SPECIAL REPORT

Resident Physician Interface in Medical Malpractice

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The scenario of a resident physician who is involved in a medical malpractice case occurs more commonly than you might think in the day-to-day practice of emergency medicine. Some more common examples might include the following:

- A patient disposition decision is made by the emergency department (ED) physician that is then countermanded by a resident physician who discharges the patient, and an untoward outcome results.
- A patient is admitted by the ED physician and cared for by a resident physician; the resident physician performs an alleged error soon after the patient's admission but prior to the next day-service attending physician's evaluation. A resulting allegation of this scenario would involve inadequate "stabilization" of the patient by the ED physician prior to floor transfer, as well as subsequent "supervision" of the admitting resident while they are physically in the ED.
- A radiology resident physician performs an evening preliminary radiology "wet reading" after consulting the ED physician for assistance and an error is made in the consultative interpretation. A poor patient outcome results.

These medical-legal scenarios distill down to the most basic question: who is responsible and to what degree?

Resident Malpractice

A case analysis for resident malpractice renders the usual morass of factors. Typically, the ED physician gives a patient care judgment that is somehow countermanded by a resident physician without on-site attending physician guidance.

An overtly simplistic analysis would attribute 100% of the liability to the ED physician, while the resident and "supervising" physician are eliminated from any responsibility as they were not independently functioning as credentialed physicians.

However, a more contemporary analysis might find that the resident physician, resident supervising physician, and the ED physician share a proportionate responsibility in a comparative negligence analysis.

The ED physician retains the proportionate share of responsibility in cases in which patient admission is refused by the resident and the patient is discharged to home. However, the resident and supervising physician share more responsibility for alleged medical negligence that occurs in cases in which a specifically credentialed activity, such as radiology interpretation, is performed.

Either analysis often still would note that the ED physician was as involved as the senior consultant and they would share responsibility. There is an additional risk of the ED physician who is insistent on his/her own care plan as opposed to the resident's plan being viewed as "non-collegial" or unable to perform in a teaching environment as they are often labeled "difficult."

Interventions: Protecting the Patient and Yourself

Legal Theory.

1. Respondeat superior. This is the "captain of the ship" premise in which the ED physician would be viewed as responsible for all departmental events whether they occur with or without his/her knowledge. It is not firmly held in all jurisdictions, yet it remains a potential analytic template for assigning negligence responsibility.

If there are differing opinions about a patient's discharge, possible interventions for protection under this premise include:

a. If the ED physician has a discrepant opinion with the resident, he or she should ask for accommodation and try to educate the housestaff; however, the patient should always be protected. A patient should not be discharged if it is not appropriate.

b. An antiquated strategy is to challenge the attending physician to come in to perform the discharge him or herself. This approach often is associated with ill will, and it cannot effectively offer complete liability protection.

c. Involve others in the discussion (e.g., patient, family, and other consultants) to develop a consensus of opinion that may help to diffuse risk.

2. Chain of administrative command. The "chain of administrative command" theory requires the ED physician to alert the department chairman if he or she believes a patient's safety is at risk. If the department chairman is unavailable, the medical staff president should be informed of the situation. There is a corollary parallel nursing requirement involved in which the staff nurse is required to notify the nursing supervisor or administrator on duty.

3. Last chance. The "last chance" tort premise notes that the ED physician often is felt to be the last person capable of reversing an errant deci-

sion-making process and that he or she can be held legally responsible.

Specific Case Law Analysis

Can a residency program director be held liable for resident acts?

It is accepted that a resident faculty "supervisor" who is on call from home and who has not been consulted is not liable for alleged resident negligence. The case of *Vasquez v. Bd of Regents* specifically applied to the vicarious liability of pediatric program coordinator who did not have actual rounding responsibility.[1] Here, the court upheld the premise that the administrative director is responsible for general educational direction, but not patient specific guidance for the rounding resident caring for the ward patient.

However, residency program directors can be charged with having and maintaining programs for adequate resident supervision. Failure to provide a structure and framework to ensure necessary resident and attending contact sustains a negligence action against a departmental chairman. *Maxwell v. Cole* involved a departmental chairman who was found liable for not having appropriate faculty supervision in place when a bladder perforation was presumably caused by the resident physician during an elective tubal ligation on a gynecologic service.[2]

How do residents share in medical negligence liability?

Resident physicians, as well as their supervising physicians, can share in the financial liability in a comparative negligence analysis. They are typically assigned less liability, with recovery limits restricted to their insurance portion limited by their proportionate liability.

As residents, this typically results in less recovery due to lower policy limits and the perception of less actual responsibility. Therefore, joint and several liability where the plaintiff may recover all damages from any defendant irregardless of proportional share of liability does not exist for negligence monetary awards above individual policy limits accruing to the excess liability carrier. *Capistrant v. Froedtert* Memorial Lutheran Hospital, Inc., a case involving a radiology resident, concluded that "all" insurance must be exhausted before the liability fund pays on appeal.[3] This is in contradistinction to the proportional liability approach in which the defendants are limited in damages to their respective causality shares of responsibility.

Who is responsible for resident-on-away rotation, the program or clinical site?

The resident rotating physician functions as a "borrowed servant" of the clinical facility, while the residency educational program has not been held liable for alleged negligence of the resident on an away rotation. *Starnes v. USA* references a military resident who was rotating at a pediatric hospital training program.[4] Here, the surgical resident allegedly committed a procedural error during central line placement in a pediatric patient; this case held the supervising community-based surgeon liable rather than the residency program director.

How accurate is radiology resident interpretation in the ED patient?

The off-hour radiology reading process appears to occur in a repetitive fashion: a verbal report of "normal" is offered by radiology, acted upon by the ED staff, and then subsequently reported as "abnormal" at some later point.

A recent study found a miniscule error rate when residents were required to interpret neuroradiological studies such as head CT scans.[5] The study reported an error rate of 0.9% of significant CT findings missed when studies were viewed by residents compared to when they were viewed by physicians. The study also reported an even lower percentage of patients whose outcomes were negatively affected (0.08%).[5]

Additional studies of this kind found an overall disagreement rate between resident and attending physician interpretation of 2% for significant events when reading head CT scans.[6] Subtler analysis reports a clear linear relationship between training experience and reading accuracy, which was manifested as a specified impression and a decrease in discrepant findings.[7] Finally, according to the study the broader array of diagnostic possibilities leading to body (thoracic, abdomen, pelvis) imaging was found to be more difficult to interpret than head CT scans for resident trainees.[8]

Resident-attending supervisory interface: who is responsible?

If a resident physician commits an alleged negligent act and does not inform the supervising attending physician of this event, the liability rests predominately with the resident.[9] The finding on appeal in *Joseph Hospital v. Wolff* overruled a previous decision that suggested that "joint enterprise" liability between a training center and clinical rotation site did not exist and that the training program was not responsible for clinical activities that occurred at the resident clinical rotation site. This case references a surgical airway where the attending was not informed of a potential error by the resident during the tracheotomy procedure; a subsequent bleeding complication occurred days later.

However, if a resident commits the alleged negligent act under the supervising physician's direct observance, as in an operative procedure acting as a "borrowed servant," the attending physician is primarily responsible as opposed to the resident or facility.[10] *Alswanger v. Smego* addresses the respondeat superior argument, suggesting that the obligation for super-

vision rested with the attending of record and not the hospital of the surgeon's employ and that this trainee remained under the surgeon's and not the hospital's control. This case continued over a delayed neurovascular complication allegedly induced by a first year surgical resident during a routine venous ligation operation.

However, in *Lilly v. Brink*, a different conclusion was arrived at in a different jurisdiction.[11] In this case, it was found that the resident physician truly acted as an independent clinician when discharging a patient from the ED with indigestion who later succumbed to a cardiac event. Here, the resident physician was found to be directly liable. The active clinician role was distinguished from the medical teaching and learning responsibilities of a resident trainee, resulting in liability.

Interventions

1. You, the ED physician, are still in charge based on case and statutory phone (EMTALA) provisions. Discuss the case with the attending, sometimes placing a second or third call and including a "cool off" period. This may modify the admitting physician's decision.

2. A strategy of asking the attending physician for an on-site evaluation that can be viewed as inflammatory, even though proper, should be attempted as a last resort. However, switching to an alternate care resource (e.g., calling another service or physician) may diffuse the situation.

3. The burden to activate the chain of administrative command is sometimes facilitated by the nursing supervisor/charge nurse or by involving the administrator-on-call as a path to the department chairman or medical staff intervention.

4. When in doubt: Do the test; admit to the hospital; and keep in the ED as an observation patient if you are uncertain.

References

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3. *Capistrant v. Froedtert* Memorial Lutheran Hospital, Inc. 2003 WI App 213, 267 Wis. 2d 455, 671 N.W.2d 400.
4. *Starnes v. USA*, United States Court of Appeals For the Fifth Circuit. No. 97-50609.
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9. *Joseph Hospital v. Wolff*, 94 S.W.3d 513 [Tex. 2002].
10. *Alswanger v. Smego* 1999 Conn. Super. LEXIS 1052.
11. *Lilly v. Brink*, 51 Va Cir 444 (2000)