LAW & MEDICINE

GME Programs Aren't Immune to Liability

Question: After being on call for 30 hours, the first-year medical resident caused a pneumothorax during a thoracentesis, which was unsupervised because of short staffing. The Accreditation Council for Graduate Medical Education has a rule that limits in-hospital on-call duty to 24 consecutive hours. The residency program itself requires all first-year residents to be physically supervised for procedures such as a thoracentesis. On his way home, the resident momentarily fell asleep at the wheel, struck a car, and injured its driver. Which of the following choices best describes the liability issues involved?

BY S.Y. TAN, M.D., J.D.

A. Residency program is liable for pneumothorax because it violated its own rules regarding supervision of procedures.

B. Residency program is liable for auto accident because unreasonable work hours were a substantial contributory cause.

C. Resident and program are jointly liable for both injuries.

D. ACGME regulations as well as residency program's own rules are likely to be used as evidentiary standards during litigation.

E. A good plaintiff lawyer will invoke all of the above.

Answer: E. Graduate medical education programs, also called residency programs, are mandated to provide the requisite services and supervision for the education of their trainees. ACGME is the overriding authority responsible for the accreditation of post-MD medical training programs within the United States. GME programs that violate their own rules naturally place themselves at risk for liability. Examples are written rules stating that catheters are to be inserted under the supervision of an attending physician, or that all elective procedures are to be performed with an attending present.

In 1984, 18-year-old Libby Zion presented to a New York hospital with fever and agitation, and died less than 24 hours after admission with an undiagnosed illness. The intern and resident caring for Ms. Zion were questioned about the delay in the patient's being seen, use of restraints, lack of supervision, the contraindicated administration of meperidine in a patient who was taking phenelzine, and failure to make a diagnosis. Although a Manhattan grand jury unanimously dismissed criminal charges, the New York State Board of Regents voted to censure and reprimand the residents for grossly negligent care.

This case alerted the nation to the issue of resident work conditions and led to the creation of the Bell Commission, which found that "inadequate attending supervision, combined with impaired house-staff judgment due to fatigue, were contributory causes of the patient's death." In 1988, the New York State Health Code implemented recommendations from the commission, limiting weekly work time to 80 hours, and consecutive hospital duty time to 24 hours. These reforms were soon adopted nationwide, with the intent of minimizing fatigue-related errors.

Supervising physicians are commonly named as codefendants for resident error, but program directors and teaching faculty who are uninvolved in direct patient care might also face legal liability, although the chances of plaintiff success are lower. In the example of *Swidryk v. St. Michaels Medical Center*, Dr. Swidryk was in his third week of obstetrical training when he delivered an infant who developed birth difficulties and brain damage. When he was sued for malpractice, Dr. Swidryk in turn sued the director of medical education, alleging that the director's failure to educate and supervise adequately was the proximate cause of his negligent care. The New Jersey Appellate Court dismissed those claims, reasoning that to decide otherwise would be to interfere with the academic decisions of the university, to encourage a pattern of educational malpractice against schools and residency programs each time a resident is sued, and to unnecessarily increase malpractice litigation if such a tort were recognized.

In another case, a California Appeals court dismissed an action against a professor who was alleged to have offered an opinion regarding treatment. The court ruled that no physician-patient relationship was formed since there was no control over the actions of the actual treating doctor and that to hold otherwise would undermine principles of academic freedom and teaching.

However, in *Maxwell v. Cole*, the chairman of obstetrics and gynecology was successfully sued for failure to develop and enforce rules regarding qualifications and supervision of trainees. The chairman was not personally involved in the care of a woman who sustained a bladder perforation caused by resident physicians. The court disagreed with the defendant that he owed no duty because no doctor-patient relationship was formed, stating: "If the chief of service fails to provide medically acceptable rules and regulations which would [ensure] appropriate supervision of ill patients, then it is reasonable to find that a breach of the standards of medical care by that individual has occurred."

Training programs face liabilities other than those arising from medical malpractice, such as disciplinary actions, employer-employee disputes, sexual harassment, etc. The incidence of auto accidents in overfatigued medical trainees falling asleep at the wheel is very high, in some surveys close to 50%, and accidents are more likely to occur in the immediate postcall period. Court decisions in analogous factual circumstances, though not involving medical trainees, have favored the accident victim. In one case, the court noted that " … the appellee (Norfolk & Western Railway Company, the employer) could have reasonably foreseen that its exhausted employee, who had been required to work 27 hours without rest, would pose a risk of harm to other motorists …" In another case, the court held that "the defendant corporation (McDonald's Restaurants of Oregon Inc.) knew or should have known that its employee was a hazard to himself and others when he drove home from the workplace after working numerous hours." ■

DR. TAN *is professor of medicine and former adjunct professor of law at the University of Hawaii at Hilo. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" (Hackensack, N.J.: World Scientific Publishing Company, 2006). Readers may contact the author at siang@hawaii.edu.*

Female Family Physicians Often Connect Well With Patients

BY MICHELE G. SULLIVAN

FROM WONCA 2010, THE CONFERENCE OF THE WORLD ORGANIZATION OF FAMILY DOCTORS

CANCÚN, MEXICO — Female family physicians tend to engage more emotionally with patients than their male colleagues, and they also report more job-related stress, a survey has found.

Such gender differences are particularly relevant now that many more women are entering medical school. "Women are coming to medical school in huge numbers, even overtaking the number of males," Dr. Brenda Lovell said.

The preponderance of literature shows that patients really benefit from having a trusting relationship with their physicians, she continued. "I think it's especially important for family physicians to build a strong doctor-patient relationship because, unlike specialists who may only see someone once or twice, family doctors see their patients over and over, sometimes for many years."

This deeper relationship, however, seems to carry a burden of greater stress for women physicians, who reported more headaches, sleep difficulties, gastrointestinal problems, and family stresses than their male colleagues.

Dr. Lovell of the University of Manitoba, Winnipeg, and her colleagues surveyed 110 family physicians in Canada about the way they interact with patients, how they cope with stress and burnout, and how stress affects them physically. Respondents used a one-to-five scale to describe how frequently they experience these issues.

The study cohort consisted of 70 men and 40 women. Men had been in practice significantly longer than women (mean 22 years vs. 15 years). Although men saw almost an equal percentage of male and female patients (55% and 45%, respectively), women saw a preponderance of female patients (67% vs. 33% men). Women also reported spending significantly more time with each patient (17.8 minutes vs. 13.3 minutes).

Women engaged emotionally with their patients significantly more often than men, taking the time to "listen carefully, show respect, provide simple explanations of diagnosis and treatment, and allow time for questions." Women also were significantly more likely to use relationship-building techniques, including sharing emotions, expressing a wide variety of emotions, and using positive emotions like smiling and reassurance.

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Women experienced physical signs of stress significantly more often. They were also more likely than men to rely on social support from friends and family and to seek professional help to deal with these issues. The women more often actively tried relaxing to relieve tension.

A second portion of the survey allowed physicians to freely express thoughts on their daily practice. When discussing practice constraints, women tended to list issues like "the politics of health care" and interpersonal factors, such as unpleasant office interactions and lack of collegial support.

Men focused more on administrative issues, such as staffing difficulties, lack of resources, and business competition.

Women said that they felt pressure to see more patients in less time and complained about administrative decisions from superiors that added to job stress. Men said they felt a loss of control because of numerous protocols that must be followed and expressed frustration at not being adequately recognized for their skills.

Decreased bureaucracy and better working conditions would go a long way toward improving the life of the family physician, "even more than higher pay," she said. ■