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SYMPOSIUM: EVOLVING MEDICOLEGAL CONCEPTS

Medical Liability of the Physician in Training

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Abstract

Background Lawsuits alleging medical negligence by postgraduate physicians in training (residents) arise from treatment received by aggrieved patients at teaching hospitals. A threshold question in determining liability is whether or not the standard of care has been violated. Courts have questioned whether the proper standard governing resident physician conduct should be that of a reasonably competent generalist physician, that of a specialty physician, or whether the standard should be some subjective determination that addresses the resident level of training.

Questions/purposes We examined legal cases in which the standard of care for a physician in training has been questioned. Additionally, we address how resident conduct can extend liability to supervising physicians and employer hospitals.

Methods Westlaw™ and LexisNexis®, two major legal databases used by law professionals, were searched to identify existing case law and law review articles related to the standard of care that applies to physicians in training. Of 57 sources initially identified, 15 legal cases and 10 law review papers addressed the standard of care pertaining to physicians in training. These selected cases and papers form the basis of the present article.

Results The standard by which the professional conduct of a physician in training is measured has varied; most recent legal cases have applied a specialty physician standard. Relevant court rulings have tried to strike a balance between patient interests versus the societal need to train physicians.

Conclusions Physician representation, nature of conduct, and extent of supervision of that conduct are relevant factors used by courts to determine liability. However, the recent standards are those of the physician who directly supervises the professional conduct of a resident in a given situation.

Introduction

As the incidence of medical malpractice litigation has increased, so have concerns and fears about the liability of resident exposure to medical liability [21]. The question of the proper standard of care by which the professional conduct of residents is evaluated is complicated by the presence of competing interests and practical policy considerations. Patients' lives and health are necessarily exposed to residents because a large volume of healthcare is delivered by residents in postgraduate residency programs throughout the United States. The long-term perspective is that societal safety and health depend on residents learning their profession so that they can practice safely and effectively as physicians. Residency programs are vital components in the education and training of physicians for the independent practice of medicine, especially for the majority of doctors today who subspecialize. The challenge for the legal profession has been to identify the best approach in dealing with

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cases in which resident care is alleged to have led to injury. Such an approach must strike a balance among the health, safety, and autonomy of patients without constricting or limiting the essential clinical education of residents.

The law of medical malpractice, however unpopular among physicians, remains an important mechanism for protecting patients. Patient protection and safety flow from liability rules that deter substandard conduct and provide compensation for victims. The measure by which a healthcare provider's professional conduct is evaluated in the legal system is called the standard of care. The standard of care in medical malpractice litigation is an important determination that directly affects the results of a lawsuit. Identifying which standard of care applies to residents is important because residents can be named as defendants in medical malpractice litigation and because their conduct can extend liability to their supervising doctors and to the employer hospital [8].

Medical malpractice cases involve negligence liability, which is a fault-based system whereby the plaintiff must offer proof that the defendant's conduct fell below a standard. In contrast, strict liability cases do not require proof of negligent conduct. Invoking a standard of conduct in negligence cases means that the law evaluates the defendant's conduct according to objective criteria rather than by a subjective assessment [10]. The objective criteria that formulate the standard of care are usually shaped by courts as case law develops. Case law defining the standard of care with respect to resident conduct is relatively sparse, partly because although residents are increasingly named in malpractice cases, the most common target of defendants continues to be the attending or supervising physicians and hospitals that sponsor or employ residents [4, 8]. Although the precise standard governing resident conduct remains elusive, case law offers valuable insight into judicial deliberation on this subject.

The purposes of our review are to (1) examine the legal reasoning in court rulings that have shaped the standard of care applicable to physicians in training; (2) identify how the informed consent process is related to resident liability; (3) examine whether resident status is relevant to the alleged claim of negligence; and finally (4) how resident liability can vicariously extend to supervising physicians and training institutes.

Search Strategy and Criteria

We searched two major law databases, Westlaw™ and LexisNexis®, using key terms such as "medical liability", "resident liability in training", "resident standard of care", "professional standard of care" and "institutional liability." The search was accomplished with the assistance of a professional law librarian and the 57 sources thus identified were then read to see whether or not they were relevant to the questions asked in this article. The 15 legal rulings and 10 law papers that directly related to the subject of legal liability of the physician in training form the basis of this article.

Transition From Student to Physician

First-year residents, also known as interns, have a temporary medical license and perform less complex medical tasks. In Rush v Akron General Hospital, a first-year resident failed to identify retained glass fragments in a traumatic shoulder wound that he sewed shut; one piece measured 3-1/4 inches [22]. The 1957 Rush ruling was the first to address the standard of care for a first-year resident; The court adopted a subjective rule that tied the standard to that which interns ordinarily possess under similar circumstances. As the following illustrations show, later court decisions that revisited this issue changed the applicable standard of care for an intern to that of a general practitioner, ie, a doctor not specifically licensed in the specialty in which the resident defendant is training.

In 1982, the legal case titled Jenkins v Clark overruled the standard of care described in Rush, holding instead that first-year residents should be held to the standard of "reasonably careful physicians or hospital emergency room operators, not of interns" [20]. Thus, the wording in the Jenkins ruling changed the standard of care from that of similar interns to at least that of an attending general practitioner working in an emergency room. According to Jenkins, to show medical malpractice, the injured patient must prove that the resident physician did something or failed to do something that a "physician or surgeon of ordinary skill, care and diligence" would (or would not) have done under like or similar conditions or circumstances [5].

A decade later, Centman v Cobb further affirmed Jenkins when it held that first-year residents are medical practitioners who must exercise the same standard of skill as a physician with an unlimited license to practice medicine [1]. Although a first-year resident practices under a temporary medical permit, the court stated that as a healthcare practitioner, a first-year resident who assumes treatment and care for patients "impliedly contracts that she has the reasonable and ordinary qualifications of her profession and that she will exercise reasonable skill, diligence, and care in treating the patient." The court further added that as practitioners of medicine, residents are bound to possess and exercise the reasonable and ordinary degree of skill, care, and diligence generally possessed, exercised, and accepted by members of their profession who practice in the same or similar localities [23].

In rulings such as Jenkins and Centman, first-year resident defendants have argued that because they do not possess a medical license, they should not be held to the standard of a licensed physician. Although acknowledging this fact, court opinions have made it clear that first-year residents cannot escape culpability, in part because they represent themselves to be physicians to the patients in their care. However, articulation of the precise standard of care for interns has not always been as clear as the rule in Jenkins or Centman. In the 1994 case of Mercil v Mathers, a malpractice claim was brought by the estate of a woman who died shortly after childbirth [15]. A first-year resident who helped during the delivery was among the defendants. The court noted that an unlicensed, first-year resident is not immune from legal duty; the standard set forth by the court required that a first-year resident must "use that degree of skill and learning which is normally possessed and used by doctors in good standing in a similar practice." In the 2009 legal case of Phelps v Physicians Insurance Company, in which parents had brought a malpractice suit to recover damages for the death of their unborn son, the Wisconsin Supreme Court held that first-year residents should be held to the specific standard of care expected of such residents [17]. These latter cases appear to leave the status of interns more ambiguous, and this remains an area in which the law is somewhat unsettled.

In summary, the trend in case law since the early 1980s has favored considering resident physicians, even those in the first year of training, as bona fide, licensed physicians when it comes to the professional standard of care in medical malpractice cases. Specifically, the law expects first-year residents to exercise at least that level of knowledge and care expected of other practitioners at a similar stage of training or that standard of care applicable to licensed nonspecialists, ie, general practice doctors. As the next section illustrates, courts have also grappled with the related issue of whether to treat resident physicians enrolled in specialty programs such as orthopaedic surgery as general practitioners or specialists.

General Practitioner versus Specialist Standard

Once residents have completed the first year of training, they normally have a license to practice medicine. Most courts have held such residents at least to the same level of care as that demanded of licensed general practitioners [8], whereas other courts have invoked a more specialized standard. Case law suggests at least three different positions adopted by courts in dealing with cases in which specialty care was rendered by a physician in training. The first approach was illustrated in McBride v United States (1972) [13]. In that case a patient had returned to the emergency room with chest pain after discharge from the hospital for the same condition 3 days earlier. A cardiology resident read the electrocardiogram, recommended hospitalization, but deferred to the patient request not to be readmitted, and the patient died shortly after reaching his home. The Court of Appeals held that the cardiology resident should be held to the standard applicable to a general licensed physician staffing an emergency room.

The second approach has invoked a specialist standard of care; in Powers v United States (1984), an orthopaedic resident performed a cervical fusion at a Veterans Administration hospital [18]. The resident did most of the neck surgery while the attending and another resident harvested a bone graft from the leg. The resident was also responsible for postoperative care of the patient, who sustained severe morbidity and paralysis of the upper limb. In holding the resident negligent in the performance of surgery and in the postoperative care, the Powers court said that the applicable standard of care was that of a specialist orthopaedic surgeon performing a similar operation. In other words, the conduct was measured against that of an attending surgeon performing a cervical fusion, although the defendant was in training. One logical explanation for the variations in court opinions in this matter is that each set of factual circumstances is different; thus, in Powers, the court found particularly egregious conduct in that the resident was in fact the professional performing the operation and the postoperative care. In the eyes of the patient therefore, the conduct of the resident physician was such that he represented himself to be an orthopaedic surgeon specializing in spine surgery.

In a third group of legal cases, the standard of care applicable to residents is either unclear or the courts have deliberately avoided deciding the legal issue. For example, in National Bank of Commerce v Quirk (1996), medical malpractice claims were brought against several physicians, including two licensed radiology residents for allegedly misreading a MRI that led to spinal injuries in a newborn [16]. A plaintiff's expert stated the standard of care for a staff radiologist and admitted that he did not know the standard applicable for a resident. Ruling in favor of the resident defendants, the court cited this uncertainty on the part of plaintiffs in specifying a standard of care as a factor guiding its decision, but the court declined to specify the desired standard itself. Other rulings on point have been consistent with the reasoning in these examples [19].

This line of judicial thinking developed further in Jistarri v Nappi (1988), in which the court modified the standard of care articulated in the Pratt and Harrigan cases to a sliding scale, holding that an orthopaedic resident who negligently applied a cast to a patient's wrist should be held to a standard of care higher than that of general practitioners but less than that of specialists [6]. The court reasoned that

the resident in the case possessed more training than a general practitioner but less than a fully trained orthopaedic surgeon. Therefore, according to the court, a fair formulation of the applicable standard of care should be higher than that for general practitioners but lower than that for fully trained orthopaedic specialists.

In 2007, a Michigan court also overruled an earlier state court ruling that had held residents to a generalist standard of care rather than a specialist standard. Gonzalez v St John Hospital & Medical Center (2007) involved a third-year resident performing colorectal surgery that led to patient injury [3]. The patient argued that a physician can be a specialist without being board-certified in the specialty, especially because the resident was receiving advanced training in general surgery at the time of the negligence. The Michigan court looked at preceding case law and decided that those residents who "limit their training to a particular branch of medicine or surgery and who can potentially become board-certified in that specialty are specialists" for purposes of the standard of care.

In rulings such as these, courts must walk a fine line between holding resident conduct accountable to some objective, equitable standard of care and accommodating the essential educational mission of residency training while also offering sufficient opportunity to injured patients to seek redress for their harm. Modern jurisprudence appears to be in favor of holding residents to a progressively higher standard as their knowledge, experience, and training develop during the residency programs, although this continues to be a gray area of medical negligence law.

Informed Consent and Resident Liability

The doctrine of informed consent before medical treatment is familiar to physicians; traditionally, informed consent encompassed a disclosure of the risks, benefits, and alternatives attendant to a planned medical intervention [14]. A recent line of legal cases has addressed the duty of disclosure of physician-specific variables also, especially those that might impact the outcome of surgery [11].

In Whiteside v Lukson (1997), the defendant attending surgeon had trained in laparoscopic surgery during a seminar but had never done the operation [25]. When complications occurred during his very first laparoscopic cholecystectomy, the issue was whether or not he should have disclosed the lack of experience to the patient in obtaining informed consent. The court, applying a reasonable patient standard, said that the lack of experience of the surgeon was not material for the purpose of obtaining informed consent; evidence related to such was therefore inadmissible. Reasonable patients may of course disagree; the issue of whether a doctor is performing his or her very first operation or has had extensive surgical experience appears intuitively relevant to patient decision-making. Although the Whiteside ruling did not involve a resident physician, it is of value in understanding how courts view disclosure of information related to physician training during the informed consent process.

Despite the Whiteside ruling, a few courts have begun to recognize a duty of disclosure that could extend to the defendant's level of experience and training. In Johnson v Kokemoor (1996), a patient injured after neurosurgery to clip a cerebral aneurysm alleged that she was not given information about the surgeon's lack of experience in performing what was a very difficult operation [7]. The Supreme Court of Wisconsin agreed and held that evidence related to the defendant's lack of experience, the difficulty of the proposed surgery, the fact that different surgeons may have various rates of success with the same procedure, and the comparable risks of having the procedure done at a tertiary medical center were all factors that fell within the general obligation of the surgeon to disclose viable options to the patient. Mindful that its ruling could expose a host of difficult questions related to surgeon experience, the Johnson court—and other courts faced with similar cases—took pains to limit the potential judicial reach of their holdings. For example, taken at face value, the Johnson holding could be construed to require all surgeons within a certain distance of the Mayo Clinic to tell patients of the option of travel to the Mayo Clinic for treatment. Residency training is a learning continuum that does not readily offer statistical generalizations or other methods of measuring experience-based risk information that could be used by courts to judge culpable conduct. Accordingly, legal scholars have offered several additional approaches to this problem.

The Relevance of Resident Status

One approach of courts when considering physician-specific information claims is to examine the issue of causation, ie, would disclosure of resident status cause a reasonable patient to choose an alternative course of action? If not, then resident status would be immaterial while obtaining informed consent from a patient [14]. A somewhat different approach was advocated by other scholars, and it raises the bar considerably for injured patients. In this latter view, the causation component requires proof not only that the harm suffered by the patient was caused by the treatment or therapeutic approach in question, but it also sets forth an additional requirement, which "concerns whether the patient's decision to undergo the procedure caused any harm in comparison to the choice that otherwise would have been

made" [24]. Under this model, the patient must not only prove that had if he or she knew about the relative inexperience of the defendant-physician, he or she would have gone elsewhere, but also that the harm alleged was caused by the treatment actually received and that this harm exceeded that which he or she might have suffered at the hands of a more experienced healthcare provider or treatment path. The problem here is that the patient might well have suffered the same outcome even at the hands of a more experienced healthcare provider, and proving otherwise is a difficult hurdle.

To resolve these complexities related to proving causation, some legal scholars have proposed a "lost chance doctrine" as a possible framework for assessing liability in cases in which physician inexperience such as it relates to resident status may affect the odds of a favorable outcome for a patient undergoing an intervention [9]. Using the earlier case of Johnson v Kokemoor as an illustrative example, evidence could be introduced comparing the usual morbidity and mortality rate of 10% for the planned procedure versus a rate of 20% for the same procedure performed by a resident [7]. Under a lost-chance doctrine model, one can calculate that 20 minus 10 equals a 10% chance of avoiding the adverse result; whether or not this was material to the patient's decision-making and should have been disclosed during informed consent then becomes a factual or legal inquiry depending on the jurisdiction. The difficulty with the lost-chance model relates to the lack of meaningful data concerning statistical comparisons of outcomes associated with different levels of physician experience and especially resident physician status.

The common theme that appears to run in all cases that have questioned whether disclosure of resident status is relevant during informed consent is the element of materiality. Where knowledge of resident inexperience would have materially affected a patient's decision whether to have surgery, it is probable that a court will permit admission of resident experience and training status into the case. The counterargument is that resident training and experience are difficult to quantify; these are fluid concepts that change remarkably as a resident physician develops professionally. Accordingly, to safeguard patients, and to shield them from unpredictable levels of experience, graduate medical education stipulates that senior attending doctors, with the experience reasonably expected of similarly situated professionals, should always supervise and control resident care of patients. Such supervision is designed to ensure, among other things, that experience and level of training of resident staff are immaterial to the outcome. This supervisory responsibility and the fact that residents are employees of teaching hospitals can extend liability arising from resident conduct to those parties, as discussed in the following section.

Extension of Liability Related to Resident Conduct

Independent of the applicable standard of care in judging resident conduct, supervising physicians and employer hospitals and teaching institutions also face liability for the errors made by medical residents. Courts have held supervising physicians liable under theories of vicarious liability when supervising physicians are present and fail to sufficiently supervise. Under the alternative theory of direct liability, courts view supervision as an inherent part of the job duties of senior physicians at teaching hospitals; therefore, claims of negligence can be brought directly against the supervising physician rather than imputed through a theory of vicarious liability. Some courts have even held supervising physicians liable when the physicians are merely on-call and not physically present at the hospitals [12].

Liability for the supervising physician is dependent on the presence of a relationship between the patient and the supervising physician. This relationship depends on the existence of acceptance of responsibility for the patient through explicit agreements or implicit indication, provisions of consultations, and recommendations regarding patient care, including an on-call agreement between the supervising physician and the hospital that allocates supervisory responsibility to the supervising physicians. Once the relationship has been established, liability turns on whether the supervising physician provided sufficient supervision under the appropriate standard of care.

Hospitals and sponsoring institutions can also be held liable for injuries arising from resident errors. Teaching hospitals have a legal duty to provide services and supervise care [2]. As a result of the duty to provide services and care to patients, teaching hospitals are held directly liable for any breaches of this duty. Therefore, all participating parties in the medical community face liability for errors committed by residents.

Discussion

Lawsuits alleging medical negligence by resident physicians typically arise from treatment received by aggrieved patients at teaching hospitals. A key issue in determining liability is whether or not the standard of care has been violated. The standard governing the resident physician could be that of a reasonably competent generalist physician, that of a specialty physician, or that based on some subjective determination considering the resident level of training. We examined legal cases and the reasoning for selecting the standard of care by which resident conduct has been measured in legal rulings. The related factors that impinge on this subject include the nature of resident

conduct, informed consent, relevance of resident status to the alleged outcome, and the role of the supervising attending physicians and teaching hospitals.

There are limitations to this study. Any review of court deliberations and the applicable law is limited by factual circumstances that apply uniquely to each case. However, the law seeks patterns in comparable legal cases, and legal reasoning relies heavily on the well-established principle of stare decisis by which judges respect the precedents established by prior decisions. Ad hoc reasoning may be intuitively satisfying in resolving the peculiarities pertaining to a selected legal case and may contribute to perceived fairness in the outcome of litigation, but such reasoning has no value in resolving future disputes because factual circumstances will vary from case to case.

We found legal rulings pertaining to the precise standard by which resident professional conduct is measured have evolved over time. From the initial, intuitive application of a standard that measured resident conduct against other, similarly trained residents, case law has evolved to hold residents to that standard demanded of a licensed general practitioner. Later rulings went further in holding resident conduct to that standard expected of the specialty sought by the resident, and it is reasonable to expect that future legal cases will find support in this view. Close examination of the relevant factors considered by courts shows that there is logic in this framework rather than an arbitrary, unfair application of a higher standard to a professional in training.

Resident training is a critical component of the US healthcare system, and the law has been deferential to the educational and training needs of future physicians whenever it has dealt with claims of medical negligence that involve a physician in training. The courts have struggled with the question of what standard of care should govern resident conduct. Unless a resident physician specifically discloses training status to the patient, most courts have held that the reasonable standard against which resident conduct is measured is that of a licensed practitioner in that specialty. Rather than an unfair benchmark, this legal reasoning accommodates the fact that residents generally hold themselves out to be physicians before patients, who therefore have a reasonable expectation of care that a similarly situated practitioner would provide. Also, because graduate medical training demands close and direct supervision of resident staff, and because patients are led to expect such supervision, it is reasonable to use the same standard of care for residents as that used to judge the conduct of attending physicians.

The answer as to which standard should govern resident conduct is neither a precise, legal formulaic solution nor an entirely subjective determination that caters to perceived notions of fairness and justice. Instead, court rulings in this area of law have examined the various interests at stake such as the need to train future physicians, the accessibility of patients to the care provided in teaching hospitals, the information provided to patients about the training of their doctor, the relevance of such information (if any) to the treatment and outcome, the nature and role of the supervision of resident physician, and the responsibility of the supervising doctors and employer hospitals in monitoring resident conduct. A logical proposition would be to hold physicians in training to that standard which applies to the supervising physician. Such a legal rule will simplify the analysis, provide clear guidance to all parties, and be consistent with public expectations that resident conduct is monitored and supervised to ensure proper balancing of training, education, and patient safety. Resident liability already extends to supervising attending doctors and employer hospitals either directly or vicariously. The physician who directly supervises the professional conduct of a resident in a given situation should be recognized as the standard by which medical care delivered by the resident can be measured. Such a rule may be of value in identifying the legal standard by which to judge resident professional conduct in future legal cases.

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