Malpractice Insurance for Mid–Level Providers: Are You Protected?

Guidelines for physicians and mid–level providers to help ensure adequate coverage and limit liability.

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Though sometimes overshadowed in the media by issues like Medicare drug coverage, medical malpractice remains a hot button issue for many care providers and their patients. Practicing in Pennsylvania, a state often noted to be in malpractice crisis, I have heard of numerous doctors leaving the state to practice in more physician-friendly areas. Many physicians across a range of specialties nationwide have gone on the offensive, taking measures to limit their liability and in some cases practicing what is termed defensive medicine.

Dermatology, though by no means insulated from the medical malpractice threat, has fared better than some other specialties that have suffered rising numbers of suits and rapidly growing premiums. Nonetheless, dermatologists have vigilantly followed developments in the realm of medical malpractice and taken action as necessary in efforts to keep premiums in check. Especially when it comes to the hiring of non-physician practitioners, dermatologists may anticipate

that acquiring liability coverage for a mid-level provider is daunting and associated with significant cost. However, liability coverage for a mid-level provider is often rather straightforward and considerably less expensive than coverage for a physician. Furthermore, as discussed below, data indicate that having a non-physician practitioner on staff may actually improve the level of care a practice provides and decrease liability risks.

Malpractice Insurance Basics

Before more generally discussing insurance coverage and associated issues, it's helpful to establish some basics regarding coverage. By nature of the physician extender's clinical role and scope of practice, he or she works under the authority of the physician. The supervising physician is ultimately liable for any act of negligence or malpractice on the part of the delegate and can and almost certainly will be named in a suit. Remember, the physician signs off on each chart. Therefore, both the physician and the mid-level provider have a stake in ensuring that the non-physician is adequately and appropriately protected.

It's important to clarify one potential misconception. There are some philosophical differences in the patient care approach of PAs and NPs as well as practical differences in training and sometimes scope of practice/supervision requirements. However, the notion that a physician who has a collaborative agreement with a NP is any more protected against a malpractice claim involving the NP is not accurate. The supervising physician is ultimately responsible for any action by a PA or NP under his or her supervision or collaborative agreement.

Rider v. Individual.
There are two primary methods of obtaining liability insurance for a mid-level provider. The first is for the provider to obtain his or her own personal malpractice coverage. Alternatively, the non-physician practitioner can be covered under the supervising physician's insurance as a rider. Fortifying personal coverage by simultaneously enrolling the non-physician practitioner in both a personal policy and as a rider on the physician's policy is possible, however the benefit—if any—may not justify the increased costs.

Although there may be specific instances in which rider coverage may prove more advantageous than personal coverage, the latter seems to represent the better option in most cases. In the event that the mid-level provider is named in a claim, he or she will have the assurance that lawyers are working specifically to protect his or her interests and achieve the most beneficial resolution.

Nonetheless, the physician must inform his or her malpractice carrier of the staffing change. Regardless of whether or not the physician obtains a rider for the mid-level provider, the addition of the non-physician provider could affect the

5 Steps to Limit Liability

Take a few simple steps early on to avoid potential problems or patient confusion.

1. Hire the right person.

Select the best qualified candidate for the position—someone you are comfortable with and you feel will fit in the practice. Be sure the candidate is qualified and trained to perform the functions you want them to.

2. Inform your insurance carrier.

Regardless of whether or not your or your practice's liability insurance carrier will cover the non-physician provider, it is essential to inform the agency of the new staff addition. It may or may not affect your coverage, but the carrier should be told.

3. Provide adequate one-on-one training with the non-physician provider.

Mid-level providers have a strong knowledge base and are capable of performing a wide range of services as permitted by local regulations. However, even those providers with previous dermatology experience need to spend time one-on-one with the physician to learn office procedures and physician preferences in order to ensure quality and continuity of care.

4. Establish scope of practice.

Be certain to thoroughly research all applicable scope of practice regulations and be sure that you and your non-physician provider comply with all local regulations.

5. Educate patients.

All patients must understand the role of the non-physician provider and be aware that they are receiving treatment from a mid-level provider, not a physician. The quality of care they receive should be identical; nonetheless, a confused or uninformed patient may feel "misled" or improperly cared for.

physician's coverage status and increase his or her premium, though this is not typical. Unfortunately, the physician's premium is not likely to decrease, either, despite evidence that having a PA on staff may actually decrease a physician's malpractice liability.[1] Data support the possibility that hiring a PA may reduce the risk of malpractice liability (*Journal of the American Medical Association* 1997 and *Archives of Internal Medicine* 1989).

A recent article concludes that, "Information from the National Practitioner Data Bank reveals that PAs incur a remarkably low rate of malpractice judgments." Furthermore, "Research shows that there is no increased liability as a result of physicians utilizing physician assistants in their practices."[2]

Claims Made v. Occurrence. Malpractice liability insurance for mid-level providers is in many ways similar to coverage for the physician, though there are notable differences, especially in significantly lower costs. Two basic types of coverage exist: "claims made" and occurrence. Occurrence policies will cover the care provider for a claim involving any incident that occurred while the practitioner was enrolled in the policy, even if the policy is no longer in effect. The carrier does not set limitations for claims filing; so long as the plaintiff can legally bring a charge, coverage will apply. Occurrence policies provide the best protection and, though somewhat more expensive than claims made policies, offer long-term peace of mind. Unfortunately, they are becoming increasingly hard to find.

Claims made coverage, by contrast, will only apply if the claim is made while the policy is still in effect. Once the practitioner discontinues coverage, he or she is no longer covered by the claims made policy. Claims made coverage is somewhat less expensive than occurrence coverage and therefore seems attractive to insurance shoppers. However, claims made coverage has drawbacks (the limited duration of coverage). With the addition of tail coverage, it actually may prove more costly over the long-term. Tail coverage refers to the supplemental insurance practitioners must purchase to "extend" the protection of the claims made policy, which is quite costly. If, for example, a practitioner intends to retire and therefore discontinue a claims made policy, he or she would purchase tail coverage to maintain protection should a patient bring a suit regarding an incident made while the claims made policy was in effect.

These scenarios clarify claims made versus occurrence policies: Suppose you are sued for an event that took place in 1998, at which time you had an occurrence policy that has subsequently expired due to your retirement. The policy would apply to the suit. However, if you had claims made coverage in 1998 but it has subsequently lapsed, the policy will not apply. If you purchased tail coverage upon discontinuation of the claims made policy, it would apply.

Additional Considerations. As previously noted, coverage for a mid-level provider can be significantly less expensive

than it is for a physician. Even a mid-level provider who is considered "high risk" (provides laser services, administers anesthesia, etc.) will pay much less for appropriate coverage than a physician would pay.

It's also important to shop around for coverage. There can be notable differences in cost and extent of coverage from one carrier to another. Look for independent ratings as well as customer reviews for various companies. Talk to company representatives and don't hesitate to ask any questions. Seek input from colleagues, professional associations, and other advisors as necessary. Some insurance company ratings can be found online; the A.M. Best Company website is a good starting point (ambest.com).

The American Academy of Physician Assistants provides general information about liability insurance through its website (www.aapa.org/gandp/risky.html) and offers a policy for PAs (www.epreceptor.com/aapa_insurance/index.html).

Philosophy of Practice

Obviously, having the appropriate malpractice insurance is essential to protecting the interests of the physician, mid-level provider, and practice. Limiting liability is also impor-

Malpractice Trends

▼ Total payments for malpractice judgments*
Down 24.5 percent 2000 to 2004

▲ Median payment*
Up to 265,000 in 2004 from $230,000 in 2000

▼ Total number of judgments against physicians*
Down 31.9 percent from 2000 to 2004

▲ "Failure to diagnose" cases
20 percent of payouts in 2004 versus 16 percent in 1991

As reported by Public Citizen, National Practitioner Data Bank
www.citizen.com

tant, though it is a broader and more complex issue. While there are numerous issues to consider, I think it is worthwhile to address some general guidelines.

The first key consideration is the practice philosophy regarding the role and benefits of a mid-level provider. Any physician seeking to hire a non-physician practitioner must recognize what the provider can and cannot do and how he or she will function within the practice dynamic. Generally speaking, despite differences noted above, PAs and NPs are both high-functioning care providers who work closely with but not under the constant direct supervision of a physician. They are qualified and able to see and treat a range of patient presentations without direct physician involvement.

As a delegate of the physician, mid-level providers are expected to provide care according to current best practice models in a manner that is consistent with the physician's management approach. However, on a case-by-case basis, the non-physician provider is expected to exercise individualized medical decision making. Besides being impractical and unnecessary, it is virtually impossible for the physician and mid-level to collaborate on each case. Therefore, when hiring, the physician should look for someone who approaches patient management, medical decision-making, and therapeutic selection in a manner that is similar to his or her own. You won't each do everything exactly the same, nor should you. But you shouldn't take divergent approaches to patient care, either. This helps ensure continuity of care.

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The ideal candidate will be someone the physician feels she or he can comfortably and efficiently work with and communicate with. The candidate will also relate well with patients and effectively communicate his or her role to them. It is important for patients to know what the mid-level provider does. Furthermore, every patient must clearly recognize that the mid-level provider is not a physician in order to avoid any confusion and potential dissatisfaction.

Scope of Practice

The physician should also have a sense of what duties/types of procedures he or she intends to delegate to the mid-level provider early in the recruitment/hiring process. Investigate local regulations to determine whether or not the non-physician practitioner is legally permitted to provide these services and under what circumstances. Then find a candidate who is qualified for or seeking qualification (special training, preceptorship, etc.) to provide these services. For example, if you want to hire a PA to do multiple laser procedures, you must be sure your state allows you to delegate such procedures (and provide supervision as mandated) and that the candidate you hire will be able to fulfill these duties.

Even if a candidate has excellent credentials and training, seems to be a good "fit" with your medical staff, but is not qualified to perform the types of procedures you have in mind, then he or she is not the right person for your practice. Avoid changing your plan just to fit the candidate, such as restructuring the distribution of labor. There must be a reason you wanted a mid-level provider to perform laser procedures rather than do it yourself. Unless you have a true change of heart, simply shifting responsibilities to accommodate the candidate will probably leave you dissatisfied in the long-run. Plus, hiring an individual qualified for the duties you have in mind will avoid the temptation to delegate inappropriately.

1. http://www.aapa.org/gandp/pamalpct.html

2. Feudale F. Busting Myths about Physician Assistants. Pennsylvania Society of PAs Summer Newsletter 2006, p.9-10. http:www.paworld.net/whatpadoes.htm.