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Medicolegal Sidebar

Medicolegal Sidebar: Resident Physician Liability

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Introduction

It is rare for the US Supreme Court to weigh in on a legal case dealing with academic medical centers and physicians in training, but in 2011 the Supreme Court upheld a Treasury Department regulation that required academic medical centers to pay social security taxes on behalf of resident physician employees [6]. Teaching institutions such as the Mayo Clinic had argued for a tax exemption instead, reasoning that resident physicians were students, or trainees, rather than full-time employees.

Beyond deciding whether resident physicians are student-trainees or employees for tax purposes are the more complex and perplexing liability issues that can arise from medical malpractice committed by physicians in training.

In adjudicating medical errors made by resident physicians, one view is that it would be unfair to judge a resident to the same standards that apply to a physician or surgeon who is fully trained. The goal of residency training is to allow new doctors to gain knowledge and skill, without the fear of lawsuits. A contrasting view is that if a patient is injured by a resident who lacks knowledge and skill needed to properly manage a medical condition, then appropriate compensation should be provided.

While society has a practical interest in training new doctors, this training cannot come at the cost of patients' lives or their health. These competing interests have shaped many legal rulings over the years. These rulings illustrate that the issues the courts must address when reviewing patient injury arising from alleged resident malpractice remain unsettled.

Case Law Involving Resident Physicians

In a 1991 medical-malpractice dispute, *Centman v Cobb* [2], two first-year resident physicians were alleged to have caused lithium poisoning, and the court had to determine what standard of conduct should apply to the care delivered by the residents. The court reasoned that because residents represent themselves as physicians when they deliver patient care, their conduct should be held to the same standard as

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a physician with an unlimited license to practice medicine. The opinion left open the question of whether a specialist or generalist standard should apply to resident conduct.

Two years after the *Centman* decision, a Michigan court reviewed an appeal in *Bahr v Harper-Grace Hospitals* [1], a case where the patient was admitted with the diagnosis of pneumonia, and suffered brain injury from cardiac arrest that went undiagnosed by a resident. In refusing to allow a cardiologist to testify against the defendant, the court held that residents are generalists, and not specialists.

Subsequent rulings from the same Michigan court would overturn *Bahr*. In 2007, the same court dealt with the liability of a third-year surgery resident who allegedly failed to diagnose intraabdominal hemorrhage, leading to patient death [4]. In *Gonzalez v St. John Hospital & Medical Center* [4], the court now reasoned that a specialty standard should apply to all those who "limit their training to a particular branch of medicine or surgery and who can potentially become board certified in that specialty as specialists" [4]. The *Gonzalez* ruling relied on another decision issued 2 years previously by the Michigan Supreme Court, which held that expert testimony against a defendant physician must be from the same specialty, and that a specialist is someone who can potentially become board certified, which would include all residents in recognized training programs [7, 8].

The above cases did not address whether residents in different years of training should have identical expectations, or if the standard of care should vary by the year in training. An earlier 1998 ruling in Pennsylvania, *Jistarri v Nappi* [5], shed some light on the issue by holding that an orthopaedic resident who caused injury from a tight wrist cast should be held to a standard that was somewhat higher than that of general practitioners, but somewhat less than that of orthopaedic specialists [5, 7]. The *Jistarri* court attempted to apply a sliding scale model to determine that standard of care that should apply to resident liability. However, the ruling proved to have little precedential value, given the practical difficulties of identifying discrete standards of care for various levels of resident training. As such, finding the proper standard by which to judge alleged resident physician misconduct remains an unresolved issue for the courts [7].

Resident Supervision

The courts have also addressed the important role of the attending physician in monitoring and supervising residents. Of note, attending physicians who supervise residents are not held to a standard of "strict liability" (ie, liability that is inferred simply because an adverse event occurred). In legal terms, "strict liability" contends that because a resident committed an error, liability would automatically be assigned to the attending physician. But this is not so for attending physicians. The injured patient has the burden of showing that the attending physician was careless or negligent in monitoring, supervising, or controlling the scope of the resident's conduct.

A relevant element in resident liability relates to perceived compulsion or duress in performing clinical duties; if so proven, these conditions can defend against resident liability. An example is that of overlapping surgery in two operating rooms, where a resident may have to perform surgery outside the scope of his/her competence because of an attending surgeon's scheduling demands. In these situations, the resident accused of malpractice can make a strong defense argument that invokes a fundamental principle of tort law from a 1941 case, where a taxi driver jumped out of his moving car to save himself from an armed assailant. The runaway cab ended up injuring pedestrians. In finding the taxi driver to have acted reasonably, the court set forth the rule that in judicial determinations of

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negligence, factual circumstances dictate whether or not an act is prudent [3]. In light of the circumstances, certain conduct, such as a resident performing an operation that is beyond his/her capability because the attending surgeon is not available may be excused.

Conclusions

Medical malpractice liability that involves academic centers and resident training remains unsettled, particularly in terms of the applicable standard of care. Society has an interest in training future physicians, while ensuring patient safety and compensation for injuries from medical errors.

We believe that it is unfair to hold a resident to the standard of a fully-trained physician, whether a generalist or specialist. Limited resident work hours should be devoted to learning, rather than defending malpractice lawsuits. Residents work only under the supervision of attending physicians and institutions that gain financially from the care delivered by residents. Accordingly, imputing resident malpractice liability to the supervising attending as a matter of law would let residents focus on training without the fear of litigation, while encouraging closer, proactive supervision, as well as institutional policy measures that minimize the risk of patient injury. However, to our knowledge, no US court has yet adopted a strict liability standard whereby resident misconduct would automatically impute to the attending physician. Practically, attending physicians are invariably named as codefendants in lawsuits alleging medical negligence against residents. A legal framework, whereby liability for the alleged misconduct itself is imputed vicariously to the attending physician, is likely to be created by a future appellate court decision. Alternatively, a state legislature may adopt statutes that create such a framework to adjudicate resident liability in medical malpractice litigation.

Until or unless the laws change, existing case law offers two practical principles related to resident liability. First, academic teaching centers must be careful not to place patients at risk by allowing residents to practice beyond their training level. The resident must be aware of his/her knowledge and skill limitations and confine clinical activities within the scope of such. Second, the teaching physician must be active rather than passive in monitoring and supervising resident staff. The on-call duties of an attending physician extend beyond merely waiting for an emergency to occur, to include a proactive role in understanding of the clinical conditions of the patients being treated by the residents, and guiding the residents through the medical-management process in order to mitigate patient risk.

References

1. *Bahr v Harper-Grace Hospitals*, 497 NW2d 526 (Mich Ct App 1993).
2. *Centman v Cobb*, 581 N.E.2d 1286 (Ind. Ct. App. 1991).
3. *Cordas v Peerless Transportation*, 27 N.Y. S 2d 198 (1941).
4. *Gonzalez v St. John Hospital & Medical Center*, 739 NW2d 392 (Mich Ct App 2007).
5. *Jistarri v Nappi*, 549 A2d 210 (Pa Super Ct. 1988).
6. *Mayo Foundation v United States*, 562 U.S. 44 (2011).
7. Wegman B, Stannard JP, Bal BS. Medical liability of the physician in training. *Clin Orthop Relat Res*. 2012;470:1379–1385.
8. *Woodard v Custer*, 701 N.W. 2d 133 (2005).