AMERICAN ACADEMY OF PEDIATRICS

Committee on Medical Liability

Professional Liability Coverage for Residents and Fellows

ABSTRACT. The American Academy of Pediatrics first developed a policy on professional liability coverage for pediatricians-in-training in 1989 and subsequently reaffirmed its basic position with slight modification in 1993. In this latest iteration of the statement, the original positions have been strengthened to address changes in the professional liability insurance industry, the structure and settings of residency training, and mandated reporting to health provider data banks. The new policy emphasizes the need to provide pediatricians in training with adequate professional liability insurance coverage and to educate residents and fellows on the importance of adequate and uninterrupted professional liability coverage—both during and after residency.

ABBREVIATIONS. NPDB, National Practitioner Data Bank; AAP, American Academy of Pediatrics; ACGME, Accreditation Council of Graduate Medical Education.

MEDICAL LIABILITY AND RESIDENTS

Because pediatric residents and fellows-in-training are closely supervised, their medical malpractice risks are theoretically less than those of other pediatricians. Under the legal doctrine of *respondeat superior,* "let the master answer," the educational institution conducting the residency program is responsible for the medical care provided by its residents during the training exercises. Therefore, the institution is liable for the defense costs, settlements, and awards for malpractice attributed to physicians-in-training. Their trainee status coupled with their lack of financial assets often precludes residents from being targeted in a malpractice suit. In those instances in which residents are named in a malpractice complaint, they are often dropped from the case early in the legal proceedings. However, physicians-in-training are not entirely free from malpractice risks.

Experts in medical malpractice are concerned that there seems to be an increase in malpractice complaints against residents. Malpractice suits accounted for the majority of litigation involving medical residents from 1950 to 1989, and residents tend to not prevail in malpractice trials as often as their more experienced counterparts.[1] From 1985 to 1998, 3 pediatricians in 10 were sued for malpractice at least once during their career in medicine, and 1 pediatrician in 10 was party to a malpractice suit from care provided during residency. The mean number of months elapsing between the alleged error or negligent event and the malpractice complaint being filed was 35.6, almost equivalent to the entire length of general pediatric residency training.[2] Therefore, it is likely that those pediatric residents named as codefendants in medical liability cases will have already completed their residency by the time the plaintiff files a claim.

It is also possible that the former residents may not know that they have been included in a malpractice claim. Depending on the specifications of the medical malpractice insurance policy, a settlement may be reached without the consent or knowledge of the defendants. In fact, the pediatricians might not find out about the settlement until after the payment is reported to the National Practitioner Data Bank (NPDB). The Health Resources and Services Administration Bureau of Health Professionals notes that the NPDB contains 1176 malpractice payments made for the benefit of residents and interns, or 1% of all malpractice payments for physicians.[3] The long-term effects of having a malpractice payment reported to the NPDB so early in a physician's career on his or her subsequent employability and insurability have yet to be studied.

An even worse scenario is possible. Without a clear understanding of the specifics of professional liability insurance (eg, coverage limits, exclusions, and the potential need for previous acts and supplemental tail or nose policies—see below), a pediatrician can be left without any liability coverage for claims filed after residency for incidents occurring during residency.

GAUGING RISK FOR PEDIATRIC RESIDENTS

Pediatricians are exceptionally vulnerable to malpractice allegations because of the long tail associated with care rendered to patients under the age of majority. The tail is the length of time established by state law from when an incident involving a minor occurs or is discovered to when a malpractice claim can be filed. Every state has established a statute of limitations to allow extra time for a malpractice complaint involving a minor to be reported. Therefore, for all physicians this lag time is measured in years, but for pediatricians the statute of limitations can be measured in decades. In some states, the limitation period begins when the incident occurred, while in other states the statute of limitations begins after the injury is discovered.

Although pediatricians are not accused of malpractice as frequently as other specialists, when they are sued, the stakes are high. The Physician Insurers Association of America, whose member companies

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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insure 60% of all physicians in private practice in the United States, reports that neurosurgeons and pediatricians have the highest average indemnity paid per file ($225 800 and $222 500, respectively), compared with $143 800 for all physicians.[4]

Given the severity of pediatric malpractice indemnities, the permanent nature of data bank reports, and the length of statute of limitations for incidents involving minors in many states, the American Academy of Pediatrics (AAP) has strengthened and clarified its recommendations on professional liability coverage for pediatric residents and fellows. These recommendations update a previous AAP statement.[5]

CURRENT ACCREDITATION COUNCIL OF GRADUATE MEDICAL EDUCATION (ACGME) REQUIREMENTS FOR PROFESSIONAL LIABILITY INSURANCE

The Academy joins other responsible medical and hospital organizations in applauding the ACGME for requiring that any educational institution seeking accreditation of its residency and/or fellowship programs must provide adequate professional liability insurance for its physicians-in-training. This requirement is specified in the ACGME *Program Requirements for Residency Education in Pediatrics* (see section II-C, 5) as stated below:

> "Liability Insurance: Residents in GME must be provided with professional liability coverage for the duration of training. Such coverage must provide legal defense and protection against awards from claims reported or filed after the completion of GME if the alleged acts or omissions of the residents are within the scope of the education program. The coverage to be provided should be consistent with the institution's coverage for other medical/professional practitioners. Each institution must provide current residents and applicants for residency with the details of the institution's professional liability coverage for residents."[6]

A 1993 study of pediatric residents in Pennsylvania revealed that 90% did not know the policy limits of their liability insurance or whether a malpractice claim against them could be settled without their permission.[7] The Academy believes that pediatric residents and fellows should be fully informed of their rights and responsibilities afforded by their professional liability coverage and should be educated on important considerations in maintaining adequate professional liability coverage throughout their careers in medicine.

AAP RECOMMENDATIONS

Therefore, the Academy urges that the *Program Requirements for Residency Education in Pediatrics*[6] be further amended as follows:

1. Adequate Coverage

Pediatric training programs must provide adequate professional liability coverage (or its equivalent in military/governmental institutions) for their residents/fellows to indemnify them from liability for potential medical misadventures that may occur during training activities. This coverage should last throughout the training period and continue to provide coverage for these training activities after residents leave the program. This coverage must include all activities that are considered part of the training program's related learning experiences regardless of the setting (eg, rotations in private medical office settings, community-based clinics, overseas experiences, etc).

A. The coverage must be comparable to that offered to other physicians employed by the hospital or training facility.

B. The policy must cover expenses associated with legal defense as well as loss protection against malpractice awards and/or settlements.

2. Documented Proof of Insurance

Pediatric training programs must furnish applicants for residency with detailed information on the professional liability coverage provided to residents and fellows. Such information should be available for the applicant when selecting a training program. On acceptance into the program, each physician-in-training should receive a written description of the professional liability coverage. If the residency program self-insures or insures its trainees under a master policy that also covers the professional staff of the teaching facility, the residents and fellows should ensure that the contract they signed states the explicit provisions of the professional liability coverage for physicians-in-training. Likewise, if physicians-in-training are covered under a separate policy, written specifically for the program's residents and fellows, a copy of the insurance policy contract should be provided to each trainee.

3. Provisions of Current Policy

Whether covered under a master policy, a separate policy for trainees, or self-insured by the institution, the resident/fellow should be provided a written document delineating these specific provisions of the professional liability insurance policy:

A. The name of the company or institution serving as the insurance carrier and appropriate contact information. If the training program self-insures its physicians-in-training for professional liability, this should be noted in writing as well.

B. The type of professional liability coverage provided for physicians-in-training (eg, occurrence, claims made, self-insured, or other). A brief explanation of the differences between various professional liability insurance products should be addressed in terms of what the variations mean to the insured resident or fellow now and after training.

C. An explanation of how settlements are reached. Residents should receive written descriptions of whether the policy allows the insurance carrier to settle a malpractice case without the permission and/or signature of the insured physician.

4. General Information on Liability Insurance

Residents and fellows should be educated on the following kinds of professional liability insurance policies:

A. *Self-insurance*. Many academic medical centers self-insure their staff. Instead of purchasing professional liability insurance, the resources of the training program (or its related institutions) pay any

losses associated with medical malpractice claims or suits against the institution, supervising physicians, and/or physicians-in-training.

B. *Occurrence*. A type of professional liability insurance policy in which the insured is covered for any incident that occurs during the term of the policy, regardless of when a claim arising from the incident is made. For example, if the alleged error or omission happened anytime during the residency training, it would be covered by the teaching facility's professional liability insurance, even if the claim is filed after the policy has expired. Occurrence policies are no longer commonly offered, but may be available through select insurance carriers, or if the program self-insures its residents. Although occurrence policies may seem to provide the broadest liability coverage, depending on the statute of limitations for minors in that state, they may not provide sufficient financial coverage over the long-term.

C. *Claims-made*. An insurance policy that provides coverage for claims arising from incidents that both occur and are reported to the insurance company while the policy is in force. A claims-made policy is in effect from the starting date of the initial policy period and remains in force from that date until it is renewed. Once terminated, future claims arising from incidents that occurred during the policy period are not covered. Typically, claims-made policies do not cover previous acts (liability for actions that took place before the effective date of the policy). Claims-made policies are often heavily discounted in the first years but as the policy matures (usually after 5 years), the rates often increase and become comparable in price to occurrence policies. The major drawback of claims-made policies is the lack of coverage if it should be terminated for any reason—premium payments are not paid or the physician changes employers, medical malpractice insurers, moves to another state, or retires. Unless a special policy is purchased (ie, tail coverage), a physician can end up with a gap in coverage and possibly an uninsured malpractice claim.[8]

D. *Claims-paid*. A variant of claims-made insurance, this is a professional liability insurance that provides coverage for claims arising from incidents that occur while the policy is in force. However, claims must be reported and paid before the policy is terminated.

E. *Tail coverage*. A supplemental policy to claims-made liability insurance that provides coverage for any incident occurring while the claims-made insurance was in effect, even though the claim was filed after the insurer–policyholder relationship was terminated. Sometimes referred to as an extended reporting endorsement, tail coverage is necessary whenever a physician insured under a claims-made policy changes carriers, becomes disabled, retires, or dies.[8] Insurance carriers often have strict policies on when tail coverage can be purchased. For instance, some insurance companies only offer the option to purchase tail coverage during the first 30 days of the claims-made policy. Tail coverage is not inexpensive. It can cost 3 times as much as the annual premium for a claims-made policy.[8]

F. *Nose coverage*. Supplemental insurance to a claims-made policy that provides coverage for previous acts or incidents that may have occurred but have not yet been filed as claims. Because the physician is seeking up-front coverage before securing a relationship with the insurance carrier, it is referred to as nose coverage and is usually comparable in price to tail coverage.

5. Extracurricular Activities/Moonlighting

The residency program should inform its residents of the institution's definition and policies concerning moonlighting and whether these activities are included in the program's professional liability coverage provided to its residents. Residents should be given explicit documentation of any other specific liability policy inclusion/exclusion clauses. Additionally, the program should warn its trainees of the potential long-term liability exposure associated with moonlighting or other professional activities that are excluded from the program's liability insurance policy.

Pediatric training programs that are recognized by ACGME are currently required to monitor the effects of outside activities, including moonlighting in or outside the primary hospital, to ensure that the quality of patient care and the educational experience are not compromised.[9] Accredited training programs must provide trainees with formal written policies on outside professional activities.

The Academy urges that pediatric educational programs also be required to notify physician trainees whether medical malpractice allegations deriving from such extracurricular activities are excluded from the training program's professional liability coverage for its residents and fellows. Trainees should be instructed not to assume that an activity must be for pay or outside the primary training facility to be considered moonlighting. Some apparently benign activities may be considered external to the residency training experience. Pediatric residents and fellows providing care outside of the auspices of the training program should verify that liability insurance with tail coverage is provided by the agency or health care facility where the moonlighting activity occurs.

The program should give its physician trainees specific examples of what constitutes moonlighting to obviate possible misunderstanding. The following situations may be examples of extracurricular activities, and, as such, might be excluded from a training program's liability coverage for its residents and fellows: volunteering as a physician at a camp for children with special health care needs; serving as an infection control consultant to a child care facility; providing sports physicals for a local high school; and staffing the emergency department in the primary training institution when not on official duty as a trainee.

6. Need for Supplemental Coverage for Excluded Activities

If tail coverage is not provided and an individual tail policy to cover extracurricular activities is too costly for the resident to purchase, the resident

should reconsider the potential costs, benefits, and risks of moonlighting. If available, the residency program should inform its trainees that they can purchase supplemental coverage for any excluded activities as an add-on to the standard professional liability insurance.

7. Settlement Decisions

The program should inform its residents and fellows in writing whether the professional liability policy allows the insurer to settle malpractice claims without the signature of the parties named in the malpractice claim. Because federal law requires that malpractice payments made on behalf of health care providers be permanently registered in the NPDB, it is reasonable that physicians-in-training be given the right to make informed decisions on whether to settle a malpractice claim or to pursue litigation.

8. Statute of Limitations for Minors

Because the length of time for which a physician may be liable for previous acts is particularly long in incidences involving pediatric patients, the residents need to understand the provisions of the statute of limitations for minors in the state in which they are being trained. The training program should provide examples of how the length of exposure affects the residents' current professional liability insurance coverage and future needs.

9. Notification of Suit and Participation in Defense

Should a pediatrician be named as a party to a suit arising from events or actions that took place during his or her training period, the program should be responsible to do the following:

A. Promptly and confidentially notify the current or former physician-in-training.

B. Provide paid time off for current residents to testify or provide a deposition in a malpractice case in which they are named. Time spent testifying or being deposed should be considered training-related business; therefore, it should not be deducted from the resident's vacation or other personal time.

C. Reimburse physicians-in-training for reasonable expenses incurred when required to testify or provide a deposition in a malpractice case.

D. Reimburse former physicians-in-training for necessary expenses incurred if required to testify or be deposed in a malpractice case for an alleged error or omission that occurred as part of the residency training programs' educational experience. This provision would make it possible for former residents/fellows no longer in the vicinity of the training program to participate in their own defense without undue financial hardship. Given that 40% of all pediatricians responding to a workforce information survey 2 years after training reported that they work outside the state in which they were trained, it is likely that a large number of pediatricians could be burdened with a long-distance malpractice case.[10]

E. Promptly and confidentially notify current or former physicians-in-training if the training program has filed a reportable action to the NPDB, the Health Integrity Protection Data Bank, or other federal or state repositories of disciplinary actions taken against physicians.

10. No Coverage Gaps

The pediatric training program should educate its residents and fellows on the importance of not allowing any gaps in professional liability coverage, particularly during career changes (eg, changing residency training programs, employers, carriers, etc). The pediatric training program should notify the residents/fellows of any changes in their exposure to malpractice claims and suits attendant on leaving the training program.

11. Other Medical Liability Issues

The pediatric training program should educate its residents in risk management, medical record documentation, legal consequences of failure to comply with health care regulations, and other strategies to prevent adverse events.

12. Career Changes

Pediatricians seeking new employment, particularly early in their careers, should make sure that there are no gaps in their malpractice insurance coverage. If the insurance that was in force during training was a claims-made policy, the resident either should negotiate tail coverage from the residency training program or nose coverage from the prospective employer. In addition, pediatricians considering a claims-made/claims-paid policy through a new carrier should anticipate the need for coverage for their subsequent tail. If a new employer has offered to pay the premiums for the professional liability insurance, it is reasonable to request that the employer also be financially responsible for providing the tail coverage. Similarly, it is reasonable for employers to specify a minimum length of employment as conditional to the provision of tail coverage.

13. Voluntary Adoption

Until the ACGME requirements for accredited residency training programs can be amended to reflect the specific provisions of this policy statement, the Academy urges pediatric training programs to adopt these recommendations voluntarily. By so doing, resident educators can equip their trainees to make informed decisions regarding liability insurance coverage, risk management, and future employment options. More importantly, the residency training programs can prevent the careers of the pediatricians they have trained from being jeopardized by inadequate or interrupted liability coverage during or immediately after the training period.

14. AAP Support

Finally, the Academy will continue its partnership in educating residents and pediatricians beginning in practice on medicolegal issues through its chapters, sections, and committees. Examples of current med-

icolegal education programs for residents and fellows are:

A. Distributing the AAP medical liability manual to second-year pediatric residents.

B. Providing chapters and residency training programs with medical liability presentations.

C. Offering starting-in-practice or life-after-residency programs seminars at scientific meetings.

D. Researching and analyzing the malpractice experience of pediatricians through the AAP Periodic Surveys.

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ADDENDUM

A policy statement on "Developmental Anomalies of the External Genitalia in the Newborn" has recently been published (*Pediatrics*. 2000;106:138–142). The purpose of this review is to identify which newborns among those with abnormal genital development need to be screened for intersexuality, to outline the investigations necessary, and to suggest indications for referral to a center with experience in the diagnosis and management of these disorders.

The 1996 policy on Timing of Elective Surgery states that "children whose genetic sexes are not clearly reflected in external genitalia (ie, hermaphroditism) can be raised successfully as members of either sex if the process begins before the age of 2 years" [see the heading under Body Image and Sexual Development]. The 2000 policy on Developmental Anomalies of the External Genitalia acknowledges the considerable recent debate about the appropriate gender assignment of newborns with the most extreme forms of genital ambiguity, and notes that some have suggested that the current early surgical treatment be abandoned in favor of allowing the affected person to participate in gender assignment at a later time.

This controversy about gender reassignment does not invalidate the other recommendations about the timing of elective surgery on the genitalia of male children with particular reference to the risks, benefits, and psychological effects of surgery and anesthesia that are present in the 1996 statement.

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