

**MEDICAL PRACTITIONERS NEED INDEPENDENT ADVICE ON INDEMNITY INSURANCE**

Medical practitioners and consultants need independent advice before they decide to change their medical indemnity provider.

That was the clear message from a breakfast briefing run by the Federation of Independent Practitioner Organisations (FIPO) recently at the Royal Society of Medicine following a survey among consultants into their views and experience of professional medical indemnity, and an independent report for consultants who operate within the £540 million annual market for medical malpractice indemnity.

Attended by representatives of private hospitals, the insurance industry, medical defence organisations, private medical insurance providers and consultants' organisations, the briefing heard that consultants are now shopping around for indemnity. This is, in part, due to subscription increases and a consequent demand from consultants for an alternative to the offering from the traditional three medical defence organisations (MDOs). The result has been the commercial insurance market stepping in to try and satisfy that demand and offer insurance at lower cost.

In fact, as Richard Packard, deputy chairman of FIPO, pointed out in a presentation to the audience, at the Royal Society of Medicine that the survey of more than 900 consultants had shown that 95.5% of those who had actually changed their medical indemnity provider had done this to reduce the cost of premiums and subscriptions.

However, 63.5% of those who took part in the survey did not know whether they held contractual or discretionary cover, while 55.6% did not know the limit of their indemnity. This point was also picked up by Dan Toner, general counsel of Spire Healthcare – the UK's second largest private hospital group - who told the meeting that consultants need to understand the risks and take advice if they are considering switching their medical indemnity provider. But, he added, there is "a scarcity of advisers" to provide unbiased opinions on cover and subscriptions or premiums.

On the subject of subscriptions and premiums, John De Bono, a barrister at Serjeants' Inn specialising in clinical negligence law, highlighted the fact that it is possible for medical indemnity providers to increase subscriptions or premiums after a claim. He added that damages awarded are now higher because life expectancy has increased.

Kevin McCluskie, ACII chartered insurance broker, who carried out the report on the medical malpractice indemnity market for FIPO, explained that the key difference between traditional medical defence organisations and new providers were the principles of discretionary or contractual indemnity, and losses occurring versus claims made.

Discretionary indemnity benefits, offered by the MDOs, are provided under a membership agreement whereby a membership application is submitted and accepted, a subscription paid and a Membership Agreement issued setting out the objectives of the society and the right to apply for indemnity. The benefit of indemnity is granted to an individual member at the discretion of the society's council and is not enforceable in a court of law. In this case there is no external regulation of the MDOs, other than normal company law.

Contractual indemnity, as offered by insurers (and the Medical Defence Union for the first £10-million of a clinical negligence claim), is where a proposal is submitted, accepted, a premium paid and a contract – insurance policy – is issued. This policy sets out the terms and conditions between the parties, what is insured and what is not insured. Most importantly, it is enforceable in a court of law, and will normally state the maximum limit of the compensation that will be paid. This type of policy provides access to the Financial Ombudsman Service and is regulated by the FSA. However, as McCluskie points out in his report, expert guidance is needed to explain the exclusions that apply to the contract and their implications.

McCluskie also highlighted the differences between claims made and losses occurring cover. Under a claims made policy, cover is triggered by the date that the insured doctor first became aware of the possibility of a claim and notified the insurer. This means, amongst other things, that consultants coming up to retirement must negotiate an extended reporting or run-off period to their policies to cover the eventuality of a claim being made after their retirement, or even after death, to protect their estate.

Under a losses occurring indemnity, cover is triggered based upon the date of the event giving rise to the claim and not when the claim was first reported. Therefore, cover is provided indefinitely.

Concluding that insurers and brokers can compete with the MDOs on service, advice and price, McCluskie also pointed out to the meeting that when medical claims inflation is running at 10% there is a need to double the limit on cover every six to seven years.

Summing up the breakfast briefing and the reasons behind its survey and independent report, FIPO Chairman, Geoffrey Glazer said:

“Our report was commissioned to throw light on medical indemnity and has shown the need for clarification of basic concepts and also for independent advice for consultants on these issues. Our survey showed that 96% of those who have switched supplier did so for price alone, which suggests that other factors were not necessarily taken into consideration.”

The results of the FIPO survey and the full report into the medical indemnity market may be found at [www.fipo.org.uk](http://www.fipo.org.uk)

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## ***Notes to Editors***

**The Federation of Independent Practitioner Organisations (FIPO)** represents professional independent medical organisations and specialist groups in Britain. It provides guidance, policies and co-ordination to membership organisations, acting on behalf of the profession to advance the cause of independent health care.

FIPO promotes the highest standards of health care provision, achieved through robust clinical governance and audit, as well as expert, independent advice for best patient care and clinical outcomes. FIPO CGAC (Clinical Governance Advisory Committee) has provided support and information to hospital Medical Advisory Committee Chairmen around the UK and has developed formal, professionally structured Guidelines to assist them in their role.

More than twenty-five professional medical organisations including Royal Colleges, the GMC and the Patients' Association have signed the FIPO Charter for Patients and their Doctors, reaffirming their commitment to high-quality patient care. The Charter outlines the ethos governing each doctor's duties to their patients, the patient's rights, and the principles inherent in best medical practice, such as the GP to consultant referral pathway. The Charter may be seen here; <http://www.fipo.org.uk/docs/patientcharter.htm>