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Professional Liability Insurance and Psychiatric Malpractice

American Psychiatric Association

Task Force Reports

This is the thirteenth report in a monograph series authorized by the Board of Trustees of the American Psychiatric Association to give wider dissemination to the findings of the Association's many commissions, committees, and task forces that are called upon from time to time to evaluate the state of the art in a problem area of current concern to the profession, to related disciplines, and to the public.

Manifestly, the findings, opinions, and conclusions of Task Force Reports do not necessarily represent the views of the officers, trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it. These reports are considered a substantive contribution to the ongoing analysis and evaluation of problems, programs, issues, and practices in a given area of concern.

Jack Weinberg, M.D.
President, APA, 1977-1978

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PROFESSIONAL LIABILITY INSURANCE AND PSYCHIATRIC MALPRACTICE

Report of the Task Force on Professional Liability Insurance for Psychiatrists of the American Psychiatric Association

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INTRODUCTION

The Rationale

For most psychiatrists, a malpractice crisis means one thing—higher insurance premiums. While there has been escalation in the annual professional liability premium required of all doctors throughout the United States, in certain areas the premium increase for psychiatrists was very dramatic. In response, feelings of concern, outrage and dismay were expressed by many APA members.

The Board of Trustees, the Council on Internal Organization and others in the association sensitive to their constitutional responsibilities, frequently have asked questions about the cost increase in the APA professional liability program when registering complaints from irate and puzzled members.

With the emergence of a complex series of social, legal and economic events productive of a nationwide crisis, it became evident there was a need for the APA to provide a careful review of the general topic of medical malpractice and professional liability insurance from the vantage point of the practicing psychiatrist.

This task force report is one of several responses to the association membership concerning this problem. It is intended to be an informative monograph which may serve to answer some questions about why APA members pay millions of dollars annually into malpractice insurance programs.

Additional pressure for this document came from an inability on the part of the Professional Liability Committee, as well as its predecessor the Committee on Member Insurance and Retirement Plans, to maintain an adequate dialogue between the Committee and the members enrolled in its program. The technical aspects of the casualty insurance business, of which malpractice coverage is a part, are much more detailed and intricate than might be suspected. For this reason, it has been impossible to review this kind of information with any but a tenacious few who have a special interest in the area.

The Content

This monograph contains a series of essays identified as chapters. Each chapter deals with a particular aspect of the general problem and the chapters are arranged in a logical order extending from what has happened in the past to what may happen in the near future. How-

ever, each is intended to stand on its own and can be read without necessary reference to prior or subsequent chapters. The intent was to serve those having topical as well as broader interest in this area.

In Chapter I, Dr. Lee describes the general concept of insurance, the beginnings of an insurance industry, the early days of professional liability insurance and the emergence of the so-called malpractice crisis.

Chapter II is divided into three parts and deals with various aspects of psychiatric malpractice. The first section describes the nature of medical malpractice and its relationship to negligence, liability and other aspects of what is called tort law. The second section covers psychiatric malpractice case law. While not an exhaustive review, sufficient cases are contained therein to dismiss the notion that psychiatrists are never sued. The third section deals with a more illusive aspect of the problem, frequency studies. It tries to answer the question how often are psychiatrists sued.

In Chapter III, Dr. Trent reviews the activity of the various committees of APA which have had the responsibility of setting up and maintaining a professional liability program for its members. He discusses the evolution of the current program and explains why certain changes have been made.

Chapter IV represents a combined effort on the part of the Task Force members to put into reasonable perspective the existing crisis in professional liability insurance as it affects all physicians and especially psychiatrists. The primary focus is on cost containment and the chapter discusses some of the alternatives which have been considered.

In Chapter V, Dr. King looks into his crystal ball in an effort to give us some idea of what may lie ahead. He discusses such diverse topics as tort law reform, litigation alternatives and the problems of going bare.

A glossary is provided. It explains how certain words are used by the insurance industry and in law.

Appendix 1 summarizes presentations made to the APA Committee on Professional Liability Insurance by three groups of insurance professionals. The subject under consideration was what would be involved if the APA were to decide to set up its own professional liability insurance company.

Appendix 2 contains informative tables pertaining to various aspects of medical malpractice.

Appendix 3 offers a specimen copy of the APA-Britton-Chubb policy and the requisite application form.

Appendix 4 contains a tabulation of the APA-Britton-Chubb professional liability program indemnity experience and a clinical categorization of attendant losses.

CHAPTER I

HISTORICAL PERSPECTIVE OF MEDICAL LIABILITY INSURANCE

Insurance, or risk-sharing, is an ancient phenomenon. One early form probably occurred when isolated cave men banded together to improve their chances of killing rather than being killed by large prey. Prior to this important advance toward civilization, only the strongest and luckiest of men could survive such an encounter. The more timid improved their chances of survival by hunting lesser animals.

Examples are common in infra-human species. Wolves are able to hunt larger prey when in packs than when alone. Ants, bees, and other species are less vulnerable in large groups.

Pre-biologic or mechanical analogies are also possible. Finned cylinders in air-cooled cars prevent the parts in contact with combustion from overheating by dispersing the heat energy quickly to other places not in contact with the primary heat source, including cooling air—spreading or "sharing" the risk prevents destruction of the individual parts. A hot poker placed in a swimming pool full of water is quickly quenched, whereas placed in a glass of water, it quickly brings the temperature of the water up, sometimes past boiling, or if the glass is small enough, until all the water boils out of the glass.

Antimenes of Rhodes organized the first known system of insurance in 324 B.C., by guaranteeing owners, for a premium of eight per cent, against loss from the flight of their slaves (1).

In the thirteenth century, the merchant guilds gave their members insurance against fire, shipwreck, other misfortunes or injuries and even against lawsuits incurred for crimes, irrespective of the members guilt or innocence (2). Many monasteries offered a life annuity. In return for a sum of money paid down, they promised to provide the donor with food and drink, sometimes also with clothes and lodging, for the rest of his life (3). A Bruges banking house offered insurance on goods as early as the twelfth century. A chartered insurance company was established there in 1310 (4). The Bardi of Florence, in 1318, accepted insurance risks on overland assignments of cloth (5). The Leicester Merchants' Guild provided for its members insurance against fire, flood, theft, im-

prisonment, disability, and old age (6). Property owners gave their property to the Catholic Church when sick as a sort of disability insurance. The Church provided an annuity in return and care in sickness and old age to the donor. It received the property free of lien at his death (7). Marine insurance was established in Spain in 1435 (8). In 1537, Guild members found relief in the insurance and mutual aid provided them against poverty and fire, but in 1545 Henry confiscated the property of the guilds (9).

In the late 1800s and early 1900s, lawsuits against ocean-going vessels involved in accidents resulting in the death of the rich achieved awards which bankrupted the companies insuring them. Dollar limits on the size of future awards were then set by international agreement. Currently, the limit of carrier liability is $50,000 per person per accident, no matter what the net worth of the insured.

Throughout most of U.S. history, lawsuits against doctors for alleged torts have been infrequent even though Blumgart (10) states that the odds of a patient benefiting from a given doctor/patient encounter only exceeded 50:50 in about 1910-12!

The form and substance of doctors' liability to patients has varied throughout recorded history. In ancient Rome, doctors were allowed to kill with impunity if requested by the patient. But if an important patient under their care died, they might in turn be put to death.

In pre-World War II Germany, doctors threatened recalcitrant patients with autopsy if they did not cooperate (11). President Lincoln successfully defended a surgeon from suit by a disappointed patient whose leg was shorter after the fracture had healed, by pointing out to the jury that the alternative treatment was amputation. Awards at that time were made largely out of the doctors' own assets, which usually didn't include professional liability insurance.

There followed a long period in U.S. history when professional liability insurance premiums were inconsequentially low ($40 to $100 per year as they still are in Canada and Great Britain) and suggested limits were also low ($100,000 or so for total coverage). As recently as 1965, a busy neurologist of my acquaintance had a rather troubled year when a patient sued him for unilateral loss of vision following an arteriogram for brain tumor. Since the suit was for over $100,000, there was a chance that the award would intrude on the doctor's own, rather than the insurance company's, assets. The jury awarded less than $100,000.

As professional liability awards started to climb, doctors bought more and more insurance at still relatively low premiums. Rubsamen (12) reported that in California in 1969, there were only three cases in which an out-of-court settlement of a malpractice action amounted to

$300,000 or more. The number of such cases rose steadily to about 34 in 1974. Where an additional $1,000,000 or even $5,000,000 of insurance coverage had originally required only a few more premium dollars per year, it soon rose to a level which few doctors could afford and shortly thereafter was either discontinued or reduced by the insurance carriers.

The crisis fell on the so-called "high risk" specialties first. These include obstetrics-gynecology, surgery (including surgical subspecialties) and anesthesiology. It was felt most acutely by the lowest grossing of them—anesthesiology (13)—whose premiums would have equaled their previous year's net income. This resulted in the "cost crisis" of 1975 when the anesthesiologists refused to work and the hospitals and surgeons were unable to work without them. This crisis was partially resolved by the formation of doctor-owned insurance companies who offered premiums of about one-third that of the crisis levels. Though the crisis did not first fall on psychiatrists, it was not long until their premiums also rose at a rapid rate. In the face of these developments many questions were heard from the APA membership. Some of these are listed below.

1. Why are professional liability premiums rising?
2. Are professional liability premiums rising faster than other insurance premiums?
3. Why did APA change insurance companies?
4. Why did APA's insurance company raise their premium rates to about the same high levels as other professional liability insurance companies?
5. Why did Merrill premium rates stay so low?
6. Why do professional liability insurance premium rates vary so much from state to state?
7. Why do professional liability insurance premium rates vary so much from subspecialty to subspecialty?
8. Should APA form an insurance company?
9. Can doctor-owned insurance companies contain losses better than standard companies?
10. What recent changes have been made in tort laws that might influence professional liability insurance premium levels?
11. Will an arbitration agreement with patients lower professional liability insurance premiums?
12. If a doctor uses proper informed consent, should he be liable for untoward therapeutic results?
13. What are the commonest grounds for professional liability suits against psychiatrists?
14. What is the average frequency of professional liability awards against psychiatrists?
15. What factors could relieve the professional liability insurance crisis?
16. Are academicians less prone to suits than private practitioners?
17. Aren't most professional liability suits against "bad-apple" doctors who should not be allowed to practice anyway?
18. Isn't it true that if a psychiatrist has been well trained, is properly certi-

fied and adheres to proper standards of care that he is not likely to be sued?
19. Should a psychiatrist "go bare"?
20. Should a psychiatrist have legal expense insurance, rather than professional liability insurance, thus maintaining the "armor" but abandoning the "plum"?
21. Isn't the professional liability insurance premium crisis due mainly to increasing plaintiff's lawyer activity?
22. Isn't the professional liability insurance premium crisis due mainly to the existence of the contingency system?
23. Isn't the crisis caused by insurance company losses in the stock market?
24. Why is "small numbers" insurance more risky than "large numbers" insurance?
25. Isn't the adoption of no-fault auto insurance partly responsible for the professional liability premium crisis in some areas?
26. Would the adoption of no-fault professional liability insurance solve the professional liability premium crisis?
27. Have patients begun to see that they are the ones that have to pay for the increased premiums for professional liability insurance?
28. Why shouldn't part-time practitioners have lower rates?

This monograph will attempt to answer some of these questions.

References

1. Glotz G: Ancient Greece at Work. New York, Norton, 1967, p 364.
2. Lacroix P: Manners Customs and Dress during the Middle Ages. New York, Appleton, 1876, p 272.
3. Davis HWC: Medieval England. London, Oxford University Press, 1928, p 376.
4. Zimmern H: The Hansa Towns. New York, Putnam, 1889, p 165.
5. Durrant W: The Age of Faith. New York, Simon and Schuster, 1950, p 629.
6. Walsh JJ: The Thirteenth the Greatest of Centuries. Brookland, British Columbia, Catholic Summer School Press, 1920, p 437.
7. Clapham JH, Power E: Cambridge Economic History of Europe. London, Cambridge University Press, vol I, 1944, p 189.
8. Thompson JW: Economic and Social History of Europe in the Later Middle Ages. New York, Century, 1931, pp 349, 422, 449.
9. Traill HD: Social England. New York, Putnam, vol III, 1902, p 127.
10. Blumgart HL: Caring for the patient. N Engl J Med 270:449-456, 1964.
11. Nielsen T. Chief of Surgery, WH Groves LDS Hospital, Salt Lake City, Utah, personal experience confided to author, 1965.
12. Rubsamen DS: Medical malpractice. Scientific American, 235:18-23, 1976.
13. Chart of annual income by subspecialty, prepared by Practice Management Consultants, Inc., Teaneck, New Jersey.

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Trent: early APA professional liability program experience
Commercial carrier experience
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1. The Concept of Malpractice

A. The Issue of Negligence

Negligence is behavior which involves an unreasonable risk of causing harm. It is the failure to exercise a degree of care which an ordinarily prudent person, under similar circumstances, would exercise. It is important to note that negligence is conduct, not a state of mind. A state of mind may be the cause of certain conduct. It is the effect of this conduct which becomes the actual negligence. Negligent conduct consists of an act or the omission of an act. It involves doing something which is unreasonably dangerous or not taking such precaution as reasonableness would require.

B. The Assessment of Risk

Any action, or inaction, can be assigned a degree of risk. The rating of risk is usually an element of the deliberations which precede election of a course of conduct. For conduct to be negligent, the assumed risk must be unreasonably great. In some cases, a large risk may be quite reasonable while in other cases a small risk might be unreasonable. Precaution need not be taken against every conceivable risk and every possible harm. The requirement is that the risk be reasonable since negligence can be assessed only in terms of the reasonableness of the risk or risks which may flow from the act or its omission. Retrospective assessment of risk is a central issue in most negligence litigation.

C. The Matter of Duty

Duty means that which one person owes another. It is an obligation to do a thing. As a technical word in law, duty is a correlative of the concept of a right. Where any person has a right, there exists a corresponding duty which rests upon another person or upon all people.

If it is considered that people have a right to good medical care, then a physician who agrees to attend a prospective patient acquires a duty to provide good treatment. This duty is derived from the patient's right to good care and from it flows an obligation which establishes liability.

D. The Meaning of Liability

In law language, the term *liability* has broad meaning. It refers to almost every responsibility or hazard as considered absolute, contingent or likely. It also means an obligation that a person is bound in law or justice to perform. When such obligation is shown to exist, failure to perform or defect in performance may provide basis for a claim or action in law.

E. The Doctor's Problem

Professional negligence on the part of the physician is called malpractice. In its broad definition, malpractice refers to professional misconduct or unreasonable lack of skill in professional duties. There are two forms of malpractice: criminal and civil. Criminal malpractice refers to professional misconduct toward a patient which is considered reprehensible because it is immoral, contrary to law, or expressly forbidden by law. Civil malpractice is improper or injudicious treatment of a patient which results in suffering, injury or death and which proceeds from negligence, carelessness or incompetence on the part of the treating physician.

F. The Legal Tests

In most malpractice cases there are two matters of major concern: negligence and liability.

Negligence is usually determined by the "conformity test." What this means is that the doctor cannot be held at fault if he conforms to the local medical practice or to the standard of practice in similar localities. This rule which came into being because it was felt that judges and juries were incompetent to assess the reasonableness of a physician's professional act or conduct, has been modified. With respect to speciality practice, such as psychiatry, conformity would pertain to nationally recognized professional standards which are adhered to and complied with by those who practice in that particular field. In almost all cases the issue to be settled is whether or not the doctor used reasonable care after all circumstances have been considered. Diagnostic errors, ineffective treatments and medical mistakes generally are not sufficient to imply negligence. Reasonable patient care, or the lack of such care, is the controlling criterion.

Liability determination is often based on a principle of law that a defendant cannot usually be found liable for harm claimed by a plaintiff unless the plaintiff can show the defendant did, in fact, cause the harm. The test most commonly used for such determination is called the "but for" rule. If the defendant was negligent and if it can be shown that "but for" said negligence, the harm to the plaintiff would not have occurred, then the negligence is considered the cause of the harm and liability for that negligence is established.

G. The Malpractice Equation

When a doctor and a patient enter into an agreement for medical care, that agreement imposes certain duties on both parties. The patient acquires a duty to submit to diagnostic procedures, cooperate in effecting treatment and to pay for these services. The doctor acquires a duty to provide a quality of medical care commensurate with his training and in keeping with contemporary standards of practice. From this duty flows both the doctor's assumption of risk and the doctor's potential for liability. Should a clinical circumstance turn adverse, on the basis of the risk assumed, the doctor may be accused of negligence. When coupled with liability for said negligence it forms the basis for a malpractice suit. These interrelationships, their outcome and the tests which apply are shown in figure 1.

2. Malpractice in Psychiatry: The Case Law

A. Problems with Somatic Treatments

1. Drugs

It would appear that there are rather few circumstances in which psychiatrists have been held liable for the adverse effect of treatment with psychotropic medication.

Saron v. State (1) was initiated by the administrator of the estate of a voluntary patient who had been in a state mental hospital and diagnosed schizophrenic. He contended that the doctors and the hospital were negligent in treating the patient's diabetes and also in prescribing isonicotinic acid hydrazide (isoniazid), asserting that this medication caused organic brain damage with subsequent pain and suffering. In this case, the trial court refused to support the contention that giving the drug constituted negligence or that it caused pain and suffering. There was some discussion of the then known side effects but it was concluded there was inadequate documentation to support contraindication for use. The hospital and doctors were absolved. The case was appealed. The trial court decision was affirmed.

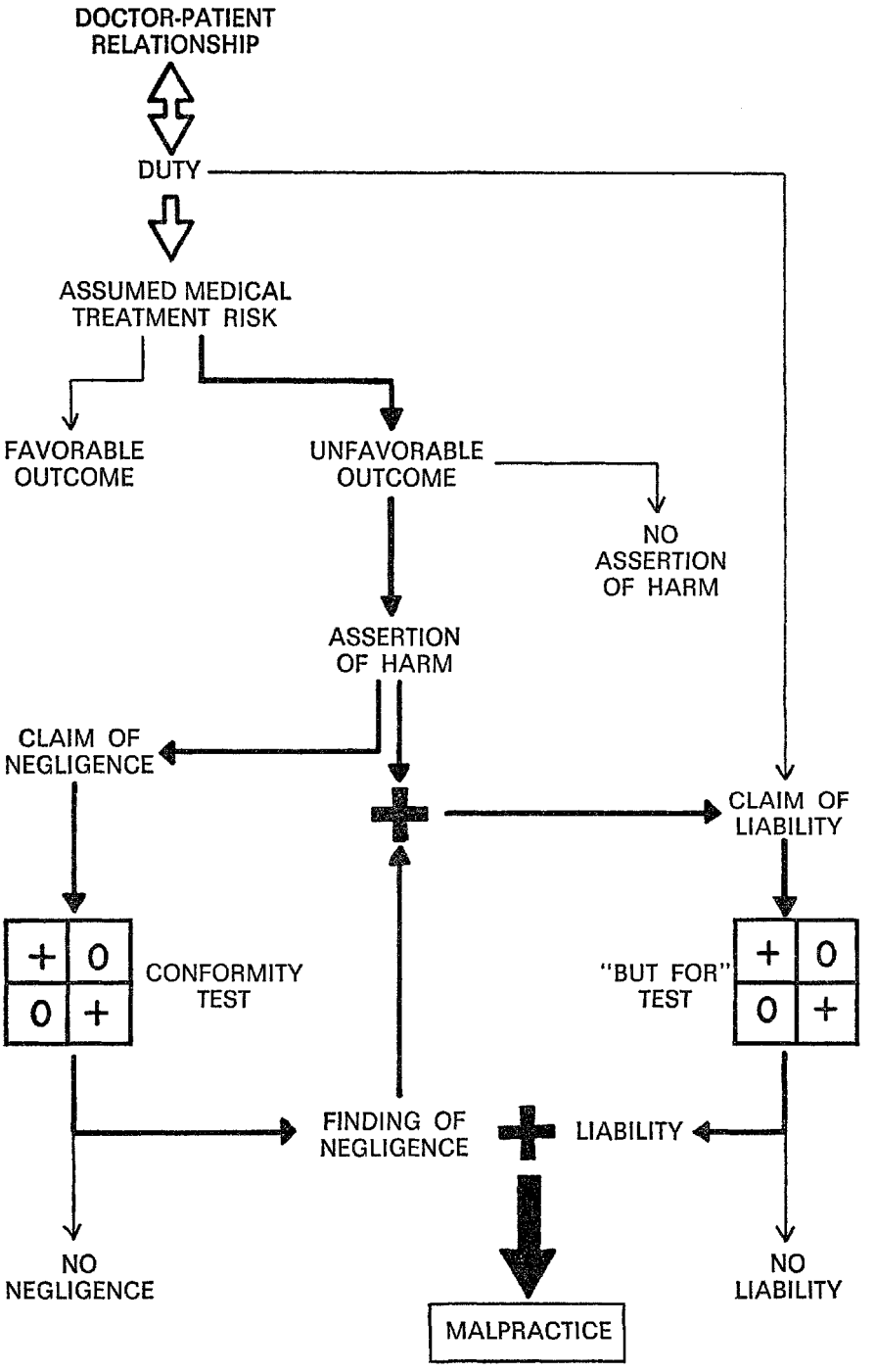

Fig. 1. Schematic representation of factors related to malpractice determinations

In a more unusual case, *Rosenfeld v. Coleman* (2) the patient first complained of migraine headache, nervousness and general weakness. At a later visit, he complained of severe pain and the defendant doctor provided the patient with a prescription for meperidine hydrochloride (Demerol). The doctor instructed his patient in the parenteral use of this drug and provided him with a syringe for its injection. Regularly scheduled psychiatric sessions were terminated after one month but prescriptions for Demerol were continued. The patient was eventually considered to be addicted and had to be withdrawn in a hospital. The allegation was that the addiction began while under the defendant doctor's care. In the trial court, this case initially concerned a measure of the psychiatrist's liability under a criminal narcotic statute. However, when heard on appeal to strike compulsory nonsuit, it was extended to indicate liability for malpractice if the doctor leads the patient to a type of behavior which it is the intent of existing statute (narcotic regulations) to avoid.

Antipsychotic medication has been used by psychiatrists for over two decades. These potent drugs exhibit an extraordinary range of pharmacologic activity. It is perhaps evidence of their utility that the many side effects encountered in their use have not resulted in a substantial number of lawsuits. This circumstance may change. Most, if not all, of these agents can induce the neurological syndrome of tardive dyskinesia. This syndrome, characterized by involuntary rhythmic movements of the tongue, face, and jaw, does not respond well to treatment and may be irreversible. Since it appears to be a direct effect of the drug (probable sensitization of dopamine receptors in response to drug induced receptor blockade), both the prescribing physician and the manufacturer could be held liable.

Tardive dyskinesia is still quite rare and the number of cases reported remains small. However, it produces a striking disability and some of these patients will surely have their day in court.

2. Electroconvulsive Therapy

As might be expected, ECT presents an opportunity for special hazards.

Brown v. Moore (3) involved a patient who thought he had cancer and was hospitalized in a private sanitarium with a diagnosis of neurosis. He was given two electroshock treatments and suffered what was presumed to be an accidental fall. Thereafter he developed progressive paralysis of his arms and legs. He died four days following the last treatment. At trial the court found the doctor and hospital negligent under the circumstances for diagnosing the illness as an hysterical paralysis and not giving skillful or adequate medical care. The trial court granted a defense motion for a directed verdict on the theory that the psychiatrist

was not a hospital employee. This was reversed on appeal and the sanitarium held liable.

In *Woods v. Brumlop* (4) it was found that a psychiatrist may be responsible for injuries sustained by a patient from electroconvulsive therapy if the evidence shows that the patient was misled by false representations that no harm could result from the treatment. In this case, a female patient testified that the psychiatrist (who also happened to be a lady) had so assured her and further indicated that she would not have agreed to treatment had she known of the risk. The doctor denied such representations and insisted that the risks had been discussed with the patient. The judgment for the patient was reversed on appeal and a new trial ordered because the lower court had allowed the patient to testify about a hearing loss alleged to be caused by the ECT. The appeals court ruled that a directed verdict in favor of the psychiatrist had been properly denied. The court said a psychiatrist has a duty to disclose to a patient the probable consequences of a treatment and the dangers inherent in said treatment. The court emphasized the right of the patient to exercise judgment in the matter of selecting treatment and weighing benefit against possible risk. The court acknowledged exception to the general rule requiring candor and disclosure. They noted that the psychiatrist had not offered testimony or requested instruction to the jury on whether or not disclosure of such risk would have alarmed her to the degree that it would have been unwise practice to fully elaborate the risk. The appeals court decided that while the patient did in fact consent to treatment, the question of whether or not the psychiatrist falsely advised the patient that the treatment held no risk and thereby rendered legally insufficient the factual consent, was an issue to be decided by the jury.

Wilson v. Lehman (5) concerned a district court which dismissed on a directed verdict a patient's action against her doctor for unauthorized and negligently administered electroconvulsive treatments. On appeal the court held that the patient was presumed to have consented to the treatments since she voluntarily submitted to them. Her husband did not attempt to have the therapy discontinued and this, it was deemed by the court, further strengthened the presumption of her consent. In this case, the patient wished to remain in the medical portion of the hospital instead of being removed to the psychiatric ward. She received a total of five electroconvulsive treatments after which time her treating physician went on vacation. While he was away, another psychiatrist transferred her to the psychiatric ward and administered six additional treatments. The patient was then discharged. Subsequently, the patient testified that she remembered nothing of her hospitalization and could not say whether or not she had consented to treatment. Her husband said that he had not agreed to therapy and did not know about the treatments until she was

moved to a psychiatric ward. The appeals court said that in the absence of evidence of false misrepresentation, the consent to electroconvulsive therapy would be presumed from the patient's voluntary submission to said treatment. The judgment of the lower court was thus affirmed. In an unusual aside, the appeals court saw fit to comment on the obvious benefit the patient had received from the treatment complained of.

Stone v. Proctor (6) involved a patient who received five electroshock treatments. The patient, who was a doctor, complained of severe pain in his low back immediately after the first treatment. The psychiatrist ordered medical treatment (local heat and injections for pain) directed at the symptoms complained of but did not order an X-ray. ECT was continued. Two days after the patient was discharged and because of increased pain, the patient went to another physician who took an X-ray and diagnosed a severe and recent compression fracture of the ninth vertebra. Evidence at the trial showed that the doctor was familiar with the guidelines for ECT developed by the American Psychiatric Association indicating "If the patient should complain of pain or impairment of function, he should receive a physical examination, including X-ray, to ascertain whether he has suffered accidental damage." The trial court would not admit the standards or the psychiatrist's familiarity with them into evidence. The trial court entered judgment of involuntary nonsuit and the patient appealed. The appeals court ruled that since the psychiatrist acknowledged the authenticity and applicability of these guidelines, they were admissible to show that the psychiatrist was familiar with the standards which should have been observed.

In *Farber v. Olkon* (7) a patient diagnosed as a chronic schizophrenic suffered a fracture of both femurs following electroconvulsive therapy. According to medical testimony during the trial this complication was considered to be a recognized hazard of such treatment although the overall incidence of such fractures was less than one percent (1%). The trial court directed a verdict when the patient was unable to bring forth expert testimony suggestive of negligence. On appeal, the court held that the doctrine of *res ipsa loquitur* ("the thing speaks for itself") does not usually apply to medical complications and accordingly there was no evidence to support an inference of negligence upon the part of the treating psychiatrist.

Johnson v. Rodis (8) concerned a patient who suffered a fractured arm during electroconvulsive therapy. The claim for damages was based upon both a breach of warranty and an implication of negligence. The patient alleged the doctor had told her prior to the inception of treatment that such treatments as given by him were "perfectly safe." In this case, the trial court ruled in favor of the psychiatrist on the basis that his expression of opinion referable to a particular course of treatment does

not in fact constitute a warranty. The patient appealed summary judgment. The appeals court found that the doctrine of *res ipsa loquitur* (with respect to implied negligence) did not apply, but reversed the trial court on the grounds that the doctor's unqualified assertion of safety could properly be regarded as a warranty.

Quinley v. Cocke (9) involved a patient who entered a hospital for treatment of a "nervous condition" brought on by acute gall bladder attacks and claimed he had received electroconvulsive treatment of unusual duration and as a result suffered a broken hip. The trial court found there was no evidence to show that the treatment had differed in any way from that which was usual and customary. The court found no evidence of negligence on the part of the psychiatrist and thus dismissed. The patient appealed. The appeals court rejected the notion that the doctrine of *res ipsa loquitur* was applicable in such case and indicated that the doctrine would not apply "where a scientific exposition of subject matter is essential." The court held this included matters of "diagnosis and scientific treatment." The appeals court affirmed the judgment of the lower court and denied the writ of certiorari.

3. Insulin Coma Therapy

Insulin coma is seldom used today. However, in the past, it was a more commonly accepted form of treatment and on occasion the basis for a malpractice action.

In *Mitchell v. Robinson* (10), the patient was considered to be mentally competent but suffering from "process schizophrenia" which was described as a rather severe emotional illness. He sought treatment for symptoms of "serious depression" and "severe anxiety, complicated by alcoholism." He consulted a psychiatrist, who happened to be a boyhood chum, and was advised that he should have a combination of electroshock and insulin subcoma therapy. The patient consented to a series of such treatments allegedly without having been told of the risks involved. During the seventh treatment, the patient suffered a "hard generalized convulsion" with the result of multiple compression fractures of the dorsal spine. The patient claimed the defendants had failed to inform him of the risk of injury even if all precautions were taken. The trial court found for the patient and rendered a judgment which was appealed by the defendant psychiatrists. The appeals court held that there was sufficient evidence to question whether or not the doctors were negligent in not informing the patient of the serious risks associated with this special form of combined treatment. The court also articulated a need for an informed consent, the absence of which could constitute a submissible issue for the jury to consider in determining negligence. The judgment against the psychiatrists was reversed and a new trial ordered.

B. Problems with Psychotherapy

In contrast to the foregoing wherein the unfortunate results of somatic therapies are only too obvious, the courts have had problems with their efforts to assess claims of bad results said to have arisen from psychotherapy. As cited by Dawidoff (11), the courts sometimes characterize the quality of care required as "ordinary," "extraordinary," "the highest degree," or by some other equally vague conceptual notion. The level of care which the law demands in a particular case may depend upon various factors related to the treatment. An English court made it a function of the "Mystery of the Illness" (12). It has been held to depend upon the gravity of the consequences of error (13), and certain qualities of the mental forces involved in treatment, such as their danger (14), the skill needed to control them (15), and the nature of interest at stake (16). Dawidoff (11) sees such a scaling of duty as analogous to the variations in the standards of care that are often imposed upon bailees (the person to whom something is entrusted, i.e. psychiatrist) having different degrees of interest in the bailment (the act of entrustment, i.e. psychotherapy) as well as the bail (professional fee, countertransference factors) itself.

Dissatisfaction with the conduct or outcome of psychotherapy is a difficult matter to assess in the court of law. For this reason, it is not surprising there have been only a small number of cases focused in this area. Perhaps the best known is that of *Hammer v. Rosen* (17). In this case, the patient who was considered to be schizophrenic was treated for over seven years by the defendant psychiatrist. At trial, one of the allegations made was that the psychiatrist had, in the course of therapy, mistreated the patient on a number of occasions. This mistreatment, it was alleged, took the form of slapping and resulted in her receiving bruises. Three witnesses testified she had been beaten more than once. The doctor claimed that his form of treatment was a technique specially designed for her form of mental illness and that there was no reason to believe that it constituted malpractice. The trial court dismissed the complaint of malpractice. The patient appealed and the appeals court affirmed the trial court decision. The patient appealed a second time and a higher court reversed the trial court stating that there was evidence which the jury should consider concerning the form of treatment described indicating that the "very nature of the acts complained of bespeaks improper treatment and malpractice." The court took the position that it was incumbent upon the defendant psychiatrist to justify such acts as proper treatment. In the absence of such justification, the presumption would be that such acts were improper and if so credited by a jury, would require a verdict for the patient on the basis of malpractice. The effect of this decision was to set aside the prior held position that expert opinion on

the part of an independent psychiatric expert was necessary to support a contention that a particular form of treatment (in this case assault on the person of the patient) was negligent and improper treatment. A new trial on the issue of malpractice was ordered. A number of prominent psychiatrists praised the defendant doctor's form of treatment as an important original contribution requiring both courage and devotion and saw the decision as a resistance to progress in treatment of the mentally ill. It is understood the case was settled and not retried.

Landau v. Werner (18) is a celebrated case heard in the British courts. In this case, which was tried at Queen's Bench, the patient was a middle-aged woman considered to be in an unstable emotional condition and suffering from an "anxiety state." She had been referred to the defendant psychiatrist for the purpose of treatment which appears to have been psychoanalytic in orientation. After about 24 visits, the patient became emotionally aroused as a result of the treatment. This had to do with certain intimate conversations which took place in the course of her psychotherapy. The patient discussed with her psychiatrist her feelings toward him and the resultant shame at such an emergence in the course of a professional relationship. The psychiatrist advised her to continue with treatment and told her that these feelings would eventually disappear. The patient reached the stage where she thought she was very much in love with her psychiatrist but fearful that she would be terminated because her emotional condition was much better. The psychiatrist was uncertain of how to handle this matter. Feeling the patient was clearly improved, but fearful of a relapse should she be subjected to an abrupt termination, he decided upon a series of social visits to be conducted outside his office. According to the testimony, the doctor and his patient visited restaurants, rode together in taxicabs, and talked of a vacation together. On one occasion, their visit took place in the patient's bed-sitting room. There was no allegation of an improper advance on the part of the defendant psychiatrist. The patient failed to recover fully as a result of these social visits and ultimately experienced a worsening of her health. After the failure of this attempt to terminate the relationship, the patient resumed conventional treatment and was ultimately given a course of electroconvulsive therapy. Subsequently, the patient attempted suicide and was then transferred to the care of another doctor. Apparently, he was unable to resolve the patient's lingering affection for her initial therapist. At trial, the patient was described as a "highly sexed emotional woman" and the doctor was admonished for attempting his social treatment under such circumstance. The court held such a departure from accepted practice required justification, which was found wanting in this case, and further suggested that novel treatments are better defended by their success than their failure. The patient was awarded a

substantial judgment. On appeal the decision of the trial court was affirmed. It was the finding of the appeals court that the psychiatrist had failed to convince that his departure from standard practice was justified and the court held that his unwise treatment led to the "grave deterioration" of his patient's health.

A more recent and flagrant example of the same sort of matter was reported in *Zipkin v. Freeman* (19). In this case, a female patient who complained of headache and diarrhea was in treatment with a male psychiatrist for over three years. She became aware of strong feelings of affection after about three months of therapy. Apparently these feelings were at least verbally reciprocated by the defendant psychiatrist. She testified that he told her that he would be able to guide her in her investments and provide her the necessary strength that she was unable to find in her husband. She claimed her doctor told her to get a divorce "in order to get completely well." Although she knew she was pregnant with twins, she left her husband and moved into an apartment over her doctor's office. Later she filed "spurious" lawsuits against both her husband and her brother to rid herself of "pent-up hostility" toward her family. On one occasion the psychiatrist allegedly "directed her to return (to her home) with a pistol he gave her and to shoot anyone who got in the way and take anything that she might want." She also attended a party where her doctor and other patients went swimming in the nude. During the trial another psychiatrist, presenting expert testimony, said that none of the events described by the patient were "proper treatment for neurosis." The trial court found for the patient. The defendant psychiatrist's insurance company appealed and disclaimed liability for their insured's actions. The appeals court found the doctor liable for malpractice on the basis of a mishandling of the transference and held that the damages sustained by the patient "were directly and proximately connected with the professional services' provided by the defendant psychiatrist. One member of the court described the defendant doctor's behavior as "willful, malicious acts" and asserted that some of them were probably criminal in nature.

Overt sexual relations with a patient was at issue in *Roy v. Hartogs* (20). This case received notice in the national press and was settled while an appeal was pending. In the trial court the patient alleged that the defendant psychiatrist sought to cure her sexual difficulty (lesbianism) by means of personal intimacy. The defendant doctor entered a motion to dismiss on the theory that causes of action involving sexual intimacy are barred by an article of the Civil Rights Law called the Heart Balm Act. The motion was denied and the court held such Act was intended only to bar actions based on broken promises of marriage, not all in which intercourse is an element. The case was tried and a substantial

judgment awarded the patient who claimed her mental condition had suffered as a result of this form of treatment. The psychiatrist appealed the finding of the trial court. While this was pending his malpractice insurer, who had refused to provide a legal defense, settled with the patient but continued to disclaim liability under the terms of the psychiatrist's policy on the theory that the sexual acts complained of did not constitute medical malpractice. In response the doctor argued that the trial court jury had, in fact, found him guilty of just that. It was probably for this reason that the psychiatrist saw fit to sue his insurance company in an effort to recover his defense costs. In *Hartogs v. Employers Mutual Liability Insurance Company of Wisconsin* (21) the judge resolved this issue by drawing a neat line between malpractice in the mind of the patient (which it was since at the outset she claimed to believe such treatment proper) and malpractice in the mind of the doctor (which it was not—since he knew and so stated at trial, that what he was doing was inconsistent with a doctor-patient relationship). The court approved the validity of the insurance company's disclaimer against the insured psychiatrist while voiding said disclaimer as to the injured patient thus supporting the satisfaction of the trial court judgment already negotiated by the carrier. To allow the psychiatrist to recover costs and expenses suffered as result of "having indulged his *concupiscentia medicus*" (fervent medical desire) through "13 months prescribed and personally administered multiple, repetitive doses of *fornicatus Hartogus*" would in the words of an apparently outraged judge "indemnify immorality and . . . pay the expenses of prurience." The court held the defendant psychiatrist "knew that his actions were for his personal satisfaction and did not constitute medical practice (and) therefore . . . could not constitute malpractice and were never intended to be included within the protective coverage of the malpractice policy." The doctor's motion to recover was denied and the insurance company's cross motion for relief granted.

C. Problems with Commitment

These examples of alleged psychiatric malpractice involve actions for improper commitment of a person to a mental hospital. Morse (22) provides a useful classification of such cases. He groups them into (a) malicious prosecution; (b) commitment as an insane person due to wrongful representation of examination and belief of insanity; (c) faulty psychiatric examination resulting in commitment and (d) false imprisonment or illegal detention.

The first category, malicious prosecution, usually involves an alleged conspiracy on the part of the psychiatrist with a patient's relative having

the intent to commit the patient to a hospital because of a severe disturbance. Such an allegation occurred in *Lowen v. Hilton* (23). In this case, the patient brought an action for malicious prosecution against his brother and a psychiatrist. The charge was that they had conspired to have him confined to a hospital. According to the testimony, the patient's brother signed a verified petition and the psychiatrist wrote a letter to a judge of a local court requesting hospitalization for the patient. The petition asserted that the patient had a thought disorder which was paranoid in nature. The court issued a hold order which resulted in the patient's confinement. About a week later, the patient was discharged from the hospital on the basis of a court order after he was found not "insane, distracted in his mind, or feebleminded." The court further asserted that he was "capable of properly managing and taking care of himself and his property without assistance." The trial court granted the defendant's motion to dismiss the patient's complaint for malicious prosecution on the basis of a statute that commitment orders of the court provide a complete protection for the confinement, examination, diagnosis, observation and treatment of patients "as against all persons." The patient appealed and the higher court reversed the decision of the trial court indicating that the statute intended to protect doctors who examine and treat committed patients and should not bar a malicious prosecution action from being brought against persons who "conspire to prosecute . . . as an insane person without probable cause."

In *Rouse v. Twin Pines Sanitarium, Inc.* (24) the case involved a patient who was treated by his family doctor following a broken ankle associated with a drinking spree. The patient was hospitalized and given sedatives. Subsequent to hospitalization, he continued to use sedatives for some period of time after which his doctor refused to renew the prescription on the basis of suspected abuse and allegedly suggested that the patient should take bromide. Apparently the patient consumed a large amount of bromide and ultimately became quite ill after a few days. The doctor was called to attend the patient and found him to be emotionally disturbed and concluded that he was mentally incompetent. The patient was taken to a sanitarium where he was then seen by a psychiatrist. A high level of bromide was found subsequent to admission. After one week with no improvement, the psychiatrist recommended that the patient be taken to a state mental hospital and following such recommendation, the patient was committed. The patient remained for about four weeks and was released. The patient brought suit against the sanitarium, the psychiatrist and his family doctor. Suit against the psychiatrist was on the basis of malicious prosecution. The trial court did not support this contention. The case was appealed. The appeals court affirmed the trial court indicating that a court order of commitment is a

bar to such an action. They cited evidence that showed that the patient was suffering from delusions and on the basis of this uncontradicted evidence the facts were held to be sufficient to constitute probable cause for the seeking of a commitment.

In another case, *Daniels v. Finney* (25), a "minister of the Gospel" telephoned the defendant psychiatrist and asked to have the psychiatrist discuss a certain patient's condition with the patient's wife and himself. Apparently the minister had been called by the patient with the expectation that he would be able to offer marital counselling. The minister talked with the patient's wife and decided to make an appointment with the psychiatrist. The patient knew of this decision and made no objection. The psychiatrist apparently made his diagnosis of the patient primarily on facts communicated by the patient's wife in the presence of the minister. Testimony was given that prior to the initial consultation, the patient had occasion to accuse his wife of infidelity and claimed that he was not the father of their two children. Apparently he had frightened her on a number of occasions and at one time "locked her in a bathroom and threatened to cut her throat." The psychiatrist considered that the patient was suffering from a schizophrenic illness and considered him to be extremely dangerous to his wife and for this reason recommended that he be committed to an institution. Apparently the wife took this statement and petitioned the court to confine her husband on the basis of his mental illness. The patient was confined prior to a hearing referable to his mental status and ultimately acquitted. Thereafter, the patient brought suit against the psychiatrist for malicious prosecution. In his defense, the psychiatrist testified that from what he had heard from the wife he understood that the patient's periods of "mental furies" were becoming more frequent "in an ever tightening spiral, and that explosion was about due." He further stated that he felt that it was important for the patient to be separated from his wife and that the patient was not cooperative in obtaining adequate assessment. A motion was made for a directed verdict in favor of the defendant psychiatrist. The trial court granted that motion and rendered such judgment. The patient appealed. The appeals court sustained the decision of the trial court. The court reasoned that to interpret the defendant psychiatrist's action as a malicious prosecution would be tantamount to holding a physician guilty of malpractice for an incorrect diagnosis which it would not. The court stated that while the psychiatrist's diagnosis might have been wrong it did not constitute malice or show lack of probable cause.

Woodruff v. Shores (26) concerned a malpractice action based upon a misrepresentation by a psychiatrist that he had examined the patient prior to executing a certificate utilized by the patient's husband to have her committed to a state hospital. In this case, the psychiatrist appeared

before the court and verified the faulty certificate. The court committed the patient who remained in a state hospital for three months following which she was discharged. Eight years later she was adjudged (for some reason) by a local probate court to be of sound mind and was restored for such purposes. The patient then brought suit against the psychiatrist based on the alleged wrongful representation that he had examined her. The state had a two-year statute of limitations referable to negligence actions and a statute which provided that the limitation could be suspended if the individual was insane during the period such action could be brought. The psychiatrist moved for dismissal on the ground that insanity as a disability did not include a sane person wrongfully committed and reasoned that the patient could not sue pursuant to the limitation imposed by the negligence statute. The trial court sustained the motion. The patient appealed. The appeals court affirmed the trial court's motion to dismiss.

Kleber v. Stevens (27) involved an allegation of faulty psychiatric examination. In this case, the patient alleged to be emotionally disturbed was committed to a state hospital for treatment following an examination by the defendant psychiatrists. At trial the jury found for the patient on the basis of a negligent psychiatric examination. The court held that the jury's finding of negligence was not inconsistent with their finding that the examining psychiatrists were not liable for false imprisonment. The psychiatrists contended that there was no physician-patient relationship or duty of care since the psychiatrists were mental health officers who were simply complying with the law. The patient asserted that the certificates used to establish the commitment were issued on the basis of statements made by her husband rather than being derived from a proper psychiatric examination. The court held the psychiatrists owed the patient "the duty of making an examination with ordinary care" and reasoned that since the psychiatrists were medical practitioners and not officers of a court they had no immunity from suit when they failed to meet conventional standards.

In contrast to the above, in *Bartlett v. Weimer* (28), the courts involved came to a different conclusion. In this case, the patient sued one of two certifying psychiatrists when his commitment was held void approximately fourteen months after hospitalization. The voiding was based on a technical provision of certain local statutes which were not complied with. In dismissing the suit, the trial court held that the psychiatrist was appointed and acted as an officer of the court when he gave his opinion as to the mental health of the patient. While acting in this capacity the court considered him to be protected by the same immunity given to judges and other judicial officers. The appeals court also ruled that a "medical witness cannot be held to ascertain, at his peril, whether

a court has fully complied with procedural requirements." The dismissal of the complaint was sustained on appeal.

In a similar manner, a court hearing *Dunbar v. Greenlaw* (29) held that the role and function of the examining psychiatrist in a commitment case is that of an expert witness appointed by municipal officers and "not *pro hac vice* (for this particular occasion) that of physician with patient."

Although there is substantial variation between the findings of various courts in different localities, there has been a general trend for the courts to hold the examining psychiatrist responsible for medical negligence referable to commitment mistakes. *Messinger* (30) asserts that in light of a recently expressed judicial sentiment that patients do not often receive adequate treatment in psychiatric hospitals, the view that negligence in a commitment proceeding is a suitable basis for a malpractice action may become more widespread.

Blitz v. Boog (31) concerned a patient who went to a VA hospital for emergency outpatient treatment as a result of an "emotional upset relating back to certain events of World War II." She was given medication and when she attempted to leave was prevented from doing so. The VA doctor arranged for her transfer to a municipal psychiatric receiving hospital where the patient was admitted and remained for a period of about eight days. According to her testimony, she suffered "beatings and indignities" at that hospital and received "improper treatment." The patient subsequently went to another VA hospital with a physical complaint and ultimately was examined by hospital psychiatrists. At the trial, the patient described her detention by the first VA hospital as an act of "wanton and wilfull" negligence. But the appeals court made of that a claim for false imprisonment ("It is, of course, the substance of the claim, and not the language used in stating it, that controls") and took note of the fact that the Federal Tort Claims Act provides the government, in instant case the VA, immunity from claims of false imprisonment. Additionally, the government was held not liable for alleged mistreatment at the municipal mental hospital unless it were contended and could be shown, which it was not, that the VA doctor knew she would get bad care. The appeals court also took the position that the doctors at the second VA hospital where the patient presented with a physical complaint were in fact working within the scope of their duties in performing a psychiatric examination and that this falls under the Federal Tort Claims Act exception of discretionary function.

Cambell v. Glenwood Hills Hospital, Inc. (32) involved the claim of a patient for damages against a hospital under the Civil Rights Act. The federal district court dismissed the action on the grounds that in order for there to be a cause of action under such act, it must be shown that

the event complained of, in this case, commitment to a private hospital, was done "under the color of state law." The appeals court determined that the hospital and the psychiatrist were acting in their private capacities and not as employees or agents of the state. Since this did not constitute a misuse of power derived from an actual vesting of authority, e.g., a state employee who uses his office to deprive of a federally protected right, the court reasoned the patient had no cause of action against the psychiatrist or the hospital under the Civil Rights Act.

In a similar case, *Duzynski v. Nosal* (33), an appeals court supported dismissal of a patient's suit against psychiatrists whom she claimed had deprived her of her civil rights by commiting her to a mental hospital. In this case, three psychiatrists were involved. Two were appointed by a court to examine the patient and thus held to have judicial immunity. The other psychiatrist, who was employed by a county mental health clinic, was acting at this time in his capacity as a private citizen and for this reason it was held that he could not be sued under the Civil Rights Act. In this case, the patient alleged that she was deprived of her freedom by reason of the failure to inform her of the purpose of the mental examination and of the nature of the proceedings which resulted in her commitment. She contended that the psychiatrists and an officer of the court conspired to deprive her of her civil rights. The trial court found no evidence of conspiracy and dismissed the suit. The appeals court held that the Civil Rights Act applies only to acts by state officials who, acting outside the function of their office, use their authority to deprive a person of federally protected rights.

A case being tried in California offers contrast. A lady who appeared to be suffering from a form of manic-depressive illness was seen by a psychiatrist at the request of her physician husband who was concerned that her behavior might jeopardize the well-being of their children. The psychiatrist saw her in outpatient consultation and advised immediate hospitalization. She entered a private facility on a voluntary basis. After three days in the hospital she wanted to leave. The psychiatrist placed her on a hold and continued the evaluation. After 72 hours he signed a notice of certification for 14 days of intensive treatment because he was convinced she was in need of further care. He also obtained consultation from another psychiatrist. She was released after 11 days as a result of her own legal intervention. She brought suit claiming malpractice, unlawful detention and conspiracy (with her husband) to not only deprive her of her freedom but to prejudicially identify her as having a mental disorder. The husband and the psychiatrist were tried as co-defendants. The jury apparently accepted the theory of a conspiracy to detain, found for the plaintiff and awarded judgment in the amount of $630,000. A portion of this judgment is in the form of punitive dam-

ages which are not normally covered by malpractice insurance. The doctor's attorney will move for a new trial and judgment notwithstanding the verdict. Should this fail, the case will go to appeal. (Personal communication to author.)

D. Problems with Control

These cases usually involve a duty on the part of a psychiatrist to properly protect a patient he is treating. The majority of such claims involve allegations of malpractice based on negligence the consequence of which may have led to injury or death. Most cases involve hospitalization and suicide. They have been collected in a recent article (34) and will be summarized below.

Homann v. Riverlawn Sanitorium (35) involved a patient who on two prior occasions attempted suicide. He eloped from a hospital and was found dead. The court found that the hospital had a duty only to observe the patient and provide medical treatment.

Hawthorne v. Blythewood Incorporated (36) concerned a patient who was admitted to a private sanitarium with a diagnosis of manic depressive psychosis. He was found to have suicidal tendencies. While in the hospital he had an attendant who remained with him at all times. One week following admission he eloped from the hospital and his body was later found in a small lake on the hospital grounds. The jury returned a verdict in favor of the family. The hospital appealed. The appeals court affirmed the decision of the trial court asserting that the hospital could be considered negligent because it had assumed, for a special consideration, the duty of keeping the patient under surveillance and the patient's suicide was a result of the hospital's failure to do so.

In *Mills v. Society of New York Hospital* (37), a hospitalized patient who left a psychiatric ward in the company of other patients and staff to take a walk, left the group, ran in front of a bus and was killed. The patient had shown improvement during the course of his hospital stay. The trial court absolved the hospital of liability and the decision was affirmed on appeal.

Stansfield v. Gardner (38) related to a similar circumstance. In this case, the patient jumped from the stairway of a hospital and subsequently sued the hospital for his injury. On appeal the court found that the hospital need not insure itself against self-inflicted injury and was required to use only ordinary care and diligence. It was the opinion of the court that the defendant hospital should be absolved of liability because a hospital is not required to guard against an action which a reasonable person would not anticipate as likely to happen.

In *Dahlberg v. Jones* (39), a voluntary patient who was considered

docile but ran away from a psychiatric hospital died as a result of exposure. The hospital was not held liable.

James v. Turner (40) concerned a chronic alcoholic who was admitted to a private hospital on a voluntary basis. The two psychiatrists who owned the hospital told the family that in the absence of a formal commitment the patient could not be held. The patient had previously threatened suicide. The patient improved and because of this was allowed to go for a walk on the hospital grounds with an attendant. He broke away, ran to a water reservoir, jumped in and drowned. The family brought suit. The jury found in favor of the family. The defendant psychiatrists petitioned the court to set the verdict aside and dismiss the suit. The trial court agreed. The family appealed the trial court decision. The appellate court reversed the trial court and the psychiatrists appealed to a higher court. That court reversed the appeals court decision on the grounds that the act which led to the patient's death could not have reasonably been anticipated.

In *Tissinger, et al. v. Wooley and Emory University* (41), a woman jumped to her death from the seventh floor of a university hospital. Her family sued the hospital and the treating psychiatrist. The trial court absolved both. The husband appealed the suit against the psychiatrist alleging an improper selection of hospital for treatment of his wife's illness. On appeal, the court held that if the hospital accepted mental patients it could not be considered negligent to use that hospital. The hospital was not found negligent because there was no evidence the patient was unattended at the time of her fatal act.

Kubas v. State (42) involved a patient who had been hospitalized for seven years and committed suicide while on pass. He was considered a chronic schizophrenic and thought "incurable." There was a prior history of one suicide attempt but for the last two years he had left the hospital on frequent passes and had not given evidence of suicidal preoccupation. The trial court dismissed on the merits a claim for damages. In a curious decision the appeals court held it was negligent to allow the patient to leave the hospital grounds unattended and awarded for conscious pain and suffering. Then in an unexplained action, which would appear inconsistent with its own determination that the plaintiff had established negligence, the court denied recovery (other than funeral expenses) and affirmed the trial court judgment.

Stallmen v. Robinson (43) concerned a husband who brought suit against four psychiatrists who ran a private psychiatric hospital. His wife hung herself in the hospital bathroom with a rope made of strips of cloth torn from her nightclothes. She had made two prior suicide attempts and was receiving electroconvulsive treatments. The jury returned a verdict against the psychiatrists. The case was appealed and the judg-

ment affirmed. The court held that the patient had been left unsupervised for an unreasonably long time and the hospital nurse should have checked the patient's restraints with greater care.

In *Hebel v. Hinsdale Sanitorium* (44), a patient wandered off from a hospital and onto a railroad track. She was struck by a train and killed. The trial court sustained a motion to strike the complaint. The family appealed. The appeals court held that the hospital, in allowing the patient to leave the ward, merely furnished a condition by which the injury was made possible. The court held that it was an independent act of the railroad company which caused her death. The alleged negligent acts of the hospital were not considered to be the proximate cause of death.

Noel v. Menninger Foundation (45) involved an elderly man who was admitted to a prominent mental hospital because of depression. He did not appear to be suicidal but the possibility was considered. On one occasion, and while hospitalized, he put his head in a bucket of water in apparent intent to drown. Sometime later and while out of the hospital with an attendant for the purpose of a walk, he ran in front of a bus and was killed. The court held the hospital liable for damages on the basis of failure to restrain a patient known to be a suicide risk. The case was considered for appeal but ultimately settled out of court.

In *Von Eye v. Hamme* (46), a patient sued a private psychiatric hospital and three doctors for damages associated with an injury sustained when she attempted to elope from the hospital by jumping from a second story window. At trial, the case turned on the issue of whether or not she had been "observed closely" as had been ordered by her doctor. The jury ruled against the hospital but absolved the psychiatrist. The hospital appealed. The appeals court affirmed the trial court's decision finding the hospital practice negligent.

Gregory v. Robinson (47) involved a mental patient who pushed his way through a normally locked ward door. The patient ran down a stairway and jumped through a window and fell more than three stories to a driveway where he received severe injuries which were not fatal. The patient brought suit for damages and the jury returned a verdict in his favor. The trial court judge set the verdict aside. The patient appealed. The appeals court affirmed the action of the trial court jurist and absolved the hospital of liability for the patient's self-inflicted injury.

In *Kent v. Whitaker* (48), a patient who was hospitalized following a suicide attempt was left alone in a room under the supervision of a nurse who had to care for other patients on the same ward. In the nurse's absence, the patient strangled herself with plastic tubing from an infusion set. The court held the psychiatrist, who was also the hospital superintendent, liable because he had the duty to use reasonable care to safeguard a known suicidal patient and had failed to do so.

Benjamin v. Havens (49) concerned a patient who was admitted to a mental hospital for the treatment of an agitated depression. She was placed in a special ward used for patients who were only moderately disturbed. Suicidal patients were normally excluded from that ward. She received five electroconvulsive treatments with a variable response. One evening, without warning, she ran down the hall and jumped, or fell, down an embankment. The patient ultimately filed suit against both her psychiatrist and the hospital. At trial, her husband asserted that he had told the doctor of prior suicidal behavior. The doctor denied being given such information and asserted that if he had been so advised he would have not placed the patient on that particular ward. The jury found in favor of the psychiatrist but against the hospital. The trial judge entered a judgment in favor of the hospital and the patient appealed. On appeal, the court affirmed the jury verdict in favor of the psychiatrist and found that the jury could find the hospital negligent because the hospital had failed to provide adequate supervision for patients in the corridor of the hospital at the time of the incident. The appeals court ordered a new trial but the hospital made a settlement.

Baker v. United States (50) involved a veteran who attempted suicide by jumping into a deep window well. He suffered left clavicular, rib and spinal fractures and six hours later an occlusion of his left artery with subsequent complete right hemiparesis and profound disability. His wife sued under the Federal Tort Claims Act claiming negligent diagnosis and treatment under *res ipsa loquitur.* The veteran was referred to the hospital by his doctor who saw him as depressed and mentioned "suicidal content" twice in his brief report tendered on admission. The wife said she told the VA psychiatrist that her husband had a "suicidal tendency." The veteran was admitted to an open ward and was able to go about the hospital and grounds for three days until he jumped into the window well. At trial the VA psychiatrist defended his choice of an open setting. The court found that since he was aware of the mental condition prior to admission, made a lengthy interview, conducted an examination and then made his own judgment that the patient did not need to be placed on a closed ward or that other precautions be taken, he had exercised the proper standard of care required under the circumstances. In addition, the court held that the doctrine of *res ipsa loquitur* did not apply since the doctrine permits, but does not compel, an inference of negligence which inference was overcome (in this case) by evidence presented by the government during trial. The court concluded: "Calculated risks of necessity must be taken if the modern and enlightened treatment of the mentally ill is to be pursued intelligently and rationally. Neither the hospital nor the doctor are insurers of the patient's

health and safety. They can only be required to use that degree of knowledge, skill, care and attention exercised by others in like circumstances."

These cases cover a period of some 38 years and are arranged in chronologic order. Most of the cases were probably decided on individual merit and it would be hard to predict outcome given any one example. However, these findings suggest a trend. In most of the early cases, i.e., before 1948, judgment favored the doctor or hospital almost without exception. After 1948, doctors and/or hospitals were held liable for negligence in about one half of the cases. It is likely this trend will continue.

E. Problems with Disclosure

These cases usually involve the allegation that a defendant psychiatrist wrongfully disclosed to a third party information concerning a patient's mental illness.

In *Hammer v. Polsky* (51), the trial court dismissed a suit against a psychiatrist for disclosing confidential information and for "false and incorrect diagnosis of . . . (a) mental condition." The patient claimed in the course of a custody proceeding the psychiatrist disclosed statements made by the patient to the psychiatrist during what the patient considered treatment. The disclosure was alleged to be without the patient's consent. It was also claimed that the psychiatrist disclosed the patient's diagnosis and therefore invaded his privacy. The appeals court held there was no liability for breach of confidence and ruled that, in the absence of an assertion that the psychiatrist was his physician, the patient could not hold the psychiatrist liable for negligent diagnosis.

Furniss v. Fitchett (52) concerned a woman and her husband both seen by the defendant physician, who was a family doctor, for the purpose of what amounted to marital counselling. Testimony revealed she was emotionally unstable and had caused domestic discord by groundless allegations of violence and cruelty against her husband. The husband discussed having his wife "certified" and later requested a report of her condition for the use of his attorney. The doctor issued a report which rather well described the wife's condition. A year later when the wife sought separation and maintenance orders, her husband's lawyer showed her the doctor's report. The wife brought an action against her doctor claiming the unexpected disclosure caused her a shock. The trial court found for her and awarded damages. The doctor moved for judgment notwithstanding the jury verdict. The appeals court reasoned that in this particular case, the physician should have foreseen that the contents of his report might come to his patient's attention and further that his patient might be injured as a result of his giving her husband this

information knowing they were then estranged and not placing a restriction on its use. The trial court held that the showing of the report to the patient by the husband's lawyer was foreseeable "and was the very thing which the law required . . . (the doctor) to take care to avoid" and that the damages resulting therefrom were "not too remote" even though the immediate cause of the injury was an act of the attorney and not the defendant doctor.

Clark v. Geraci (53) involved a patient who had been discharged from government service and sued his psychiatrist for disclosing to his employer that his absence from work was associated with drinking. On one occasion, the psychiatrist told his patient that his employer had requested a letter explaining the nature of the patient's illness. The patient asserted that he had requested the psychiatrist not to send a letter disclosing his problem with alcohol and asserted that the letter which was sent was responsible for causing his employer to fire him. At the trial, the patient claimed the psychiatrist had committed malpractice by divulging a confidential communication. In this case, the court reasoned that disclosure could be recognized as a basis for suit "because the duty of secrecy is implied by our statutory law and widely conceived of in the doctor-patient relationship." However, in this case the court then directed judgment for the psychiatrist on the grounds that since the doctor had, in the past supplied explanations for the patient's absence from work which did not in fact disclose his primary problem with alcoholism, said actions placed the psychiatrist in the position of telling a partial truth. For this reason, the court ruled the patient may not stop his psychiatrist from divulging the remainder of a proper assessment. The court also took note of the fact that there was evidence to suggest that the patient's discharge was due to his repeated absence and not to disclosure of his alcoholism.

In *Morris v. Rousos* (54), an action was brought against a university student health service psychiatrist by a student-patient for injuries caused by an alleged wrongful act in connection with the patient's commitment to a state mental hospital. The patient claimed the psychiatrist had written a letter indicating that he (the student) "was suffering from a presenile psychosis or an early arteriosclerotic change" and asserted the psychiatrist could not properly diagnose that illness because he had not examined him for that condition. The student alleged that a copy of this report was placed in the university files thus reducing his chance for employment following completion of his studies. The trial court entered summary judgment in favor of the psychiatrist and the student appealed. The appeals court held that it could not be presumed that the psychiatrist was without sufficient facts on which to base his diagnosis. The presumption was that he had acted "in a fair and efficient manner

and that when the contrary of this is averred, it should be specific and detailed." The trial court's judgment was affirmed.

Berry v. Moench (55) involved a psychiatrist who was asked by another physician for "your impression" of a young man the psychiatrist had seen as a patient years before. The letter explained that the former patient was "keeping company" with a certain young girl and that her parents had come to the physician making request for advice. At trial, a letter was produced in which the defendant psychiatrist had written to his physician colleague indicating that since the letter was without authorization the patient's name would be omitted. The psychiatrist, however, went on to describe his patient giving a diagnosis of "manic depressive depression in a psychopathic personality" and volunteered information that suggested that his former patient would make a most unsuitable marital partner. Ultimately the patient became aware of this letter and sued the psychiatrist for libel. The trial court held that concern for the young girl's "well-being and happiness" was a sufficient interest for the psychiatrist to protect and further that it was within the generally accepted standards of "decent conduct" for the doctor to reveal the information on her behalf. The court went on to point out that while truth is a defense in a libel action, a psychiatrist is not free to disclose all information he obtains about his patient. However, the court reasoned that in certain cases the physician has a "qualified privilege" to disclose information when there is a "higher duty" to furnish information which, although defamatory, may protect an important interest. The court determined that such disclosure must "be done in good faith and reasonable care must be exercised as to its truth; the information must be reported fairly; and only such information should be conveyed and only to such persons as are necessary to the purpose."

Gasperini v. Manginelli (56) was an unusual case involving a psychiatrist who while treating a patient, wrote a report giving a diagnosis. The psychiatrist failed to add a "Jr." to his patient's name. The patient's father, possessed of similar name, sued the psychiatrist for libel. The father claimed that the statement made by the psychiatrist reflected "actual malice" and that the disclosure ruined both his credit and reputation. The psychiatrist said his report concerned only his patient, the son, and that he gave the report to the son's wife who knew it referred to her husband. The trial court refused a motion for dismissal of the libel suit. The court reasoned "that a statement . . . intended to refer to and may be true of one person does not, as a matter of law, make it impossible to be defamatory of another" and if it is so that "everyone who read the writing understood that it referred to the son is a question of fact to be developed at trial." The court cited a prior decision which held that: "The question is not so much who was aimed at as who was

hit." After due consideration, the court found it could not be said, as a matter of law, that the cause of action, i.e., the libel suit, was either a sham or legally insufficient.

F. Other Problems

1. Need for Consultation

As a general rule, if the treating physician is a psychiatrist he is not under an obligation to consult another psychiatrist with respect to a given patient. His failure to do so will not normally constitute negligence (57). In one of the cases just described (56), the patient claimed treatment was commenced without consulting another psychiatrist. The court denied the allegation of malpractice and said, "Defendant was himself a psychiatrist who had been called in by the family physician. It is understandable that he did not see the need for a consulting psychiatrist." However, in *Landau v. Werner* (12) the court held that in the absence of improvement the treating psychiatrist has a duty to consider referring the patient for the purpose of obtaining treatment from a different source.

A recent case, *Semler v. Psychiatric Institute of Washington* (58) imposed liability for harm to a third party upon a psychiatric hospital and a probation officer. A patient who had been indicted for abducting a young girl was hospitalized pending trial. The court accepted his guilty plea, sentenced him to 20 years imprisonment, and suspended sentence on condition of continued treatment and confinement. The hospital psychiatrist assured the judge that the patient could benefit from treatment and was not a danger to others, so long as he remained in the hospital. While on inpatient status the patient was granted passes to visit family on holidays and weekends. These passes were recommended by the hospital doctor and, through the probation officer, approved by the court. About nine months following admission, the hospital doctor advised transfer to day care status with parental supervision at night. This was approved by the judge. In response to the patient's request, the probation officer granted a series of passes which allowed the patient to leave the state for the purpose of exploring job and living opportunities with more distant relatives. These passes were approved by the doctor but not submitted to the court. Assuming the patient would be leaving the state, the psychiatrist discharged the patient from the hospital. When the patient learned that he could not, for legal reasons, move to his relative's home, he returned to his doctor who advised continued treatment but did not return him to day-care status. The doctor put him in an outpatient group and the patient continued to live with his parents. He found a job and subsequently began to live alone. The patient told his probation officer about the change in treatment status but the officer did

not report it to the court. About one month later the patient killed a young woman. The victim's mother sued the hospital and psychiatrist who as co-defendants filed a complaint against the probation officer. The trial court awarded judgment to the mother and required the probation officer to pay half. The appeals court affirmed the trial court decision and asserted that the "special relationship created by the probation . . . imposed a duty (on the hospital, psychiatrist and probation officer) to protect the public from the reasonably foreseeable risk of harm . . . the state judge had already recognized." The trial court found insufficient evidence to prove malpractice. However, on appeal the court held that even in the absence of malpractice the doctor was liable because his "duty was not restricted to providing acceptable treatment . . . it embraced . . . a duty to comply with the court order so the public would be protected." The probation officer was required to share liability because the court ruled his failure to report the change in patient status constituted negligent discharge of a ministerial duty and not an exercise of discretionary judgment shielded by statutory immunity. The judgment of $25,000 was affirmed and a subsequent writ of certiorari denied.

2. Need for Adequate Records

Merchants Nat'l Bank & Trust Company v. United States (59) involved a VA psychiatrist and hospital chief of staff who had received a telephone call from a veteran's wife objecting to her husband's pending release. While on leave, the veteran killed his wife. The psychiatrist was found negligent for having failed to make adequate notation of her call in the chart and also for his failure to pursue the matter with the doctors and staff directly in charge of the patient.

3. Need to Warn Others

In *Sealy v. Finkelstein* (60), the trial court took the position that while there may have existed a duty on the part of the treating psychiatrist to warn a practical nurse who was caring for an emotionally disturbed patient, the doctor could not be held liable for failure to warn in the absence of evidence that he knew from prior experience that the patient was, in fact, dangerous.

An additional finding of the court in *Merchants Nat'l Bank & Trust Company v. United States* (59) was that a psychologist could be considered negligent for failing to make an employer aware that a psychiatric patient placed in his employ for the purpose of vocational rehabilitation was dangerous in that he might run off and harm a family member.

Tarasoff v. The Regents of the University of California (61), a recent California case, initially imposed on psychotherapists a duty to warn a third party of the potential dangerousness of a mental patient.

The case involved a university student who was in treatment with a clinical psychologist in an outpatient setting. The psychologist was supervised by a psychiatrist. When the patient informed the psychologist of his intent to harm a young lady who had rejected his advances, the psychologist notified the police who subsequently questioned the student and determined that he need not be apprehended. The student withdrew from treatment and at a later date murdered the young lady. See *People v. Poddar* (62). Her parents sued the university claiming, among other things, that they should have been told of the danger to which their daughter was exposed. The regents of the university denied a duty to warn and their contention was supported by the trial court and subsequently affirmed on appeal. The case went to the state supreme court and a decision was filed in December 1974. Therein the court stated: "When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning." This finding caused immediate and grave concern on the part of mental health professionals referable to its potential impact on the practice of psychotherapy. In response, the defendant university joined by other interested parties (including the APA) petitioned the court for a rehearing of the case. Acting without precedent, the court granted the petition. The APA et. al. amicus curiae brief was filed in January 1975. It argued that the imposed duty to warn established an unworkable standard because psychiatrists cannot predict violence and such a duty is inconsistent with the nature of psychotherapy. It also asserted that the court misweighed the balance between a need for psychotherapy and a need for public safety and in so doing seriously infringed patients' rights. The brief suggested statutory commitment as the proper method for protecting society from violent patients. In July 1976 the California Supreme Court filed a second Tarasoff opinion describing an even broader duty: "When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances." It should be noted that the California statute which provides a psychotherapist-patient privilege expressly grants exception to that privilege with implicit right to disclose confidential communications if, in the opinion of the treating professional,

the communication gives reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that the disclosure of the communication is necessary to prevent the threatened danger. The court's finding in this case would appear to make obligatory that which under existing law had been discretionary. While the force of this decision applies only to California psychotherapists, it is unlikely that it will be ignored in other jurisdictions. California has been a bellwether state with respect to social legislation and cases allied to this issue have already surfaced elsewhere. Excellent reviews by Stone (63) and Gurevitz (64) provide greater detail.

3. Frequency Studies

The professional literature on psychiatric malpractice is sparse. One of the first systematic surveys of malpractice in psychiatry was reported by Bellamy (65). He reviewed psychiatric malpractice cases which reached the level of the appellate courts during the preceding fifteen years. He found that during the interval from 1946 to 1951, three cases were decided. Five reached the appellate court between 1951 and 1956, and between 1956 and 1961 ten cases were decided. These cases are a matter of public record and available in abstract form. The study, however, has one drawback—only one case in a hundred goes to appeal. This means that a substantial number of cases which were settled before going to court, or not taken beyond the trial court, remain unrepresented. The case which goes on to appeal is important in that it may establish precedent. However, it is most probable the bulk of malpractice expense rests with those cases settled far earlier in the legal process.

Rothblatt and Leroy (57) cite a study giving psychiatric malpractice figures for the years 1931 through 1971. Between 1931 and 1940, there were only three cases. Between 1941 and 1950, there were seven and between 1951 and 1960 there were nine. But in the last interval between 1961 and 1971, there were a total of twenty-five cases. These data would appear to show substantial escalation of claims frequency. However, it is important to consider that during this same time interval other factors were operative. American psychiatry moved from a custodial to an active treatment posture and it is certain that the number of psychiatrists in practice as well as the number of patients being treated by psychiatrists increased sharply during the reported interval. In 1970 a study of psychiatric malpractice in Southern California was reported (66). The study was an effort to examine at the source, i.e., the claims office used by the insurance company, the incidence and character of psychiatric malpractice on a regional basis between 1958 and 1967. During that ten year interval, a total of 37 claims were filed. There were more claims in the

later years. However, this was offset by the larger number of psychiatrists at risk. During the interval under study, the average claim rate was slightly less than 1.5 claims per hundred psychiatrists per year. This means you would have to have about 70 psychiatrists work a full year to generate one claim. Most cases were settled before trial. Of the six which went to court, four were won, one was lost, and one was settled during the trial. Pretrial settlement costs averaged only a little more than $1,000 per case.

In a recent paper Trent and Muhl (67) reviewed the current position of American psychiatrists referable to their vulnerability for lawsuits in malpractice. They state that the average American physician might properly expect to have one lawsuit every five to seven years of practice in contrast to which the psychiatrist is likely to be sued about once for every 50 to 100 years of practice. In a more recent article Trent (68) reported the experience of the American Psychiatric Association Professional Liability Program since its inception in October 1972. That program now has approximately 17,000 doctor years experience over a course of 3½ calendar years. To date, the program has generated a total of 212 claims yielding a claim frequency of 1.24 claims per 100 doctors per year. By most accepted standards these data are immature and it is probable that the claim frequency in this program, which has been gradually increasing, will continue to do so.

Loss experience from a program in New York (69) which covered 11,000 doctor years during the period 1967-1973 yielded a total of 145 claims for a frequency of 1.3 claims per 100 doctors per year. During an earlier period, 1963-1970, a California program (70) developed loss experience for a total of 2,700 doctor years producing a total of 103 claims for a frequency of 3.7 per 100 per year. This more adverse experience in the California study probably reflects that the majority of doctors insured under that program were hospital-based psychiatrists.

A recent survey (71) polled California psychiatrists referable to their malpractice experience. Of 1,504 respondents, 166 notified of a claim or potential claim during the preceding five years. This yielded a claim frequency of approximately 2.0 per 100 doctors per year. Since these data reflect the incidence of the notification of a potential claim as well as the occurrence of an actual claim, the figure of 2.0 suggests that the incidence of malpractice suits in psychiatry may be more stable than suspected.

References

1. *Saron v. State*, 24 AD 2d 771, 263 N.Y.S. 2d 591 (3d Dep't 1965).
2. *Rosenfeld v. Coleman*, 19 Pa.D. & C 2nd 635, 35 North. Co.R.206 (C.P. Northampton County Ct. 1959).

3. *Brown v. Moore,* 247 F. 2d 711 (3d Cir. 1957).
4. *Woods v. Brumlop,* 71 N.M. 221, 377 P. 2d 520 (1962).
5. *Wilson v. Lehman,* 379 S.W. 2d 478 (Ky. 1964).
6. *Stone v. Proctor,* 259 N.C. 633, 131 S.E. 2d 297 (1963).
7. *Farber v. Olkon,* 40 Cal. 2d 503, 254 P. 2d 520 (1953).
8. *Johnson v. Rodis,* 251 F. 2d 917 (D.C. Cir. 1958).
9. *Quinley v. Cocke,* 183 Tenn. 428, 192 S.W. 2d 992 (1946).
10. *Mitchell v. Robinson,* 334 S.W. 2d 11 (Mo. 1960).
11. Dawidoff DJ: The malpractice of psychiatrists. Duke LJ 1966:696-716, 1966.
12. *Landau v. Werner,* Q.B. March, 1961; 105 Solicitor's Journal 1008 (1961).
13. *Pennell v. Cummings,* 75 Me. 163 (1883).
14. *Landau v. Werner,* Q.B. March, 1961.
15. *Connor v. Winton,* 8 Ind. 315 (1856).
16. *McCandless v. McWah,* 22 Pa. 261, 268-269 (1853).
17. *Hammer v. Rosen,* 7 N.Y. 2d 376, 165 N.E. 2d 756, 198 N.Y.S. 2d 65 (1960).
18. *Landau v. Werner,* Q.B. March, 1961.
19. *Zipkin v. Freeman,* 436 S.W. 2d 753 (Mo. 1968).
20. *Roy v. Hartogs,* 366 N.Y.S. 2d 297 (1975).
21. *Hartogs v. Employers Mutual Liability Insurance Company of Wisconsin,* 391 N.Y.S. 2d 962 (1977).
22. Morse HN: The tort liability of the psychiatrist. Buffalo L Rev 16:649-687, 1967.
23. *Lowen v. Hilton,* 142 Colo. 200, 351 P. 2d 881 (1960).
24. *Rouse v. Twin Pines Sanitarium, Inc.* 162 Cal. App. 2d 639, 328 P. 2d 536 (1958).
25. *Daniels v. Finney,* 262, S.W. 2d 431 (Tex. Civ. App. 1953).
26. *Woodruff v. Shores,* 354 Mo. 742, 90 S.W. 2d 994 (1945).
27. *Kleber v. Stevens,* 39 Misc. 2d 712, 241 N.Y.S. 2d 497 (Sup. Ct. 1963).
28. *Bartlett v. Weimer,* 268 F. 2d 860 (7th Cir. 1959).
29. *Dunbar v. Greenlaw,* 152 Me. 270, 128 A. 2d 218 (1956).
30. Messinger S: Malpractice suits—the psychiatrist's turn. J Legal Med 3:21-29, April 1975.
31. *Blitz v. Boog,* 328 F. 2d 596 (2d Cir. 1964).
32. *Cambell v. Glenwood Hills Hospital, Inc.* 224 F. Supp. 27 (D.C. Minn. 1963).
33. *Duzynski v. Nosal,* 324 F. 2d 924 (7th Cir. 1963).
34. Slawson PF, Flinn DE, Schwartz DA: Legal responsibility for suicide. Psychiatric Quart 48:50-64, 1974.
35. *Hohmann v. Riverlawn Sanitorium,* 103 N.J.L. 458, 135 A. 817 (1927).
36. *Hawthorn v. Blythewood, Inc.,* 119 Conn. 677, 174 A. 81 (1934).
37. *Mills v. Society of New York Hospital,* 274, N.Y.S. 233, 242 App. Div. 245, 270, N.Y. 594, 1 N.E. 2d 346 (1936).
38. *Stanfield v. Gardner,* 56 Ga. App. 634, 193 S.E. 375 (1937).
39. *Dahlberg v. Jones,* 232 Wis. 6, 285 N.W. 841 (1939).
40. *James v. Turner,* 184 Tenn. 563, 201 S.W. 2d 691 (1941).
41. *Tissinger et al. v. Wooley and Emory University,* 50 S.E. 2d 122 (1948).
42. *Kubas v. State, 96* N.Y.S. 2d 408, 198 Misc. 130 (1949). Aff'ds 104 N.Y.S. 2d 856, 278, App. Div. 887 (1951).
43. *Stallmen v. Robinson,* 364 Mo. 275, 260 S.W. 2d 743 (1953).

44. *Hebel v. Hinsdale Sanitorium,* 2 Ill. App. 2d 527, 119 N.E. 2d 506 (1954).
45. *Noel v. Menninger Foundation,* 180 Kan. 23, 299 P. 2d 38 (1956).
46. *Von Eye v. Hamme,* 245 F. 2d 756 (8th Cir. 1957).
47. *Gregory v. Robinson,* 338 S.W. 2d 88 (1960).
48. *Kent v. Whitaker,* 58 Wash. 2d 569, 364 P. 2d 556 (1961).
49. *Benjamin v. Havens, Inc.* 60 Wash. 2d 196, 373 P. 2d 109 (1962).
50. *Baker v. United States,* 226 F. Supp. 129 (1964).
51. *Hammer v. Polsky,* 36 Misc. 2d 482, 233 N.Y.S. 2d 110 (Sup. Ct. 1962).
52. *Furniss v. Fitchett,* (1958) N.Z.L.R. 396.
53. *Clark v. Geraci,* 29 Misc. 2d 791, 208 N.Y.S. 2d 564 (Sup. Ct. 1960).
54. *Morris v. Rousos,* 397 S.W. 2d 504 (Tex. Civ. App. 1965).
55. *Berry v. Moench,* 8 Utah 2d 191, 331 P. 2d 814 (1958).
56. *Gasperini v. Manginelli,* 196 Misc. 547, 92 N.Y.S. 2d 577 (Sup. Ct. 1949).
57. Rothblatt HB, Leroy DG: Avoiding psychiatric malpractice. Cal Western L Rev 9:260-272, 1973.
58. *Semler v. Psychiatric Institute of Washington,* 538 F. 2d 121 (1976).
59. *Merchants Nat'l Bank & Trust Company v. United States* 272 F. Supp. 409 (D.N.D. 1967).
60. *Sealy v. Finkelstein,* 206 N.Y.S. 2d 512 (Sup. Ct. 1960).
61. *Tarasoff v. The Regents of the University of California I* 529 P. 2d 553, 118 Cal. Reptr. 129 (1974).
Tarasoff v. The Regents of the University of California II 551 P. 2d 334, 131 Cal. Reptr. 14 (1976).
62. *People v. Poddar,* 10 Cal. 3d 750, 518 P. 2d 342, 111 Cal. Reptr. 910 (1974).
63. Stone AA: The Tarasoff decisions: suing psychotherapists to safeguard society. Harvard L Rev 90:358-378, 1976.
64. Gurevitz H: Tarasoff: protective privilege versus public peril. Am J Psychiatry 134:289-292, 1977.
65. Bellamy WA: Malpractice risks confronting the psychiatrist: a nationwide fifteen year study of appellate court cases 1946 to 1961. Am J Psychiatry 118:769-780, 1962.
66. Slawson PF: Psychiatric malpractice: a regional incidence study. Am J Psychiatry 126:1302-1305, 1970.
67. Trent CL, Muhl WP: Professional liability insurance and the American psychiatrist. Am J Psychiatry 132:1312-1314, 1975.
68. Trent CL: Early claims experience with the APA professional liability program. Read at the 128th annual meeting of the American Psychiatric Association, Anaheim, California, May 5-9, 1975.
69. Loss experience: New York. Unpublished loss data, Employers Insurance of Wausau program.
70. Loss experience: California. Unpublished loss data, Nettleship Pacific Indemnity program.
71. Slawson PF: Psychiatric malpractice: a state-wide survey. Unpublished. Read at the 130th annual meeting of the American Psychiatric Association, Toronto, Ontario, May 2-6, 1977.

CHAPTER III

THE ROLE OF THE AMERICAN PSYCHIATRIC ASSOCIATION IN PROFESSIONAL LIABILITY INSURANCE

For many years prior to 1972 the American Psychiatric Association sponsored a professional liability program for its members offered in several states. In the late 1960's and early 1970's as professional liability insurance began to take on national prominency and as premiums began their escalation, the officers of APA attempted to find an insurance company of the strongest financial status, admitted and licensed in each state, which would be willing to undertake a national insurance program for psychiatrists. An additional requirement on such a company was to furnish APA with complete claims data. The company handling the previously sponsored program was unwilling to fulfill these requirements. After several attempts by officers and committee persons at several levels in APA over a several year period a suitable company was selected in 1972. The change came about primarily because the previous broker either would not or could not supply information to APA about the types of claims against psychiatrists, furnish actuarial data on the losses, and did not offer insurance underwritten by an insurance company licensed in all states of the United States where the insurance was offered. In addition, complete coverage was not available and many members of the Association were not able to obtain the insurance in some states where it was not offered. The earlier insurance company itself was not rated one of the highest financial strength by acceptable reporting agencies.

With this background, in 1972 the Joseph A. Britton Agency was able to negotiate with Chubb and Sons to offer a professional liability policy. This policy was designed under the guidance of the APA Insurance Committee to cover the specific types of exposures encountered by psychiatrists. Coverage was available to psychiatrists on a nationwide basis. However, at this time the program is not offered in some areas because of special problems. In Puerto Rico a volatile legal climate and especially unfavorable loss experience by Chubb and Sons, Inc. has resulted in its refusal to insure in that area.

The APA program offers coverage for the individual practice of

psychiatry and/or neurology as well as for partnerships and professional associations. Professional employee coverage is included without charge; however, this does not apply to licensed physician employees. Prescribing ECT is covered; however, administering this therapy entails an additional charge of 50% of the individual premium. The program will insure APA members practicing in almost all settings, such as solo private practice, clinics, government service, and hospitals except that hospital superintendents cannot be insured for their administrative liabilities. The policy was designed especially to insure American psychiatrists against the peculiar hazards of the profession including libel, slander, false imprisonment, or unlawful detention suits, and suits resulting from committee work associated with a professional society or hospital as well as claims arising from bodily injury, sickness, or disease—including death. The program was recently amended to offer a 50% premium reduction for psychiatrists employed full time in an organization or governmental agency who may wish to conduct a limited private practice up to fifteen hours a week. An additional premium is required for more than fifteen hours a week. For those who wish greater detail concerning the provisions of the current APA-Britton-Chubb policy, a specimen copy and application form are presented as Appendix 3.

Under the new program APA began a closer relationship with the broker and the insurance company. The insurance company through the broker regularly furnished APA information on the number of members insured, the type of coverages selected and an analysis of all claims and incidents reported to the broker or to the insurance company. The company willingly opened its records to objective analysis by an independent national consulting actuarial firm for review of loss experience. For the first time, this arrangement gives APA a mechanism for independent assessment of the appropriacy of annual premium levels and changes.

As an additional part of the program the Joseph A. Britton Agency, a New Jersey brokerage specializing exclusively in medical professional liability insurance, developed a Loss Control or Claims Review Committee. This Committee has several important functions. As claims against psychiatrists are reported and developed, those which involve potential indemnity payments greater than $1,000 are reviewed in detail by members of the Loss Control Committee. Indemnity means money paid directly to a claimant as a result of judgment or settlement of a lawsuit. Legal expenses are not considered when determining which cases are to have Committee review. This Committee then votes on recommendations from Committee reviewers to either defend or settle claims against psychiatrists contingent upon the Committee's opinion about whether deviation from accepted standards was or was not present in the claim. In this

capacity psychiatrists not only furnish valuable expert review and opinion to their insurance company and its lawyers about validity and appropriateness of claims against the program, but also have an opportunity to become personally familiar with all of the types of claims made against psychiatrists so that as the numbers of claims develop, any patterns or statistical trends which emerge can be communicated as appropriate to APA for recommended changes or safeguards in the practice of psychiatry. The Loss Control Committee, by its mechanism of making recommendations for settling or defending claims, which by the way, the insurance company has obligated itself to follow, gives APA a more substantial control over the tendency of some lawyers to settle claims for a nuisance value in order to avoid litigation, or for company to settle for its own expediency. This is direct support from APA to a sued member in his usually lonely struggle with an angry claimant. The Loss Control Committee also helps protect the member against an improper settlement if, in truth, the member has a defensible situation. This is especially important since two or more adverse claims against a psychiatrist in a five-year period not only bring about a 100% surcharge in premiums, but also subject the insured psychiatrist to individual underwriting, a review procedure in which the insurance company may refuse to renew coverage. In the latter unfortunate circumstance the uninsured member may ask the Professional Liability Committee to review his/her case. Should the review find extenuating circumstances or other considerations, the Committee may request the insurance company to reconsider the underwriting action in question.

As professional liability premiums have dramatically escalated since 1972, APA members nationwide have clamored for an explanation since the known incidence of claims against psychiatrists has been low. Psychiatrists traditionally have been charged the same rate for insurance as general practitioners and other Class 1 physicians because in any small state insurance program there are usually insufficient numbers of participating psychiatrists for accurate rate setting for such a small group. It is felt by many that psychiatrists being lumped together with other Class 1 practitioners has been unwarranted. It is believed that psychiatrists have fewer claims which are handled for a smaller dollar figure than other such Class 1 physicians. Sensitive to these issues, the underwriters of the current APA program have continued to set APA premiums at a discount from Class 1 rates in all States. This reflects the insurance company's concurrence that the actual losses for psychiatrists are less than for other Class 1 physicians. When enough actuarial data is available, the insurance company has expressed a willingness to operate the APA program on a self-rating basis. It is optimistically hoped by all involved that the ultimate premium will turn out to be substan-

tially lower for psychiatrists than for general practitioners and Class 1 physicians. At that time, appropriate rate adjustments would be made. However, for many years since psychiatrists have been lumped together with Class 1 physicians, no separate actuarial data has ever been kept for the practice of psychiatry itself. It is for this reason that the question of the pure premium level for the practice of psychiatry has not heretofore been satisfactorily answered. For this reason the Professional Liability Committee, unfortunately, has never been able to supply interested members hard psychiatric loss data substantiating current premium levels. Only in 1976 did the National Association of Insurance Commissioners begin to require all insurance companies to report psychiatric losses separately from other types of cases. Thus, ultimately there will be a national body of data available on psychiatric losses in addition to the APA program itself. However, APA members have been impatiently awaiting these figures because of the rapid escalation of premiums especially in California, Florida, Ohio, New Jersey and New York. Members in many other states, however, have continued to be exceptionally pleased with their premium and with the operation of the program. They have been satisfied with the financial security offered by the current program.

Although the APA program is not available in some states because of laws which either require all physicians to participate in a special state program or pool, or in other states because of other insurance regulations, all American psychiatrists should profit eventually from the nationwide APA program. The actuarial data which will accrue should have a nationwide effect. Discounts from Class 1 premiums offered by the APA program because of its size, could be so convincing and actuarially sound that APA members in non-participating states may be able to influence their respective Insurance Commissioners and programs using APA data.

The Committee on Professional Liability is still struggling with many current issues. For example, the insurance company recently found it necessary to reduce top limits of coverage to $1 million instead of the previous $5 million limit. Many psychiatrists will find this unsettling inasmuch as claims are frequently pressed with initial requests for damages greater than $1 million. The psychiatrist, with such a claim raised against him, is faced with the problem of waiting for several years for the outcome of such a suit and possibly missing many nights of sleep if the claim is indeed a serious one.

The APA Board of Trustees has been especially sensitive to the needs of the Professional Liability Committee and has financially supported expensive actuarial studies recently contracted for. Funding for such studies is necessary for APA to maintain its own independent

assessment of the operation and premium structure of its professional liability program. The relationship of an actuarial study to an insurance program may be compared quite closely with the function of an independent auditor reviewing the books of an organization to make sure that everything is in order. This is a normal and necessary function of any business or any program.

Because of the increasing complexity of insurance issues in the American Psychiatric Association, and the greater importance which all types of insurance have for the security of involved members, the Board of Trustees has set up an Office of Member Benefits to greatly enlarge the scope of services to members in areas which are so vitally important to all of us both personally and professionally. The job description of the Director of this new office is as follows:

1. Continually reviews existing member benefit programs (i.e., professional liability insurance, life, health, and disability insurance, retirement plans) in light of member needs;
2. Modifies existing programs and develops new programs;
3. Handles member complaints; coordinates with both members and provider companies;
4. Examines member complaints for implications of program improvement and member education;
5. Handles inquiries from members about details of programs;
6. Prepares brochures and articles for *Psychiatric News* to provide information to members and promote available programs;
7. Serves as a focal point for all member complaints and inquiries which are outside the purview of the Membership Services and Studies Division;
8. Coordinates member benefit programs with the administrative and communication facilities of District Branches;
9. Serves as staff liaison for the Committee on Member Insurance and Retirement Plans, the Retirement Plan Committee, the Task Force on Professional Liability Insurance, and other APA components concerned with member benefits;
10. Coordinates with the Administrative Services Division with respect to the employees' benefit program and APA's liability insurance plans.

When this Office is implemented, having a professional insurance person in the Central Office of APA, in addition to the backup support of the insurance administrators, brokers and insurance companies, it should be a very meaningful step forward in strengthening APA's concern about the day to day problems of individual members. This increased staff support also gives the individual committees associated with various member insurance programs an opportunity to devote more professional time to the serious matters of policy, program development, and other considerations which, when carried out by APA members on the respective committees, makes these insurance programs truly of, by, and for the membership.

On a national level, as a more organized effort develops to study medical malpractice itself, the American Psychiatric Association most assuredly will have special expertise to offer in the design and execution of well planned studies to shed light on interpersonal and psychiatric problems related to malpractice claims in medical and surgical areas. Breakdown in doctor-patient communications of various sorts appears to be involved frequently in the precipitation of these claims. Additional study to better anticipate and handle disgruntled response of patients who have experienced bad results and vent their feelings by a suit against the doctor, may well be an additional fertile field for future investigation.

CHAPTER IV

THE CRISIS IN PROFESSIONAL LIABILITY INSURANCE

The crisis was manifested by substantial premium increases and a sudden curtailment of the available market. This was followed by a variety of responses on the part of physicians, attorneys and legislators with mutual accusations referable to the parties and interests affected. Multiple factors were operative, no one of which could be considered solely responsible for initiating the crisis. Some of these are listed below and each is discussed in turn. While not exhaustive, the list includes most of the major issues.

1. Economic Factors

Double digit inflation coupled with international economic circumstances led to an unanticipated change in our national economy. One result was an erosion of the dollars committed by insurance companies to surplus and reserve funds. Many insurers considered their available resources close enough to a critical level that they began to liquidate securities and losses to a point that their capacity to write new policies was significantly abridged. With depleted portfolios, these companies were in no position to reinvest and thus participate in the subsequent market recovery. The result was that certain carriers experienced an unprecedented depletion of capital over a brief interval of time. The crisis for doctors followed as an aftermath of the crisis that the insurance companies had experienced with respect to the depletion of capital. Within a brief period of time, the companies took action. Some withdrew from the market; others raised premiums to levels that had never been anticipated either by the insureds or the companies themselves. Certain companies did both. The obvious initial result was a significant and unanticipated increase in overhead expenses for most practitioners. It is unfortunate that this impact was most severely felt by practitioners with part-time or marginal practices, some of whom are or were engaged in providing needed care to the less affluent members of the community. However, all doctors were affected, but with different results dependent upon their type of practice.

2. Changed Attitudes in the Social Climate

The crisis can in part be attributed to a changed attitude that patients have adopted toward the providers of medical services. This was stimulated in part by the emergence of consumerism and augmented by an unrealistic expectation of the capacity of physicians to deliver consistently good results in a health care system saturated by the attractive but often unrealistic expectations of high technology as widely disbursed through various media. The result has been an increased incidence of malpractice actions associated with untoward results or disappointment with outcome in the absence of demonstrable negligence.

3. Changes in the Legal System

Perhaps as an off-shoot of a greater emphasis on consumer satisfaction and an increase in litigation conscienceness, attorneys in many areas have shown greater interest in participating in malpractice suits. Their enthusiasm has placed a burden on the tort system by extending the protection afforded patient litigants to areas far beyond those originally intended by existing legislation. For example, in California certain proposed legislation would have set premiums in a range of from $4,000 to $8,000 per year. This would have provided coverage at virtual parity for individuals with such diverse practices as pediatrics and neurosurgery. Most psychiatrists practicing under that program would have enjoyed the lowest rate classification, but at the same time would have experienced a substantial increase in actual premium dollars paid. Because psychiatry represents but a small fraction of total medical practice, psychiatrists traditionally have been rated as a function of so-called "Class 1 Physicians," a group which includes internists, pediatricians, neurologists and certain other practitioners. Most professional liability insurance companies base their premiums for psychiatrists at these levels or at a fraction thereof. With premium escalation, the amount of premium asked of psychiatrists began to assume a greater than anticipated economic burden and soon caused widespread concern. Since insurance companies traditionally do not keep close actuarial control on the relatively small part of their book involving professional liability risks, they were caught by surprise with sudden geometric increases in losses and an inability to actuarially lay the financial responsibility for these losses at specific speciality doorsteps.

4. The Response to the Crisis

When the insurance industry dramatically increased premiums in an effort to prevent further losses, physicians sought relief from various sources. There was immediate appeal to legislators and in some states

laws were swiftly passed only to suffer subsequent challenge on constitutional ground. Another avenue of recourse was for medical society representatives to bring pressure to bear on their state insurance commissioners, some of whom ordered certain companies to continue to write professional coverage in the state at rates to be determined by the commissioner following an investigation of the alleged circumstances.

In a number of states, the response was a formation of joint underwriting associations (JUA). This amounts to a legislative effort directed toward maintaining coverage backed by the state government when insurance was no longer available from ordinary commercial resources. This maneuver, while attractive in some respects to high-risk practitioners, in most cases, offered little to the lower risk, non-surgical physician. In those states where the JUA was made mandatory and became the exclusive provider, the result was an emergence of a grossly discriminatory rate pattern manifested by a striking compression of previously established risk classifications with a large elevation of lower premiums.

In the Fall of 1972, and for the reasons stated in Chapter III of this Task Force Report, the American Psychiatric Association endorsed sponsorship of the current APA-Britton-Chubb insurance program setting the premiums at a discount of 10%-25% from the leading carrier or medical society program in each individual state. At the time this seemed like a highly satisfactory formula. It was believed by all, including the insurance company, that psychiatric claim frequency and actual dollar losses on each claim would be less than the experience of Class 1 physicians but the exact amount on a nationwide basis was not known because prior to that time insurance companies had either not separated psychiatrists from other Class 1 physicians or had kept such information as a business secret. Chubb and Son (Vigilant) agreed to continue with this practice until enough loss data was developed on the APA program to allow it to become self-rated. Self-rating is an insurance concept that means that premiums charged to the insured members would be proportional to the actual losses. Unfortunately, due to the so-called long tail of medical malpractice, it takes at least five years and a sufficiently large number of claims for a reasonably credible amount of loss data to be developed and allow for full self-rating of a professional liability insurance program. While the need for this interval was known at the outset of the program, neither the insurance company nor the APA committee had any expectation of a 200%-500% increase in insurance premiums for some areas of the United States. Premiums for APA insured psychiatrists were regularly increased and large amounts of cash appeared on the reports furnished to the APA Board of Trustees along with notice of very minimal payouts. Because of the long tail, suspicions developed and serious questions were raised about the soundness of APA's program and whether

members were being overcharged. These questions grew from the lack of understanding of the long period of time between the clinical event leading to a malpractice claim, or the reporting of a potential claim, and the final settlement of that claim. This series of events may require from four to nine years depending upon the locality. It often reflects a clogging of the court calendar and the slow rate at which legal case work proceeds. Because of this, large amounts of money must be kept in reserve by insurance companies, not only for cases that are reported but also for cases that are not yet reported but can be reasonably expected to be reported in future years. See Table B of this chapter.

During this period of time, there were other serious questions raised about the insurance company's insistence upon waiting for a large number of claims to be filed before self-rating of the APA program could be instituted. The matter, not well-known outside of insurance circles, has to do with the need for what can be called credible data. Credible data means having enough claims to satisfy insurance company actuaries that under similar circumstances and exposure, in the future, the claim frequency will be the same as it has been in the past. Between 600 and 1100 claims are usually required by actuaries to be satisfied that the experience is fully credible or reliable. Even insurance industry actuaries question the number and the ultimate value of these data when the number of claims are slow in accumulating.

To make matters worse, other companies providing professional liability insurance for certain special groups of psychiatrists offered a much lower premium than APA in certain states but were not willing to write such coverage in all areas. These events added additional fuel to some members' suspicions and to the APA crisis itself. If, for example, APA had had several additional years of operation with loss data which had matured with an adequate number of claims already processed, and had therefore become already self-rating, it is unlikely that the APA crisis itself would have developed to the extent that it has. At this time, the first major losses are beginning to appear and the insurance company is beginning to make payouts. Psychiatrists who have previous questions may now begin to experience some understanding of the need for the company to accumulate necessary surplus and reserves to cover losses which may occur in the future.

The following tables show the financial experience of the APA program through the Fall of 1977. Table A shows the amount of premium, number of claims and loss as of 31 August 1977. Table B shows the percentage of loss paid out for medical malpractice over the United States in a typical professional liability program. It demonstrates the long tail phenomenon of medical malpractice. Table C applies the cumulative percentage of losses paid, as shown in Table B, to current APA program

TABLE A

APA-Britton-Chubb Professional Liability Program
Premium Allocation by Policy Year

Policy Year	*Premium Collected ($)*	*Claims*		*Loss or Potential Loss**
		Closed	*Open*	
1973	57,178	4	2	18,488
1974	500,562	21	19	345,461
1975	1,017,382	24	44	478,745
1976	3,276,827	39	64	474,434
1977	5,505,335	0	25	215,475
TOTALS	10,357,284	93	154	1,532,603

* These amounts reflect the total claim payment and processing activity for the policy year. Included are: paid indemnity, legal and investigative expense and monies set aside in anticipation of the probable cost of known claims.

TABLE B

National Average of Medical Malpractice Loss Payouts By Year

Incident Year	*Cumulative % Of Final Losses Paid*	*Incident Year*	*Cumulative % Of Final Losses Paid*
1	2%	8	75%
2	5	9	82
3	13	10	87
4	24	11	92
5	42	12	96
6	55	13	100
7	66	14	

Source: Insurance Services Office, Unpublished data supplied by APA actuary.

experience and indicates that, at least in this early phase, the APA program is relatively consistent with national medical malpractice claims experience.

The schedule shown in Table B has recently been revised based on more refined data from the American Insurance Association/Insurance Services Office (AIA/ISO) loss distributions. These cumulative percent losses by year are presented as Table D. When these rates, which indicate a more rapid payment of losses, are applied to premium collected (from Table A as in former example), the actual loss paid by the APA-

TABLE C

Comparison of projected and actual payment of losses in APA-Britton-Chubb program using payout rate shown in Table B

I.	*Policy Year*	*Premium Collected ($)*		*% Payout*		*Projected Loss Payments ($)*
	1973	57,178	×	42	=	24,015
	1974	500,562	×	24	=	120,135
	1975	1,017,382	×	13	=	132,260
	1976	3,276,827	×	5	=	163,841
	1977	5,505,335	×	2	=	110,106
				TOTAL		550,357
II.	1973-1977 Actual loss payments*					
	Indemnity 319,436					
	Expenses 194,324					
	Total					513,760
III.	Program paid out 93% of projected loss					

* As of 31 August 1977.
Source: brokers report, Appendix 4, p 1.

TABLE D

National Average of Medical Malpractice Incurred and Paid by Year

Incident Year	*Cumulative % Losses*	*Incident Year*	*Cumulative % Losses*
1	1.1	9	87.5
2	6.8	10	91.3
3	17.9	11	94.4
4	35.6	12	96.7
5	51.8	13	98.4
6	65.3	14	99.5
7	75.0	15	99.9
8	82.1	16	100.0

Source: AIA/ISO Loss distributions, includes incurred and closed cases.

Britton-Chubb program falls to 76% of the projected amount as shown in Table E.

This is probably a more accurate reflection of the program's ultimate loss development since the revised projection is based on a broader range of loss data. While the difference between the projected and paid losses

TABLE E

Comparison of projected losses (incurred and paid) in APA-Britton-Chubb program using revised payout rate shown in Table D

I.	*Policy Year*	*Premium Collected ($)*		*% Payout*		*Projected Loss Payments ($)*
	1973	57,178	×	51.8	=	29,618
	1974	500,562	×	35.6	=	178,200
	1975	1,017,382	×	17.9	=	182,111
	1976	3,276,827	×	6.8	=	222,824
	1977	5,505,335	×	1.1	=	60,559
				TOTAL		673,312
II.	1973-1977 Actual loss payments*					
	Indemnity	319,436				
	Expenses	194,324				
	Total					513,760
III.	Program paid out 76% of projected loss					

* As of 31 August 1977.
Source: brokers report, Appendix 4, p 1.

may indicate a more favorable experience for psychiatry in contrast to other forms of medical practice, confirmation of this attractive trend must await further loss emergence.

An additional factor to bear in mind is that professional liability loss experience will vary in different states and even between certain localities within a state. California, which is considered to have a liberal judicial climate, provides an instructive example. Table F compares California to the other states insured by the APA-Britton-Chubb program with respect to incurred losses, earned premium, policies in force and outstanding reserves. Although the losses in California are large, the number of psychiatrists is small. For this reason, the numbers are not reliable but the losses in themselves are significant with respect to the total program.

The APA is now in the fifth year of its new professional liability program. It is hoped that the insurance company will adhere less rigidly to its original criteria for premium setting as claims loss experience in the program approaches actuarial credibility. It can reasonably be hoped these changes will come about quickly since several thousand doctor years of experience have been accumulated under the APA program.

TABLE F

Comparison of Incurred Losses, Earned Premium, Policies in Force and Outstanding Reserves Between California and the rest of the APA Professional Liability Program

Incurred Losses* for the *Calendar* year 1976($)		
California	223,711	or 40% of Program's incurred loss for that period
Rest of APA Program	329,359	
Earned Premium for the *Calendar* year 1976($)		
California	370,623	or 8% of Program's earned premium for that period
Rest of APA Program	4,426,618	
Policies in force as of December 31, 1976		
California	266	or 4½% of policies in force as of that date
Rest of APA Program	5,625	
Total outstanding reserves as of December 31, 1976($)		
California	278,750	or 37%
Rest of APA Program	466,450	

* Incurred losses include: indemnity payments; allocated expenses; reserves on 1976 cases; and reserve revisions on outstanding claims from prior years.

For those interested in greater detail, the indemnity experience of the APA-Britton-Chubb program, as provided by the broker, is included as Appendix 4. This appendix also includes a breakdown of losses with various clinical categories.

5. The Possible Alternatives

Prompted by the liability crisis, APA held hearings and heard proposals from insurance brokers, attorneys and consultants who detailed the advantages and disadvantages of the various forms of doctor-owned companies. A summary of these deliberations is contained in Appendix 1. Some aspects of the findings are discussed below.

A. Purchase of an Existing Dormant Insurance Company

This strategy is occasionally used because it solves the significant problem of providing a vehicle whereby insurance can be written for a wide geographical area by one company without having to go through the often involved and time consuming procedures of approval by in-

dividual insurance commissioners necessary before one is allowed to write insurance in a given state on an admitted (licensed) basis.

The obvious advantage of such a tactic is to shorten the "start-up" time required to get a program operative. In this way, conversion to a psychiatrist-owned program could be done with reasonable dispatch.

This strategy has some disadvantages. The first is cost. Dormant insurance companies which are licensed to write in a significant number of states are sold only infrequently. As a result, the market is not well defined and it is difficult to determine a fair purchase price. One company offered to APA was licensed in 47 states and carried a price tag well in excess of $1,000,000. Another disadvantage is the risk, or potential risk, of inadvertently assuming liabilities associated with the prior operation of the company purchased. In most cases, this risk can be reduced or eliminated by documents signed at the time of acquisition.

B. Formation of a New Company

An alternative discussed with APA and staff members who attended the sessions was that of forming our own new company. There are certain advantages with this approach in that ownership, management and direction of the company would come from the membership who would be free to set policy independent of most outside agencies with the important exception of the state insurance commissioner.

APA ownership would provide for a more flexible method of setting premiums and would allow for direct control of claims management, loss containment and underwriting practices. It would also make risk selection at the local level more feasible. Ultimately, these efforts would result in a substantial reduction of program cost as a reflection of loss experience. These efforts, primarily directed toward loss control, would be consonant with APA's position on quality assurance for patient care as provided by those psychiatrists who participate in the program.

Another potential advantage would be preclusion of excess profits by the underwriter since self-ownership would provide for maximum possible control of premiums charged the insured. An association-owned program would allow for better control over reserving practices. This means the estimation of the ultimate cost of a claim at the time it is reported to the insurance company would be in the hands of a member-responsive control committee not subject to the arbitrary, profit oriented and divided allegiance of a commercial underwriter.

It should be recognized there are significant disadvantages associated with setting up a APA owned and operated program. The first and perhaps the most conspicuous would be the cost. This type of program would require very substantial funding. At its inception, this would involve legal fees, filing fees, the cost of a feasibility study and other

administrative expenses. The major problem would be the acquisition of surplus. It is a requirement in all states that before an insurance company can accept premiums, the company must demonstrate to the satisfaction of the insurance commissioner the accumulation of sufficient funds to enable timely payment of potential claims. This surplus capitalization would have to come from an initial contribution by the insured members or be provided by APA from some other source. The amount involved is large (an informed estimate set it at $5,000,000), and acquisition could present a serious problem. It should be noted that if this surplus were to be accumulated in the form of an individual assessment at the time the first premium is paid, the assessment, unlike the actual premium paid, cannot under most circumstances be considered a business expense for tax purposes. Another problem is that of the uncertainty of how the formation of a psychiatrist-owned company would affect the tax status of APA as parent organization.

Most doctor-owned professional liability companies were organized in areas where such action was mandatory. For example, when all commercial companies withdrew from an area or when the doctors believed they were being overcharged. To date, independent actuarial studies obtained by APA do not lead to a conclusion of overcharge.

An additional concern is that an association program would carry with it a substantial financial commitment both on the part of the insureds and the association, divestiture of which could result in significant loss. This is especially relevant now because the status of national health insurance remains uncertain. It is entirely possible that within a few years federal legislation would make this type of program unnecessary for many, if not all, members.

Another matter to consider is the risk of insolvency from adverse loss experience. An APA owned program would probably be restricted to and limited by the parent organization membership. It would be a small program compared to most insurance companies. Adverse loss experience would have greater impact and the possibility of insolvency would actually be enhanced by the modest scope of this well intended effort in professional risk sharing. Any psychiatrist-owned program will, of necessity, have to compete with other programs. There is a possibility, if not a likelihood, that in some cases the program could not be competitive. This would further limit the number of participating members providing an even smaller exposure base from which to operate.

CHAPTER V

THE FUTURE OF PROFESSIONAL LIABILITY INSURANCE IN THE UNITED STATES WITH RECOMMENDATIONS FOR POSSIBLE ACTION

This is an attempt to assess the short and long term future regarding medical malpractice insurance, especially for psychiatrists. It is quite evident that psychiatrists will remain inextricably bound to the same dilemma facing our non-psychiatric medical colleagues.

There will be uncertainty for some time in the insurance industry regarding all forms of liability insurance. In some instances, large insurance companies have become unstable and required refinancing, support, and restructuring to avoid insolvency. This may well continue in the future. Insurance companies involved in product liability insurance will be faced with a profound escalation of claims and damages. Premium structures may become erratic and confused. There will probably continue to be premium increases and withdrawal from these markets by insurance companies. We are now witnessing these problems in the medical malpractice area. There is also a climate of litigation which is somewhat unpredictable and is growing rapidly and encompassing other professional fields as well. For example, members of the legal profession are now finding themselves facing malpractice claims at an escalating rate due to inadequate preparation of cases, failures at following established legal standards, etc. Public officials are now, in many instances, finding themselves compelled to carry even higher liability insurance coverage. This climate is encouraging an increased sensitivity and desire on the part of the public to sue for real or imagined damages. As a consequence, we will find in our own medical malpractice area that there will be fewer companies able to participate, even with exorbitant rates, and the available market of insurers may shrink rapidly.

Many objections have been raised by irate professional associations regarding excessive insurance company profits and the faulty use of actuarial data. In some cases, such claims may be justified. Nonetheless, insurance companies are often unwilling to participate in competition

because profits may prove illusory and losses in the future could be potentially enormous. Loss data is often incomplete and there will still be significant guesswork in underwriting because of inadequate actuarial data and an unpredictable future. Primary insurers, underwriters, reinsurers, and surplus line carriers are all cautious and they will continue to be so. Insurance companies are more and more limiting their professional liability commitments even where such business has been profitable. One reason is because of the characteristic long tail of malpractice claims and thus the need for insurance companies to maintain increasingly large surpluses for long periods of time; in effect, the companies wish to place less of their eggs in this shaky basket especially where other prospects for investments are more attractive to them. For the moment, the trend will continue to be that of withdrawal from the market or towards minimal commitments by the insuring companies.

Each state will continue to maintain somewhat different insurance availabilities. Likewise, Chubb will probably continue to carefully monitor its exposure. The Merrill Management Company will not be writing new business in California. The various state JUA's, and "physicians' own" companies and others will also be increasing rates.

For the short term, psychiatrists may not suffer excessively. We will probably bite a small bullet and accept increases. Our other medical colleagues will be in greater economic pain. It is difficult at this moment to project a long-term view of malpractice insurance and its impact on psychiatry. There are some experts who feel that while increased rates will continue, the escalation will level off and, with stabilization and normalization, there will be an increase of companies in the insurance market. There are other experts who predict continued escalation of rates and continuing insurer withdrawal.

The ultimate fear is that with a spiral of increasing awards, with a resultant escalation of rates, that ultimately we may face a collapse of the entire health delivery system as we know it today. There are many who feel that changes may have to be made in the insurance structure lest we have a grinding down to a halt of the malpractice insurance structure with psychiatrists linked to the dilemmas of our other medical colleagues. We will probably see many changes taking place with respect to types of insurance coverage by individuals in their various regions and states; tort law changes, limitations of damages, various compensation plans to manage adverse outcomes, and strengthening of the various regulatory agencies and increases in authority of the PSRO's including various efforts at disciplining and controlling incompetent practitioners. We will no doubt see many legislative trade offs which will serve to increase the regulation of the practice of psychiatry.

Quest for Insurance

For both the short and long term, we are going to find many individuals, groups, and hospitals shifting and making efforts at locating newer and less costly available methods of malpractice insurance.

The purchase of "claims-made" policies will increase especially in those areas like California where premium rates are escalating and out of reach of some individuals. Claims-made underwriting is not a completely new development. For example, Lloyds of London has issued such policies for the past ten years. In the usual "claims incurred" or "occurrence" policies, regardless of when a claim is submitted, it is charged to the policy year of the injury or occurrence. In claims-made policies there is no long tail and only claims submitted during the year the policy is in force may be charged to the policy. Claims-made advocates suggest that this approach is closer to a pay-as-you-go type policy since the insurer is responsible only for claims submitted during a given year; uncertainties of the long tail are diminished and development of yearly rates is based on experience factors of the immediately preceding year. For the short term and initially, claims-made premiums are but a fraction of occurrence policies. Of course, if one continues with a policy on a year by year basis, rates increase markedly in order to cover the developing tail. This type of policy is perhaps an advantage to new physicians just starting out in practice who cannot afford the overwhelming burden of conventional occurrence policies. It is then essential for the physician to carry liability coverage for any period, say, after cancellation of a policy, retirement, death and probation of the estate. Most present claims-made insurers provide such extension of coverage.

It is important to note that claims-made approaches do not alter statistics or the frequency or dollar amount of claims. For this reason, ultimately rates must catch up to occurrence-type policies. Thus, those who argue against claims-made concepts see any savings as illusory, transient, and a potential risk to the physician.

There will probably be a continuation of the development of many new private companies created by physicians for the purpose of insuring themselves and groups which they form. Many of these self-insurance approaches represent an attempt to spread the risk and while they will no doubt continue to flourish, often represent an illusory coverage and will continue to expose such individuals to future risk.

We will continue to see the development of other innovative and ingenious attempts at solving the malpractice problem. Many groups have developed and have become involved with "offshore malpractice insurance." These companies, called "captive" companies because they insure primarily the individuals or institutions who own them, have

been formed because the individual states do not permit the formation of such malpractice companies without being under the control of state insurance departments. Since they cannot be formed on U.S. soil, they are formed in Bermuda or Grand Cayman Island, and no doubt in the future elsewhere. These offshore companies thus avoid state control. Significant economies are achieved because surpluses are minimal and often not required at all. The critics of these self-insured and claims-made techniques suggest that these approaches may be of some value to hospitals and some individuals in stabilizing or reducing premiums, but that the risks are enormous. Nonetheless, we can anticipate further similar efforts being developed.

Should conditions warrant, there may be further study by APA of the feasibility of setting up an APA captive. For the moment, such studies indicate complicated legal problems, a substantial capitalization required to provide adequate surplus, and substantial risk factors.

Going Bare

Throughout the country, an increasing number of physicians, including psychiatrists, have made a decision to discontinue their professional liability insurance. This trend will probably continue. At the present time, perhaps 7% of the doctors in private practice are "going bare." In California, estimates are that 20% of physicians have discontinued malpractice insurance. Out of economic and other necessities, this percentage could increase markedly. Other physicians have not gone all the way, so to speak, but have reduced the amount of coverage in malpractice insurance. In individual instances, there may be balancing considerations in doing this. For the most part, this alternative can be considered perilous. It is highly doubtful that any attorney would withhold action because there is no insurance. Physicians are generally considered to be financially well off and seizure of their assets should provide adequate funds to cover most damage awards. Even if such assets were to be transferred to others in advance of a suit, such divesture could be challenged. Assets accumulated after commencement of a suit plus future income might well be made available through court action, including garnishment. This unpleasant application of bankruptcy may not even be available. Further, the maneuverings and manipulations required to obscure and transfer future income would place the "bare" physician in endless legal involvements. Serious legal struggles with protracted litigation would no doubt be consequence and the economic burden of having to obtain one's own counsel would be substantial. Most importantly, the psychological struggle of going it alone could be overwhelming. This is even more so because of the protracted period of time

involved in malpractice cases. Once a physician elects to go bare, this action places the physician in a potential for catastrophic loss indefinitely.

Tort Law Changes

In the future, there will no doubt be increasing efforts at modifying medical malpractice law in the various state legislatures. It is doubtful, however, that tort law changes would have any significant effects on malpractice rates or malpractice insurance availability in the immediate future. The major tort reforms will probably be concerned with minor alterations in the statutes of limitations; modifications in some areas with respect to the definition of medical malpractice; the concept of *res ipsa loquitur* (where, in effect, the defendant-physician must prove he/she was not the negligent party in the fact of obvious circumstantial evidence that negligence occurred) and the issue of informed consent and physician representations to patients.

Limitations of Damages

It is anticipated that many legislatures will alter the amount of damages awarded to injured individuals. This would encompass a limitation on damages for pain and suffering. In some states, for example, a ceiling of $100,000 is maximum; in others, $250,000. Contingent fee arrangements and schedules will no doubt be increasingly recommended in the various legislatures. The concept of structured awards, i.e., payment not in lump sums but rather to afford economic and medical security for injured patients, will be increasingly legislated. Other proposals will be those establishing a collateral source rule to allow introduction of evidence at a malpractice trial of other compensation or reimbursements that a patient might have received from other sources. It is anticipated that increasingly legislatures will modify or remove the *ad damnum* clause. The *ad damnum* clause is merely the establishment of the dollar amount warranted for recovery from the defendant. The entire area of damage limitations, and especially those limiting damages for pain and suffering, will be open to challenge on constitutional grounds.

Litigation Alternatives

It is anticipated that we will see considerable experimentation and development of efforts at avoiding costly court trials in malpractice situations. Arbitration, both binding and non-binding, is being experimented with in various states. The evidence is still not conclusive as to how much arbitration actually reduces the malpractice dollar. There are some who suggest that the trend toward arbitration will result in greater costs to physicians since more small claims would be settled. In addition to

the likelihood of facing more small claims, there is a tendency of arbitration panels to give something to the plaintiff regardless of merit.

It can be anticipated that more states will develop mediation panels which would tend to expedite malpractice cases. It is not known if mediation panels significantly alter the dollar expense in malpractice. We recommend continuing study of this concept where utilized as, for example, in New York.

Further Directions

The malpractice crisis, as noted, has forced many doctors into the liability insurance business. There are now in operation 13 physician-owned medical society sponsored professional liability insurance companies with more being proposed. A major problem facing these companies is marginal capitalization, with relatively few participants. Some companies may be on shaky ground. One of the problems is the difficulty many of these companies may have in obtaining adequate reinsurance on favorable terms. More and more, these reinsurance companies will probably be pulling out of the market if trends continue. The AMA has set up AMACO (American Medical Assurance Company) which is being assisted by the Kemper Insurance Company and hopes to help medical society sponsored physicians insurance companies obtain reinsurance. This trend will probably continue and may be of some help in stabilizing future premiums.

A possible further development which may assist in stabilizing the insurance structure would be the establishment of federal malpractice reinsurance. Federal reinsurance on a standby basis is also being studied in Washington for product liability insurance. For the government to become so involved would require legislation and no doubt certain controls over standards of care and some tort reform requirements. If successful, this might allow companies to decide against pulling out of a state and might even encourage other companies to return.

The increasing cost of medical care is of great concern to both state and federal government. With the advent of national health insurance, the government would become increasingly interested in reducing health and malpractice costs. The increasing cost of malpractice insurance could lead to a hastening of the nationalization of health care with all its attendant constrictiveness and limitations.

Thus far there has been a relatively stable claims pattern in psychiatry albeit with quantitative increases in recent years. This pattern will probably continue. However, with changing patterns in psychiatric care if trends continue, we may see some changing patterns in claims. This could be a result of the increasing use of newer drugs, other invasive techniques in psychiatric care, and increasing use of paraprofessionals.

There are those who feel that with some continuing alterations in court reform along with changing patterns economically and socially, with the advent of private and governmental reinsurance, and with increasing education, there will be a return of insurance companies to the malpractice market and some stabilization so that the increase in insurance rates will not rise in excess of the rest of the economy.

There are a large number of experts who feel in the short run that there will be uneven but continuing insurance rate increases throughout the country, and that ultimately the present tort law liability insurance system for medical malpractice will break down. Resultant rates would rise to such unacceptable levels that the entire malpractice system would gradually grind to a halt with impairment and compromise of the health delivery system. These experts envisage hospitals shutting down, physicians ceasing to carry malpractice insurance or reducing their coverage to the ultimate detriment of the public.

Study of Compensation Systems

If we are indeed moving towards a breakdown of our present system, we will probably see increasing reviews of our entire reparations system. Under present and future study will be attempts to remove the determination of negligence from consideration in such reparations. Fault finding and the legal and administrative efforts at determining blame for medical injury (or poor results) is the costliest aspect of professional malpractice liability insurance. These determinations are far more costly than the ultimate payment in damages to the suffering victim. Determining blame is costly, capricious, and unpredictable. Any reparations system which removes culpability could be an answer to this dilemma. This, in effect, introduces no fault insurance in the malpractice area, as perhaps modeled after workman's compensation management for medical injuries. The funds available for this system could come from existing insurance programs or other funding within the states. There are those who argue that there would result deprivation of individual rights to suit and proper damages and that no fault insurance could become even more costly as a result of increasing claims without significant alteration in dollar costs.

Because of the escalation of all negligence actions, sweeping changes are being recommended for the entire reparations system of which medical malpractice is only a portion. Since 1974, New Zealand has had a no fault comprehensive accident compensation system. Sweden, since 1975, has operated a no fault medical injury compensation system in which injured patients still retain their right to sue for damages if they so elect. Both the New Zealand and Swedish approaches are worthy of close scrutiny.

Continuing education in all aspects of professional liability insurance is essential for psychiatrists and all physicians. With some understanding of the folkways of the industry, the current legal climate and identified areas of risk, the informed practitioner will be able to select from available options those best suited to his/her needs. It will be important to stay informed and participate in the development of new concepts in a turbulent area of professional practice.

SELECTED READINGS

American Medical Association: Malpractice in focus. Chicago, American Medical Association, August 1975.

APA task force report: Malpractice insurance: an update for psychiatrists. Psychiatric News, December 17, 1976, p 2.

Bernzweig EP: The need for a national policy on injury reparations. N Engl J Med 296:569-570, 1977.

Bernzweig EP: Why the malpractice crisis has to get worse to get better. Medical Economics, January 24, 1977, p 37.

Breo D: Medicine's new venture: insurance. American Medical News, January 3, 1977, p 11.

Cooper JK: Sweden's no fault patient injury insurance. N Engl J Med 294:1268-1270, 1976.

Curran WJ: Malpractice insurance: a genuine national crisis. N Engl J Med 292:1223-1224, 1975.

Curran WJ: The malpractice insurance crisis: short term and long term solutions. N Engl J Med 293:24-25, 1975.

Curran WJ: How lawyers handle medical malpractice cases: an analysis of an important medicolegal study. NCHSR Research Report Series, DHEW Publication No. (HRA) 76-3152.

Fowler E: Burden of product liability insurance. New York Times, January 30, 1977, sec D, p 3.

Harsham P: Offshore malpractice insurance. Medical Economics, February 7, 1977, p 215.

Hartley WD: Helping the hurt: to accident victims, New Zealand offers the balm of money. Wall Street Journal, September 16, 1975.

Matt JA: Professional liability—going bare. J Med Soc NJ 73:1000-1002, 1976.

Report of the special advisory panel on medical malpractice. State of New York, January 1976.

Reynolds J: Tips from the big groups on heading off malpractice problems. Medical Economics, January 10, 1977, p 173.

GLOSSARY

ADMITTED COMPANY: meets requirement of state insurance laws, licensed to do business in the state, usually participates in state operated insolvency fund.

AGENT: a person authorized to act for another, in law the concept of agency conveys to an employer liability for the acts of an agent, in insurance a salesperson who may work for or be a broker.

APPEALS COURT: reviews the decision of a trial court, concern is with errors in law not findings in fact.

BROKER: the insurance middle man, he/she places the risk with the underwriter and receives a small percentage of the premium for the effort.

CAPTIVE: insurance company set up by an organization specifically to handle its insurance needs.

CARRIER: informal name for an insurance company.

CERTIORARI, WRIT OF: part of the legal review system, it enables an appeals court to get more information in a pending case (Latin: to be informed).

CLAIMS-MADE POLICY: newer form of malpractice insurance, covers only claims filed during policy year, usually cheaper than occurrence form of policy.

DEFENDANT: the person against whom the action in law is brought, the person sued, usually "us".

DUTY: in law language refers to an obligation derived from an acknowledged right, e.g., an expressed right to good medical treatment imposes upon doctors generally a duty to provide it.

IBNR: incurred but not reported, anticipated insurance losses, monies set aside to pay anticipated losses.

INCURRED LOSS: insurance program reporting term, includes paid indemnity, legal and claims expense, reserves on open cases and a factor based on a projection of incurred but not reported losses.

INDEMNITY: a contract by which one party engages to secure another against anticipated loss, compensation given to remedy a sustained loss.

INTERINSURANCE EXCHANGE: a group cooperating through an attorney in fact to insure each other, a reciprocal.

JUA: joint underwriting association, state mandated program for the purpose of risk sharing between insurance companies.

LIABLE: obligated in law to make compensation, restitution or give satisfaction.

LOSSES PAID OUT: monies actually paid in claims settlement or to satisfy judgments.

MALPRACTICE: professional misconduct, unreasonable lack of skill with respect to professional duties, includes illegal and immoral conduct.

NEGLIGENCE: doing something a reasonable and prudent person would not do or not doing that which such person would do, a legal delinquency resulting from failure to show care.

NON-ADMITTED COMPANY: not subject to state regulatory provisions, may provide insurance coverage not otherwise available.

OCCURRENCE POLICY: usual form of malpractice insurance, covers risk of practice during policy year irrespective of when claim is filed.

OFF SHORE CAPTIVE: an insurance company set up outside of a country, usual intent is to avoid onerous regulation.

PLAINTIFF: a person who brings an action in law, the person who sues, usually "them".

POLICY: the insurance contract, usually specifies the nature of the risk and limitations of coverage.

PREMIUM: money paid in return for compensation in event of loss from an insured peril.

PRO HAC VICE: a law phrase meaning for this one particular occasion (Latin: for this turn).

RECIPROCAL: a group cooperating through an attorney in fact to insure each other, an interinsurance exchange.

RESERVE: monies set aside in anticipation of an underwriting loss.

RES IPSA LOQUITUR: rebuttable presumption of negligence, requires both means of injury to be in exclusive control of defendant and accident to be of a type that would not occur in the absence of negligence, used to place a burden of proof of non-negligence upon a defendant (Latin: the thing speaks for itself).

RISK: the hazard of the loss contemplated in the policy of insurance, a specified peril.

SOVEREIGN IMMUNITY: precludes liability when a state is engaged in a function of government, less common now.

SURPLUS: accumulated premium available to pay future claims, not reserved to a specific claim, can be invested.

TORT: a violation of a duty owed another and imposed by law, a civil wrong (from the Latin torquere—to twist or wrest aside).

UNDERWRITER: in return for a premium accepts liability for and pays insured losses.

APPENDICES

APPENDIX 1

HIGHLIGHTS OF MEETING OF COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE JANUARY 1977

1. ADVANTAGES AND DISADVANTAGES OF ESTABLISHING OR PURCHASING A COMPANY

a. *Britton Agency* (broker for APA professional liability program)

Advantages: APA would have its own insurance company and be in complete control (subject to 50 state insurance commissioners) and do what it wants with investment income.

Disadvantages: APA would need a large staff (New Jersey company has 30), of which at least five would be in the over $30,000 salary bracket. The tail on claims is expected to get longer because of drug-reaction-based claims and failure to diagnose physical conditions. Physician-owned companies are usually created in crisis situtations, and Britton doesn't think APA has a crisis. Also, the market is competitive since many states have state medical society programs.

b. *ADMINCO* (a California based subsidiary of Frank B. Hall Inc. which administers medical liability insurance programs).

Advantages: APA would have complete disclosure of data and fairness to members, and would be able to direct its own policy and decision making.

Disadvantages: There may not be enough members who would join; APA could not offer the security of Chubb & Son Plan (now available to APA members through the Britton Agency).

c. *American Health Systems* (a Chicago consulting firm which organizes medical society insurance captives).

2. CAPITALIZATION REQUIREMENTS

a. *Britton Agency*

Capitalization of a company to write a one million dollar policy would have to be at the $10,000,000 level without reinsurance. With reinsurance, the amount of capital required could be as low as $3,500,000 depending upon the amount and terms.

b. *ADMINCO*

$4 million would be needed to establish a company operating in three or four states (California, Florida, New York, etc.).

c. *American Health Systems*

$20 million would be needed for 7000 members.

3. LIMITS OF COVERAGE

a. *Britton Agency*

APA cannot write insurance in excess of 10 percent of capitalization to any one insured individual. It costs one third more to be insured for a million dollars than for $100,000.

b. *ADMINCO*

Amounts of coverage of $100,000/$300,000 and $1,000,000/$3,000,000 were discussed. Claims-made coverage can be acceptable if the proper insurance is available (i.e., true treaty reinsurance).

c. *American Health Systems*—not discussed.

4. ORGANIZATIONAL BOND

a. *Britton Agency*—not discussed.

b. *ADMINCO*—not discussed.

c. *American Health Systems*

In most states it runs $250,000 to $300,000; for 50 states the costs would run $15 to $16 million.

5. FEASIBILITY STUDY

a. *Britton Agency*

A feasibility study is necessary, and should include legal, actuarial, SEC, and other expertise.

b. *ADMINCO*—not discussed.

c. *American Health Systems*

A feasibility study should first be undertaken in a small number of states where APA has a heavy membership. The study would include how to market the plan, how to handle defense, the staffing required, budget necessary for implementation, and availability of reinsurance.

6. APA EVALUATION OR STEERING COMMITTEE

a. *Britton Agency*

An evaluation committee should be organized to evaluate the feasibility and advise APA regarding its findings.

b. *ADMINCO*

APA would have a Board of Directors who would set company policy, decide on whom to exclude from coverage, etc. There should be an investment counselor to recommend investment of proceeds. The Board of Directors would be composed of APA members.

c. *American Health Systems*

Physician involvement throughout is very important. A London broker stated that he would not consider reinsurance without heavy physician involvement in management of the program.

7. DETERMINING MEMBER INTEREST IN OWNING OR CREATING COMPANY

a. *Britton Agency*

A general statement was made relative to the need to determine membership interest before proceeding.

b. *ADMINCO*—not mentioned.

c. *American Health Systems*

The proposed feasibility study would assess membership interest.

8. CAPTIVES (OFFSHORE AND COLORADO)

a. *Britton Agency*

Offshore captives, usually in Bermuda, are not considered suitable for professional liability companies. There is a law permitting a captive in

Colorado; for this, APA would need a minimum premium of $1 million per year; home office principal staff must be in Colorado, and all books, records, and capital would have to be in Colorado. The Colorado captive is a nonadmitted company in other states.

b. *ADMINCO*

The possibility of establishing a Colorado captive for three or four states was mentioned. It could possibly be done with a letter of credit of $600,000, or possibly for less.

c. *American Health Systems*—not mentioned.

9. ADMITTED VS. NONADMITTED COMPANIES

a. *Britton Agency*

Admitted companies are fully licensed in all states where they operate. Nonadmitted (also known as surplus lines) companies are not fully licensed in all states where they operate. In some states, laws are as rigid for nonadmitted companies as for admitted companies. For example, Michigan would not admit the Colorado captive mentioned above; New Jersey has a list that a company must get on to be approved as a surplus lines company. Other states have laws that nonadmitted companies can only write insurance if they can prove it is not available via any other market. In New Jersey, nonadmitted companies must offer the same type of coverages that other companies are offering in the state, but nonadmitted companies must offer it at higher rates than admitted companies. Members in nonadmitted companies will not have the same protection that those in admitted companies have (e.g., Chubb offers a full-scale program in every state). Insolvency funds protect admitted carriers but not nonadmitted carriers.

b. *ADMINCO*

Companies can be nonadmitted in most states (for example, Lloyds is admitted only in Illinois, and only because Illinois law insists on it). Admitted companies get the protection of state insolvency laws, but they also may be assessed in the event of other companies' insolvencies. Insolvency liability is limited to $5 million per company. There are problems with being nonadmitted in some states, but there are ways of getting around them.

c. *American Health Systems*

This group does not consider it feasible to have the physician-owned company admitted in all 50 states. They suggest the surplus line option. All states have provisions in their codes for placing a risk with essentially a surplus line carrier—codes vary from state to state, but in general, a broker who is licensed as a surplus line broker in the state can place a risk with a nonentered carrier, if the risk that he/she is placing cannot be placed generally in the state with entered carriers. The language in most of the states' codes is somewhat loose on what "generally available in the state" means. It would be possible that in some states the carrier would not be admitted, but in most states it would. A state should be picked in which there is an insolvency fund, and do surplus lines in other states. Some states have limited insolvency funds ($5 million), others (New York, Illinois) are unlimited. Illinois is worth considering because the insurance department is very professionally run and regulated. To make sure how many states would let in a carrier through surplus lines, it would be necessary to select a brokerage firm that has presence in all the states. California would not be a good state of domicile. Nonadmitted carriers cannot charge lower rates than admitted carriers.

10. METHODS OF OBTAINING COMPANY (PURCHASE VS. ESTABLISHING)

a. *Britton Agency*

Creating APA's own company would take longer than purchasing an existing one; with an existing one, we could be in business within one year. Assets in normal insurance companies' balance sheets are usually bonds and common stocks—this should be considered if purchase is indicated.

b. *ADMINCO*

The disadvantage to purchasing an existing company is that one might be purchased for $1.5 million and we might not be able to obtain reinsurance; it would then be worthless.

c. *American Health Systems*—not mentioned.

11. REINSURANCE

a. *Britton Agency*

Reinsurance is available at Lloyds on a retrospective rating plan; New Jersey Medical Society pays Lloyds 15 percent of all premiums they collect; this percentage is adjusted based on experience, to a minimum of 2% and a maximum of 27½%.

b. *ADMINCO*

Reinsurance is easier to obtain on a claims-made program than an occurrence program, if it is true treaty insurance. They usually want 5% profit.

c. *American Health Systems*

Some captives have trouble obtaining reinsurance. Reinsurance is very important; otherwise, too much capital is required. Lloyds is the only reinsurer at present. Selection of a broker in London is important in dealing with Lloyds. APA is the 32d group of physicians American Health Systems has dealt with; of these 32, 10 deals were made (7 were claims-made, 3 occurrence). Our plan should be nonassessable. In Illinois, American Health Systems were able to obtain occurrence reinsurance. Again, broker selection both in the U.S. and London is of great importance. Reinsurance rates in New Jersey are 15%, subject to retroactive adjustment (maximum of 27½%, minimum 2½%).

12. OTHER SALIENT POINTS

a. *Britton Agency*

Questions were raised concerning the particular company APA had been invited to purchase. Why is the company for sale? It may have been created for a special purpose and the company no longer can use it for this purpose and wants to divest itself of it. What are its assets and liabilities? What lines of insurance have they offered in the past? What continuing liabilities exist as a result of having written insurance? What are the expense to premium ratios, and loss expense to earned premiums ratios, for the last five years? Can other management take over and still be accepted as a licensed company? In all states? Is there a better company available?

b. *ADMINCO*

This company would propose to provide all services insurance companies provide and APA would supervise them. Cost: a percentage of gross premiums and cost of employee to supervise, plus cost of CPA. It would probably be 12½ to 15% of gross premiums. The minimum charge is usually $200,000 but this would be waived if APA would really promote the company. The cost of getting started would be $35-$55,000, plus $2-$3,000 additional per state to

get admitted in other states after three years. An in-house executive would be needed to satisfy regulatory authorities. APA would have its own board of directors. $135,000 would get this started in California (licensed) and doing business on a nonadmitted basis in New York and 2 or 3 other states to start.

c. *American Health Systems*

Capitalization can be accomplished in various ways; selling securities is not recommended (if state lines are crossed, SEC is involved). One way to raise capital is to sell two kinds of premiums (regular premium plus one-time deposit premium). The deposit premium is tax-deductible if none of it is returned during the year.

The feasibility study (mentioned above) would first study a small number of states with heavy APA membership (California, New York, Florida). If we cannot get into several of these states, we would not be able to sell the idea of a captive to our members. The cost of the feasibility study would be based on hours spent. To examine the marketing part would probably be $10-$15,000 (hourly rates average $55). American Health Systems would consider doing the survey on a fixed-fee basis. Cost for a *total* feasibility study, nationwide, would be about $40,000. It would be done in pieces, and at some point it may become clear that APA is better off with Chubb.

APPENDIX 2

A number of informative tables prepared by Dr. Benjamin Lee who has had a long-standing interest in medical malpractice are presented here. Tables 1 through 7 concern various factors associated with the emergence of the professional liability crisis. Tables 8 and 9 rank subspeciality aspects of suit prevalence and income.

TABLE 1

Major Factors in Professional Liability Crisis

1. Semantics-Malpractice has different meaning in legal and medical context
2. Legal overkill; too many lawyers
3. Marcus Welby syndrome
4. Doctors too naive and gullible (compulsive personality takes blame whether deserved or not) financially and legally
5. Increasing consumerism
6. Barratry—abuse of process
7. Inappropriately liberal litigation climate; inadequate legal checks and balances on system
8. Lay jurors required by system to form opinions which only experts can properly form
9. Sub-conspiratorial collusion of courts, lawyers, and insurance companies (JAILer conspiracy)
10. Nightmare for doctors is paradise for lawyers
11. Medical tort victim compensated much more handsomely than victim of other accidents
12. Risk of untoward result should be assumed and paid for if desired by the patient, given informed consent

13. Inefficiency of tort system at compensating victim. Only 1 in 9 collect anything—even those get only 17¢ on the dollar
14. Law provides inadequate immunity to doctors from harassment, though judges, lawyers, accountants, and government bureaucrats have legal presumption of "regularity" (competence)
15. Paradoxic effect: existence of high limit liability insurance is the only source of funding for the inefficient process which guarantees that large awards will be made
16. Product liability ethos (doctrine of absolute liability in tort system) inappropriately applied to medicine
17. Absence of 100% medical insurance including catastrophic insurance makes suits necessary to pay victims' medical bills
18. Inappropriate application of adversary system to scientific questions. Manicheanism was abandoned by science centuries ago, why allow it to persist in the law?
19. Doctors poorly armed for litigation combat. Treated inequitably when they try
20. Correlation with subspecialty of doctor
21. Correlation with degree to which he/she has life and death in his/her hands
22. The income of the subspecialty in question
23. The degree of exposure of the subspecialty in question
24. Case finding activity and efficiency of plaintiffs' lawyers
25. Doctors' erroneous over-valuation of the health-effectiveness of their wares—actually far less health effective than hygienic practices and personal habits
26. Tax status of PLI awards
27. Magnitude of award
28. Size of legal fee for PI work
29. Inappropriate ex post facto awards
30. Disproportionate financial rewards for certain services
31. Unrealistic ideas of what constitutes "competence"
32. The legal passivity of doctors and especially psychiatrists
33. Absence of unified action on the part of doctors of all specialties
34. Collapse of sovereign immunity of non-profit institutions
35. Faulty assumption that insurance company pocket is infinitely deep: deepest pocket theory
36. Cost plus aspect of medical care, including prof. liab. insurance
37. Fee-splitting by lawyers
38. Customer hesitation level for PLI

TABLE 2

Minor Factors in Professional Liability Crisis

1. Periodic payments
2. *Ad damnum* clause
3. Collateral source rule
4. Problem hasn't affected most lawyers until recently—the few that it did benefitted by it (PI lawyers)

5. Passage of "no-fault" auto insurance makes lawyers look to PL cases for work
6. Unrealistic ceilings allow high awards
7. Change in doctor-patient relationship; we should insist on being called "doctors"—not providers or some such
8. Too many foreign medical graduates of uncertain qualification
9. Doctors watched too closely for optimum performance
10. Statute of limitations unrealistically long
11. True malpractice
12. "Bad-apple" doctors
13. Doctors not as good as they used to be
14. Doctors too busy to "spend time" with patients—academic syndrome
15. Character disorder in patients and lawyers
16. Inefficient peer review. Not enough PSROs, etc.
17. Insufficient continuing education
18. Rip-off by insurance companies
19. Arbitration not available
20. Relicensure
21. State subsidy of PL Insurance
22. Doctor-owned companies
23. Doctors no worse than before—mistakes being unearthed more often now
24. Insufficient informed consent
25. Insurance companies trying to recoup losses in stock market through raising PLI premium rates
26. Doctors insufficiently noble
27. MD maldistribution; if we worked where "needed, we wouldn't be sued
28. MD attempts procedure beyond his/her qualifications

TABLE 3

Physician Factors

1. Marcus Welby syndrome
2. Personality disorder in doctors (compulsive personality)
3. Doctor affluence—including professional liability insurance
4. Insufficient sovereign immunity
5. Doctors poorly armed for litigation combat
6. Correlation with subspecialty of doctor
7. Correlation with degree to which life and death are in his/her hands
8. Doctors' erroneous overvaluation of the health effectiveness of their activities
9. Disproportional financial rewards for various physician services
10. Unrealistic ideas of what constitutes "competence"
11. The legal passivity of doctors and especially psychiatrists
12. Absence of unified action on the part of doctors
13. The "cost-plus" aspect of medical care
14. "Customer hesitation level" for professional liability insurance buyer (the doctor)
15. Too many doctors—rusty tool hypothesis
16. Change in doctor-patient relationship

17. Inefficient peer review; not enough PSROs, etc.
18. Insufficient continuing education
19. Relicensure
20. Doctor owned insurance companies
21. Doctors not worse—mistakes simply being uncovered more often
22. True malpractice by doctors
23. Doctors insufficiently "noble"
24. Doctor maldistribution
25. Doctors attempting procedures beyond their competence

TABLE 4

Legal Factors

1. Legal overkill—too many lawyers
2. Barratry—abuse of process
3. Inappropriately liberal litigation climate
4. Lay jurors required by system to form opinions which only experts can properly form
5. Sub-conspiratorial collusion of courts, lawyers, and insurance companies (JAILer conspiracy)
6. Nightmare for doctors is paradise for lawyers
7. Medical tort victim recompensed much more handsomely than victim of other accidents
8. Informed consent problems—when patient is informed and consents to risk, he/she should insure if he/she wishes at own expense and at prevailing free market prices, not be forced to against will
9. Tort system inefficiency, only 17¢ on the dollar goes to victim
10. Law inequitable: patient can sue for contingency fee but doctor must post $25,000 bond to countersue
11. Law allows considerable immunity for lawyers and judges, accountants, and bureaucrats (presumption of bureaucratic regularity) but treats doctors very differently—legal harassment
12. Product liability ethos (absolute liability) applied inappropriately to practice of medicine which is far from an exact science with a certain outcome not guaranteed
13. Inappropriate application of Manichean adversary system to scientific questions. Science abandoned Manicheanism and precedent long ago—why should they persist atavistically in the law?
14. Litigation is the lawyer's game—doctors at a disadvantage not playing on their own court and by the lawyer's rules even when their own (not the lawyer's game) is being judged. Their records privileged; ours are not etc. They can split fees, we can't, etc.
15. Case finding activity and efficiency of plaintiffs' lawyers
16. Size of legal fee for PI work
17. Inappropriate application of ex post facto standards to old "torts"
18. Unrealistic ideas of what constitutes competence
19. Collapse of sovereign immunity of non-profit institutions
20. Faulty assumption that insurance company pocket is infinitely deep
21. Fee splitting by lawyers

22. Tort reform factors: periodic payments, *ad damnum* clause, collateral source rule, ceilings on awards, statute of limitations, redefinition of informed consent
23. Legal aspect of PLI crisis largely invisible to lawyers since so few of them do such work and the volume of such work in the average firm is so low —crisis not visible to them until their premiums become unreasonable or confiscatory

TABLE 5

Insurance Factors

1. Nature of risk changing: funds now being used to recompense untoward results rather than pay for "malpractice"
2. Absence of 100% medical insurance including catastrophic care
3. Rip-off by insurance companies (windfall profits?)
4. Insurance companies trying to recoup their losses in stock market by raising premiums?
5. PLI company not competent to manage risk settlement—insufficient medical expertise—profit motive not sufficient to assure legal battle for all legitimately defensible cases

TABLE 6

Consumer-Patient Factors

1. Semantics
2. Marcus Welby syndrome
3. Increasing "consumerism"-patients are patients, not consumers
4. Lay jurors required by system to pretend to expertise they don't have, including financial expertise
5. Risk of untoward result is the patient's, assuming informed consent, therefore he/she should bear and pay for the risk if he/she chooses
6. Inadequate medical insurance forces PLI insurance to pay their bills: a situation which wouldn't arise if they were adequately insured
7. Insufficient informed consent

TABLE 7

General Economic Factors

1. Inflation
2. The PLI common
3. Medical market not really free, nor is PLI market—captive or cost plus instead. Could be freed up more than it is. Medical and hospital and insurance company monopolies

4. Doctors rich, patients poor—Robinhood principal. The IRS and everybody takes a bite out of doctors, why not us?
5. Tax status of PLI awards and medical tort awards
6. Size of fee for PLI work
7. Disproportionate fees for certain services: fees should be geared to cost effectiveness and health effectiveness
8. Deepest pocket doctrine
9. Customer hesitation level for PLI buyer
10. Too many doctors—provider induced demand, medical oversell
11. Medical manpower problems
12. Passage of no-fault insurance for automobiles
13. Change in doctor:patient relationship to consumer:provider:third party payer:government:peer reviewers etc.
14. MD "maldistribution"

TABLE 8

Rank Order of Specialties by Net Annual Income and Prevalence of Malpractice Actions

By Net Annual Income

1. Plastic surgery
2. Otolaryngology
3. Neurosurgery
4. Orthopedics
5. Urology
6. Thoracic surgery
7. Radiology
8. Proctology
9. General Surgery
10. Ophthalmology
11. Cardiology
12. Pathology
13. Obstetrics-Gyn
14. Allergy
15. Dermatology
16. Psychiatry
17. Internal Medicine
18. Anesthesiology
19. General practice
20. Gastroenterology
21. Physical Medicine
22. Pediatrics
23. Neurology

By Prevalence of PL Actions

Cardiac surgeon
Neurosurgeon
Orthopedic surgeon
Plastic surgeon
General surgeon
Thoracic surgeon
Otolaryngologist
Proctologist
Urologist
GP (with maj surg)
Radiologist
GP
Dermatologist
Ophthalmologist
Allergist
Hematologist
Internist
Pediatrician
Psychiatrist
Pathologist

TABLE 9

Rank Order of Subspecialties by Patients, Other Doctors, and Prevalence of Professional Liability Actions

By Patients	*By Other Doctors*	*By Prev of PL Actions*
1. Neurosurgeons	Chest surgeon	Cardiac surgeon
2. Chest surgeons	Cardiologist	Neurosurgeon
3. Cardiologists	Neurosurgeons	Orthopedic surgeon
4. Ophthalmologists	Neurologist	Plastic surgeon
5. Plastic surgeons	Internist	General surgeon
6. Orthopedic surgeons	Ophthalmologist	Thoracic surgeon
7. Neurologists	Plastic surgeon	Otolaryngologist
8. Obstetrician-gyn.	Pathologist	Proctologist
9. Pediatrician	Orthopedic surgeon	Urologist
10. Radiologist	Radiologist	GP (with maj surg)
11. Urologist	General surgeon	Radiologist
12. General surgeon	Pediatrician	GP
13. Internist	Gastroenterologist	Dermatologist
14. Anesthesiologist	Ob-Gyn	Ophthalmologist
15. Otolaryngologist	Psychiatrist	Allergist
16. Gastroenterologist	Urologist	Hematologist
17. Pathologist	Otolaryngologist	Internist
18. Registered nurse	Anesthesiologist	Pediatrician
19. Psychiatrist	Preventive medicine	Psychiatrist
20. Preventive medicine	Dermatologist	Pathologist
21. Dentist	Allergist	
22. General practitioner	General practitioner	
23. Allergist	Physiatrist	
24. Physiatrist	Dentist	
25. Pharmacist	Director of nursing service	
26. Dermatologist	Hospital administrator	

APPENDIX 3

SPECIMEN COPY
APA PROFESSIONAL LIABILITY POLICY

Psychiatrists' and Neurologists' Professional Liability and Professional Premises Liability Policy

In consideration of the payment of the required premium, in reliance upon the statements in the declarations made a part hereof and subject to all of the provisions of this policy, the company agrees with the named insured as follows:

PART I

PSYCHIATRISTS' AND NEUROLOGISTS' PROFESSIONAL LIABILITY INSURANCE

I. COVERAGE AGREEMENTS

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of:

Coverage A—Individual Professional Liability

Injury arising out of the rendering of or failure to render, professional services by the individual insured, or by any person for whose acts or omissions such insured is legally responsible, except as a member of a partnership, performed in the practice of the individual insured's profession described in the declarations including service by the individual insured as a member of an accreditation or similar professional board or committee of a hospital or professional society,

Coverage B—Partnership Liability

Injury arising out of the rendering of or failure to render, professional services in the practice of the profession described in the declarations by any person for whose acts or omissions the insured is legally responsible as a partner,

Coverage C—Corporate Liability

Injury arising out of the rendering of or failure to render, professional services in the practice of the profession described in the declarations by any person for whose acts or omissions the corporate insured, or professional association, is legally responsible,

Coverage D—Professional Employee Liability

Injury arising out of the rendering of or failure to render, professional services by an employee other than a licensed medical practitioner personally performed in the practice of the employee's profession in the course of his employment by either the individual insured under Coverage A, the partnership insured under Coverage B, or the corporation insured under Coverage C,

and the company shall have the right and duty to defend any suit against the insured seeking such damages, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and, with the written consent of the insured, such settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements.

Exclusions

This insurance does not apply under Part I:

(a) to liability of the insured as a proprietor, superintendent or executive officer of any hospital, sanitarium, clinic with bed and board facilities, laboratory (except an X-ray or pathological laboratory if the insured is engaged in practice as a pathologist or radiologist) or business enterprise other than that stated in the declarations;
(b) any claim for which coverage is afforded under Part II of this policy.

II. LIMITS OF LIABILITY

Regardless of the number of (1) insureds under this policy, (2) persons or organizations who sustain injury, or (3) claims or suits brought on account of injury, the company's liability under Part I is limited as follows:

The total liability of the company for all damages because of injury to which this insurance applies, sustained by any one person, shall not exceed the limit of liability stated in Part I of the declarations as applicable to "each claim."

Subject to the above provision respecting "each claim," the total limit of the company's liability under Part I for the damages shall not exceed the limit of liability stated in Part I of the declarations as "aggregate."

III. THIS INSURANCE APPLIES ONLY TO INJURY WHICH OCCURS DURING THE POLICY PERIOD AND WITHIN THE POLICY TERRITORY.

IV. DEFINITIONS

When used in this policy Part I (including endorsements forming a part hereof):

"each claim" means all claims or suits brought on account of injury sustained by any one person;
"injury" means;

(a) bodily injury, sickness or disease, including death, sustained by any person;
(b) false arrest, detention or imprisonment, or malicious prosecution;
(c) the publication or utterance of a libel or slander or of other defamatory or disparaging material, or a publication or utterance in violation of an individual's right of privacy; except publications or utterances in the course of or related to advertising, broadcasting or telecasting activities conducted by or on behalf of the named insured;
(d) wrongful entry or eviction, or other invasion of the right of private occupancy;

"insured" means;

(a) under Coverages A and B, the individual named in the declarations as insured and whose principal practice is conducted within the United States, its territories or possessions;
(b) under Corporate Liability, the corporation named in the declarations and any executive officer, director or shareholder thereof while acting within the scope of his duties as such provided that no such person shall be an insured under this paragraph (b) with respect to liability for his personal acts of a professional nature;
(c) under Professional Employee Liability, any employee, other than a licensed medical practitioner, while acting within the scope of his duties as an employee of either the individual insured under Coverage A, the partnership insured under Coverage B, or the corporation insured under Coverage C.

"policy territory" means anywhere in the World, provided, however, that if claim is made or suit is brought elsewhere than within the United States of America, its territories or possessions, the company's rights and duties with respect to the investigation, defense and settlement of claims or suits and the

insured's duties with respect to the investigation, defense and settlement of claims and suits shall be as follows:

(a) The company shall have the right but not the duty to investigate and, with the consent of the insured settle such claims and defend such suits;
(b) In any case in which the company elects not to investigate, or to settle, and if the company requests the insured to provide defense, the insured, under the supervision of the company, shall make or cause to be made such investigation and defense as are reasonably necessary, and subject to the prior authorization by the company, will effect to the extent possible such settlement or settlements as the company and the insured deem prudent;
(c) The company shall periodically reimburse the insured for the reasonable cost of such investigation, defense or settlement.

In the event the named insured establishes residency and practice in a country other than the United States, its territories or possessions, then, as of that date Coverage applies only to claims brought in the United States, its territories or possessions.
The company's duties under this paragraph cease after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements.

PART II

PROFESSIONAL PREMISES LIABILITY INSURANCE

I. COVERAGE AGREEMENTS

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of

Coverage E. injury or
Coverage F. property damage

to which this insurance applies, caused by an occurrence and arising out of the ownership, maintenance or use of the insured premises as a professional office and all operations necessary or incidental thereto, and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company's liability has been exhausted by payment of judgments or settlements.

Exclusions.

This insurance does not apply under Part II:

(a) to liability assumed by the insured under any contract or agreement except an incidental contract; but with respect to injury or property damage occurring while work performed by the named insured is in

progress, this exclusion does not apply to a warranty that such work will be done in a workmanlike manner;
(b) to injury or property damage arising out of the ownership, maintenance, operation, use, loading or unloading of

(1) any automobile or aircraft owned or operated by or rented or loaned to the named insured, or
(2) any other automobile or aircraft operated by any person in the course of his employment by the named insured;
but this exclusion does not apply to the parking of an automobile on insured premises, if such automobile is not owned by or rented or loaned to the named insured;

(c) to injury or property damage arising out of and in the course of the transportation of mobile equipment by an automobile owned or operated by or rented or loaned to the named insured;
(d) to injury or property damage arising out of the ownership, maintenance, operation, use, loading or unloading of any watercraft;
(e) to injury or property damage due to war, whether or not declared, civil war, insurrection, rebellion or revolution or to any act or condition incident to any of the foregoing;
(f) to any obligation for which the insured or any carrier as his insurer may be held liable under any workmen's compensation, unemployment compensation or disability benefits law, or under any similar law;
(g) to injury to any employee of the insured arising out of and in the course of his employment by the insured; but this exclusion does not apply to liability assumed by the insured under an incidental contract;
(h) to property damage to

(1) property owned or occupied by or rented to the insured,
(2) property used by the insured, or
(3) property in the care, custody or control of the insured or as to which the insured is for any purpose exercising physical control;

but parts (2) and (3) of this exclusion do not apply with respect to liability under a written sidetrack agreement and part (3) of this exclusion does not apply with respect to property damage (other than to elevators) arising out of the use of an elevator at the insured premises;

(i) to property damage to premises alienated by the named insured arising out of such premises or any part thereof;
(j) to injury or property damage arising out of structural alterations which involve changing the size of or moving buildings or other structures, new construction or demolition operations performed by or on behalf of the named insured.
(k) to any claim for which coverage is afforded under Part I of this policy.
(l) to injury or property damage arising out of (1) the named insured's products, or (2) reliance upon a representation or warranty made with respect thereto if the injury or property damage occurs after physical possession of such products has been relinquished to others and occurs away from premises owned by or rented to the named insured.

II. PERSONS INSURED

Each of the following is an insured under this Policy Part II to the extent set forth below:

(a) if the named insured is designated in the declarations as an individual, the person so designated but only with respect to the conduct of a business of which he is the sole proprietor, partner or member;
(b) if the named insured is designated in the declarations as other than an individual, the organization so designated and any executive officer, director or shareholder thereof while acting within the scope of his duties as such;
(c) any employee of the named insured;
(d) and any other person or organization while acting as real estate manager for the named insured.

III. LIMITS OF LIABILITY

Regardless of the number of (1) insureds under this Policy Part II, (2) persons or organizations who sustain injury or property damage, or (3) claims made or suits brought on account of injury or property damage, the company's liability is limited as follows:

Coverage E—The limit of injury liability stated in Part II of the declarations as applicable to "each person" is the limit of the company's liability for all damages because of injury sustained by one person as the result of any one occurrence; but subject to the above provision respecting "each person," the total liability of the company for all damages because of injury sustained by two or more persons as the result of any one occurrence shall not exceed the limit of injury liability stated in the schedule as applicable to "each occurrence."
Coverage F—The total liability of the company for all damages because of all property damage sustained by one or more persons or organizations as the result of any one occurrence shall not exceed the limit of property damage liability stated in Part II of the declarations as applicable to "each occurrence."
Coverage E and F—For the purpose of determining the limit of the company's liability, all injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

IV. DEFINITIONS

When used in this Policy Part II (including endorsements forming a part hereof):

"automobile" means a land motor vehicle, trailer or semitrailer designed for travel on public roads (including any machinery or apparatus attached thereto), but does not include mobile equipment;
"elevator" means any hoisting or lowering device to connect floors or landings, whether or not in service, and all appliances thereof including any car, platform, shaft, hoistway, stairway, power equipment and machinery; but does not include an automobile servicing hoist, or a hoist without a platform outside a building if without mechanical power or if not attached to building walls, or a hod or material hoist used in alteration,

construction or demolition operations, or an inclined conveyer used exclusively for carrying property or a dumbwaiter used exclusively for carrying property and having a compartment height not exceeding four feet;

"incidental contract" means any written (1) lease of premises, (2) easement agreement, except in connection with construction or demolition operations on or adjacent to a railroad, (3) undertaking to indemnify a municipality required by municipal ordinance, except in connection with work for the municipality, (4) sidetrack agreement, or (5) elevator maintenance agreement;

"injury" means;

(a) bodily injury, sickness or disease, including death, sustained by any person;
(b) false arrest, detention or imprisonment, or malicious prosecution;
(c) the publication or utterance of a libel or slander or of other defamatory or disparaging material, or a publication or utterance in violation of an individual's right of privacy; except publications or utterances in the course of or related to advertising, broadcasting or telecasting activities conducted by or on behalf of the named insured;
(d) wrongful entry or eviction, or other invasion of the right of private occupancy;

"insured premises" means (1) the professional office premises designated in the declarations, (2) professional office premises alienated by the named insured (other than premises constructed for sale by the named insured), if possession has been relinquished to others, and (3) professional office premises as to which the named insured acquires ownership or control and reports his intention to insure such premises under this policy and no other within 30 days after such acquisition; and includes the ways immediately adjoining such premises on land;

"mobile equipment" means a land vehicle (including any machinery or apparatus attached thereto), whether or not self-propelled, (1) not subject to motor vehicle registration, or (2) maintained for use exclusively on premises owned by or rented to the named insured, including the ways immediately adjoining, or (3) designed for use principally off public roads, or (4) designed or maintained for the sole purpose of affording mobility to equipment of the following types forming an integral part of or permanently attached to such vehicle; power cranes, shovels, loaders, diggers and drills; concrete mixers (other than the mix-in-transit type); graders, scrapers, rollers and other road construction or repair equipment; air-compressors, pumps and generators, including spraying, welding and building cleaning equipment; and geophysical exploration and well servicing equipment;

"named insured" means the person or organization named in the declarations of this policy;

"named insured's products" means goods or products manufactured, sold, handled or distributed by the named insured or by others trading under his name, including any container thereof (other than a vehicle), but "named insured's products" shall not include a vending machine or any property other than such container, rented to or located for use of others but not sold;

"occurrence" means an accident, including injurious exposure to conditions, which results, during the policy period, in injury or property damage neither expected nor intended from the standpoint of the insured;
"policy territory" means the United States of America, its territories or possessions;
"property damage" means injury to or destruction of tangible property.

V. POLICY PERIOD; TERRITORY

This insurance applies to injury or property damage which occurs during the policy period within the policy territory.

PART III

SUPPLEMENTARY PAYMENTS

I. COVERAGE AGREEMENTS

The company will pay on behalf of the named insured reasonable

Coverage G—Legal Defense Costs

incurred in the defense of any suit against the named insured, during the policy period and within the policy territory, alleging liability for acts arising out of the named insured's profession described in the declarations but not covered by this policy or any other policy, providing:

(a) there is no coverage under this section for legal expense incurred due to alleged criminal act;
(b) written notice of claim must be given to the company as soon as practicable after commencement of loss under this coverage. Notice given by or on behalf of the named insured to the company, or the agent, with information sufficient to identify the named insured, shall be deemed notice to the company.

Coverage H—Expense Incurred or Loss of Income

The company will pay, in addition to the applicable limit of liability for each claim or occurrence covered under Part I and Part II of this Policy:

(a) all expenses incurred by the company, all costs taxed against the insured in any suit defended by the company and all interest on the entire amount of any judgment therein which accrues after entry of the judgment and before the company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the company's liability thereon;
(b) premiums on appeal bonds required in any such suit, premiums on bonds to release attachments in any such suit for an amount not in excess of the applicable limit of liability of this policy, but the company shall have no obligation to apply for or furnish any such bonds in excess of the applicable Policy Limits;
(c) reasonable expenses incurred by the insured at the company's request, including actual loss of fees or salary (but not loss of other income) not to exceed twenty-five dollars ($25) per day during each of the first three days because of his attendance at hearings at such request.

(d) one hundred dollars ($100) per day with a maximum amount payable of $2,500 per suit as income lost, when his practice was suspended due to his being in court as a defendant to a covered claim, at the request of the company; provided, that coverage under this section will only commence after the insured has attended a total of three (3) days in court, in defense of a suit covered by this policy.

CONDITIONS APPLICABLE TO ENTIRE POLICY

1. Premium. All premiums for this policy shall be computed in accordance with the company's rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.

The named insured shall maintain records of such information as is necessary for premium computation, and shall send copies of such records to the company at the end of the policy period and at such times during the policy period as the company may direct.

2. Insured's Duties in the Event of Injury or Property Damage.

(a) In the event of an injury or property damage, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable. The named insured shall promptly take at his expense all reasonable steps to prevent other injury or property damage from arising out of the same or similar conditions, but such expense shall not be recoverable under this policy.

(b) If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

(c) The insured shall co-operate with the company and, upon the company's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of injury or property damage with respect to which insurance is afforded under this policy; and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The insured shall not, execept at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

3. Inspection and Audit. The company shall be permitted but not obligated to inspect the named insured's property and operations at any time. Neither the company's right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the named insured or others, to determine or warrant that such property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

4. Assignment. Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon; if, however, the named insured shall die, such insurance as is afforded by this policy shall apply (1) to the named insured's legal representative, as the named insured, but only while

acting within the scope of his duties as such, and (2) with respect to the property of the named insured, to the person having proper temporary custody thereof, as insured, but only until the appointment and qualification of the legal representative.

5. Action Against Company. No action shall lie against the company unless, as a condition precedent thereto there shall have been full compliance with all of the terms of this policy, nor until the amount of the insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the company.

Any person or organization or the legal representative hereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this policy to the extent of the insurance afforded by this policy. No person or organization shall have any right under this policy to join the company as a party to any action against the insured to determine the insured's liability, nor shall the company be impleaded by the insured or his legal representative. Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the company of any of its obligations hereunder.

6. Other Insurance. The insurance afforded by this policy is primary insurance, except when stated to apply in excess of or contingent upon the absence of other insurance. When this insurance is primary and the insured has other insurance which is stated to be applicable to the loss on an excess or contingent basis, the amount of the company's liability under this policy shall not be reduced by the existence of such other insurance.

When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the company shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(a) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the company shall not be liable for a greater proportion of such loss than would be payable if each insurer contributes an equal share until the share of each insurer equals the lowest applicable limit of liability under any one policy or the full amount of the loss is paid, and with respect to any amount of loss not so paid the remaining insurers then continue to contribute equal shares of the remaining amount of the loss until each such insurer has paid its limit in full or the full amount of the loss is paid.

(b) Contribution by Limits. If any of such other insurance does not provide for contribution by equal shares, the company shall not be liable for a greater proportion of such loss than the applicable limit of liability under this policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

7. Subrogation. In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

8. Changes. Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or estop the company from asserting any right under the terms of this

policy; nor shall the terms of this policy be waived or changed, except by endorsement issued to form a part of this policy, signed by an executive officer of the company.

9. Cancellation. This policy may be canceled by the named insured by mailing to the company written notice stating when thereafter the cancellation shall be effective. This policy may be canceled by the company by mailing to the named insured at the address shown in this policy, written notice stating when not less than ten days thereafter such cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice. The effective date and hour of cancellation stated in the notice shall become the end of the policy period. Delivery of such written notice either by the named insured or by the company shall be equivalent to mailing.

If the named insured cancels, earned premium shall be computed in accordance with the customary short rate table and procedure. If the company cancels, earned premium shall be computed pro rata. Premium adjustment may be made either at the time cancellation is effected or as soon as practicable after cancellation becomes effective, but payment or tender of unearned premium is not a condition of cancellation.

10. Declarations. By acceptance of this policy, the named insured agrees that the statements in the declarations are his agreements and representations, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing between himself and the company or any of its agents relating to this insurance.

11. Conformity to Statute. Terms of this policy which are in conflict with the statutes of the state wherein this policy is issued are hereby amended to conform to such statutes.

In Witness Whereof, the said VIGILANT INSURANCE COMPANY, has caused this policy to be signed by its president or secretary, but it shall not be valid unless countersigned on the declarations page by a duly authorized representative of the company.

Secretary
President

NUCLEAR ENERGY LIABILITY EXCLUSION ENDORSEMENT—BROAD FORM

It is agreed that:

I. The policy does not apply:

A. Under any Liability Coverage, to *injury* or *property damage*

(1) with respect to which an *insured* under the policy is also an insured under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an insured under any such policy but for its termination upon exhaustion of its limit of liability; or

(2) resulting from the *hazardous properties* of *nuclear material* and with respect to which (a) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or (b) the *insured* is, or had this policy not been issued would be, entitled to indemnity from the

United States of America, or any agency thereof, under any agreement entered into by the United States of America, or any agency thereof, with any person or organization.

B. Under any Medical Payments Coverage, or under any Supplementary Payments provision relating to first aid, to expenses incurred with respect to *injury* resulting from the *hazardous properties* of *nuclear material* and arising out of the operation of a *nuclear facility* by any person or organization.

C. Under any Liability Coverage, to *injury* or *property damage* resulting from the *hazardous properties* of *nuclear material*, if

(1) the *nuclear material* (a) is at any *nuclear facility* owned by, or operated by or on behalf of, an *insured* or (b) has been discharged or dispensed therefrom;

(2) the *nuclear material* is contained in *spent fuel* or *waste* at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of an *insured*; or

(3) the *injury* or *property damage* arises out of the furnishing by an *insured* of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any *nuclear facility*, but if such facility is located within the United States of America, its territories or possessions or Canada, this exclusion (3) applies only to *property damage* to such *nuclear facility* and any property thereat.

II. As used in this endorsement:

"hazardous properties" include radioactive, toxic or explosive properties;
"nuclear material" means *source material, special nuclear material* or *byproduct material;*
"source material," "special nuclear material," and *"byproduct material"* have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;
"spent fuel" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a *nuclear reactor;*
"waste" means any waste material (1) containing *byproduct material* and (2) resulting from the operation by any person or organization of any *nuclear facility* included within the definition of *nuclear facility* under paragraph (a) or (b) thereof;
"Nuclear facility" means

(a) any *nuclear reactor,*

(b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing *spent fuel,* or (3) handling, processing or packaging *waste,*

(c) any equipment or device used for the processing, fabricating or alloying of *special nuclear material* if at any time the total amount of such material in the custody of the *insured* at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235,

(d) any structure, basin, excavation, premises or place prepared or used for the storage or disposal of *waste,*

and includes the site on which any of the foregoing is located, all operations conducted on such site and all premises used for such operations;
"nuclear reactor" means any apparatus designed or used to sustain fission in a self-supporting chain reaction or to contain a critical mass of fissionable material;
"property damage" includes all forms of radioactive contamination of property.

APPLICATION FOR PSYCHIATRISTS AND NEUROLOGISTS PROFESSIONAL LIABILITY INSURANCE

CHUBB & SON INC.
Manager — Vigilant Insurance Co.
100 William Street, New York, N.Y. 10038

Mail Completed Application to:

JOSEPH A. BRITTON AGENCY
855 MOUNTAIN AVENUE
MOUNTAIN, NEW JERSEY 07092

Please complete or mark with an "X" where applicable:

1. Name _____

   Office Address _____

2. I desire coverage to be effective _____ (Coverage will be effective as of 12:01 a.m. Standard time, at address of insured.)

3. I understand that my policy will include coverage for Individaul Acts, Professional Employees, Professional Premises, Legal Defense costs and Indemnification for Time in Court.

   I ☐ do ☐ do not desire coverage for Electroconvulsive Therapy.
   I ☐ do ☐ do not desire coverage for Special Neurological Procedures. (i.e., Angiograms, Arteriograms, Myleograms, Pneumoencephalograms)
   I ☐ do ☐ do not desire Partnership or Professional Corporation Coverage.

4. Please provide Professional Acts Liability and Premises Bodily Injury Coverage for the limits I have indicated:
   ☐ $100,000/300,000 ☐ $500,000/1,500,000 ☐ $1,000,000/3,000,000

5. My Practice includes the following:

a. Speciality & Sub-Specialty	% of Patients Involved	Speciality & Sub-Specialty	% of Patients Involved
☐ Psychiatry	_____	☐ Neuro-Psychiatry	_____
☐ Psychoanalysis	_____	☐ Neurology	_____
☐ Child Psychiatry	_____	☐ Member in Training	_____
☐ Admin. Psychiatry	_____	☐ Retired	_____
☐ General Medicine — No Surgery	_____	☐ General Medicine — Minor Surgery	_____

b Procedures	% of Patients Involved	Procedures	% of Patients Involved
☐ Group Therapy	_____	☐ Drug Prescription	_____
☐ Electroconvulsive Therapy	_____	☐ Special Neuro Procedures	_____
☐ Other Somatic Therapies	_____	(Angiograms, Arteriograms, Myleograms, Pneumoencephalograms)	

c. I also engage in the following practices or procedures not listed above: _____
This involves _____% of my patients.

6. a. I ☐ am ☐ am not a member of a Partnership.
b. I ☐ am ☐ am not an officer, director or shareholder of a Professional Corporation.
c. The trade name of our Partnership or Incorporated name of our Professional Corporation is _____
It includes the following physicians. (Attach a separate list if more than three)

NAME	POSITION

d. I ☐ am ☐ am not employed by a physician, group, hospital or educational institution.
My employer is _____

7. a. I, or the Partnership or Corporation of which I am a member, employ the following physicians. (Do not list partners, officers, directors or shareholders.)

NAME	SPECIALTY	NAME OF PROF. LIAB. CARRIER	LIMITS OF LIAB.

b. I, or the Partnership or Corporation of which I am a member, employ full or part time employees as indicated:

Clerical	No. _____	Social Worker	No. _____
Nurse (Reg. or Prac.)	No. _____	**Other (Describe)** _____	No. _____
Lab. Technician	No. _____	_____	No. _____
Psychologist	No. _____	_____	No. _____

8. I, or the Partnership or Corporation of which I am a member occupy the following premises:
Location: No. 1—Address _____ Area (Sq. Ft.) _____
Location: No. 2—Address _____ Area (Sq. Ft.) _____

PLEASE COMPLETE BOTH SIDES OF APPLICATION

THE FOLLOWING QUESTIONS MUST BE ANSWERED:

1. *Year of birth* _____ *My office telephone number is* _____. *(Include Area Code)*

2. a. I was graduated in the year _____ from _____
(Name of School)

with a _____ degree.
(Type)

b. Since graduation I have practiced my profession in the following places:

LOCATION	DATES	IN WHAT CAPACITY

c. I am duly licensed and registered to practice as a _____ under the laws of all jurisdictions in which I practice except as follows: _____

d. No professional license issued to me including my narcotics license, has ever been revoked, suspended or restricted, except as follows:

_____

_____

e. I do not own nor act as administrator of a hospital, sanitarium, clinic with bed and board facilities or any other medical business enterprise such as a laboratory except as follows: _____

_____

3. I have been a member of the American Psychiatric Association since _____, I also belong to the following Medical Association or Societies: _____

_____

4. a. No claim or suit has been filed against me for professional errors or mistakes, nor am I aware at this time of any circumstances which may result in a claim or suit, except as follows: _____

_____

_____

b. For Professional Liability insurance, no company has canceled, declined to issue, offered coverage at higher than standard rate or subject to a deductible except as follows: _____

_____

5. a. The name of my present or immediate past Professional Liability insurance carrier is: _____

b. I was insured by this company since _____ This insurance expires on _____

c. I am also covered presently for professional liability by an insurance policy carried by the following hospital, clinic, medical group or educational institution: _____

I UNDERSTAND THIS IS AN APPLICATION ONLY; IT DOES NOT CONSTITUTE AN INSURANCE POLICY, AND THAT INSURANCE SHALL BECOME EFFECTIVE ONLY UPON ISSUANCE OF A POLICY OR WRITTEN BINDER. I FURTHER UNDERSTAND NO PAYMENT IS REQUIRED UNTIL POLICY AND INVOICE ARE RECEIVED.

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

_____ _____

(Signature of Applicant) (Date)

APPENDIX 4

Chubb/Pacific Indemnity Experience (APA)
Psychiatrists/Neurologists

Revised as of 8/31/77

Exp. Year	*Earned Premium*	*No.*	*Claims Closed Ind.*	*Exp.*
1973	57,178	4	1,000	6,633
1974	500,562	21	132,930	61,081
1975	1,017,382	24	117,256	97,654
1976	3,276,827	39	68,250	26,649
1977	5,505,335	5	0	2,307
TOTAL	$10,357,284	93	$319,436	$194,324

Exp. Year	*Claims Open No.*	*Reserve**	*Reported Incurred*	*Reported Loss Ratio*
1973	2	10,855	18,488	32.3
1974	19	151,450	345,461	69.0
1975	44	263,835	478,745	47.1
1976	64	379,535	474,434	14.5
1977	25	213,168	215,475	3.9
TOTAL	154	$1,018,843	$1,532,603	14.8

* Includes 30% Allocated Loss Adjustment Expense Loading.

Categories of Loss

	Number of Claims
1. Failure to Supervise	71
2. Improper Therapy	63
3. Failure to Diagnose	20
4. Wrongful Commitment	19
5. Breach of Confidentiality	18
6. Drug Reactions	14
7. Subpoena	9
8. Bill Complaints	8
9. ECT	6
10. Libel and Slander	5
11. Committee Activities	2
TOTAL	235