the policy, the Medical Protective Company's sample policy states it will defend the insured against allegations of criminal misconduct.
97. See State Farm Fire & Cas. Co. v. First Nat'l. Bank of Pekin, 2 Ill. App. 3d 768, 277 N.E.2d 536 (1972), (although the court considered a general liability policy, the rationale extends to malpractice insurance as a form of liability insurance).
and the establishment of medical injury review panels.\textsuperscript{103}

The addition of section 1013a to the Illinois Insurance Code is an important provision for the physician as a malpractice insurance consumer. Under this section, a carrier cannot refuse to renew any existing malpractice insurance policy at rates in effect on June 10, 1975, unless the company has obtained prior approval from the Director of Insurance. This approval is impossible unless the carrier has provided financial evidence to the Director justifying an increase. Final approval of any raise of rates or non-renewal cannot occur until the Director has held public hearings on the matter. While the practical problems of implementing this procedure may be great,\textsuperscript{104} the holding of public hearings gives the doctor a greater voice and leverage in his dealings with insurance carriers.

The addition of Article XXXVI to the Insurance Code is designed to allow study of the crisis in medical malpractice insurance and to guarantee availability of medical malpractice insurance in Illinois through a joint underwriting association. The article creates a Medical Injury Insurance Reparations Commission which is charged with the responsibility of developing a comprehensive medical injury reparations system to provide prompt and equitable compensation to victims of medical injury at a reasonable cost.

The commission is composed of the state Directors of Insurance and Public Health, three members of the Senate and three of the House of Representatives, and twelve members appointed by the governor. These latter twelve members must include health-care providers, insurance industry representatives, and members of the general public, as designated by the Article.

It is the commission's duty to formulate a medical injury compensation plan.\textsuperscript{105} Primary consideration is to be given to establishing an insurance reparation system underwritten by private insurers on a self-supporting basis. This commitment to private insurance underwriting signifies a continuing policy of the state to avoid direct subsidization of the insurance industry.

\textsuperscript{103} See note 46 \textit{supra}. The addition of § 58.2 to the Civil Practice Act bans the use of release agreements in Illinois as a condition precedent to receiving medical treatment. Release agreements used by doctors to exculpate liability are declared void as against public policy of the state if they are used as a condition to a patient receiving treatment. Pub. Act. No. 79-960, § 58.2 (Sept. 12, 1975). According to a statement by Governor Walker, this section is designed to protect patients' rights in the state. "News From the Office of the Governor", September 12, 1975 (copy on file in Loyola Law Journal Office).

\textsuperscript{104} See note 46 \textit{supra}. These problems were noted by Governor Walker in his release to the press when he signed the two bills into law. "News From The Office Of The Governor", September 12, 1975 (copy on file in Loyola Law Journal Office).

\textsuperscript{105} The new law charges the Commission with the duty to present its plan to the Governor and General Assembly on or before January 1, 1976. Pub. Act No. 79-962, § 654 (Sept. 12, 1975).
The commission is authorized to consider and recommend fundamental changes in state law and policy concerning medical injury. The statute suggests that the commission's plan may include provisions for: a) reducing the incidence of medical injuries through the establishment of standards of care and peer review procedures; b) reducing the costs of administration and processing of claims; c) altering existing law governing the eligibility of the injured party for compensation, including the amount of compensation, the statute of limitations, and the elements of loss for which compensation may be recovered; d) compensation upon other than the traditional fault or tort system.106

In light of the current crisis in medical malpractice insurance, some may question the creation of a commission to study the problem, rather than some affirmative and immediate action. However, the complexity of the problem makes detailed review a necessity. The entire legal system of compensation for medical injury will come under scrutiny in an effort to generate a feasible and efficient insurance reparation system. The creation of the temporary joint underwriting association gives the commission time to give full consideration to the alternative solutions available.

The underwriting association is a temporary unincorporated, not-for-profit entity. Its purpose will be to preserve the status quo in the medical malpractice insurance market by guaranteeing that this insurance will be available during a two-year period while the commission formulates its plan. Eleven directors, selected from the insurance and medical professions, will administer the association. The association and its reserve fund will be financed by an assessment on insurance carriers which write all forms of liability and casualty insurance authorized by the Insurance Code.107

During its two-year tenure, the association is to underwrite medical malpractice insurance in Illinois if the Director of Insurance determines that the private voluntary market cannot provide sufficient insurance. To the extent that the association is not able to provide adequate insurance availability from the initial funding, the company-members of the association are to share its net losses from operations. Both the initial assessment and allocation of losses among the carriers will be based on the percentage of the insurance market each carrier serves.

The Illinois legislation provides immediate remedies to the insurance crisis and lays the groundwork for future revisions. While the effectiveness of the various provisions remains to be seen, the Illinois legislature has taken a measured step in the right direction.
CONCLUSION

Today's situation makes medical malpractice insurance a requisite for the health-care provider. The need for the insured and insurer to work together for improvements in the health care and insurance system is apparent. Through a combination of preventative law and medicine, the physician can minimize the probability of suffering a crushing personal judgment. With more effective loss-prevention techniques, the insurer may also optimize the efficiency of the insurance system. The Bar, medical societies and insurance industry all have parts to play in generating workable solutions to the present crisis. But even after these changes occur, the medical malpractice insurance consumer will need to know what his premium dollar is purchasing.

By carefully examining the insurance contract and utilizing the insurance alternatives available to him, the physician will be able to minimize the certain risks inherent in the practice of even the diligent physician.

JAY J. PRICE