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## Standard of Care for Residents and Other Medical School Graduates in Training

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# Standard of Care for Residents and Other Medical School Graduates in Training

## **Keywords**

Standard Care, Medical school graduates, Post-Graduate Medical Education, Residents

# THE STANDARD OF CARE FOR RESIDENTS AND OTHER MEDICAL SCHOOL GRADUATES IN TRAINING

JOSEPH H. KING\*

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“Learning must be stolen, taken as a kind of bodily eminent domain.”<sup>1</sup>

#### INTRODUCTION

One January, two-year-old Jeffery Felice complained of pain when he urinated.<sup>2</sup> Jeffery’s parents also noticed that the foreskin of his penis had difficulty retracting.<sup>3</sup> They took the child to a physician, who diagnosed his condition as “phimosis”<sup>4</sup> and recommended circumcision surgery.<sup>5</sup> The surgery was performed on February 2nd by Dr. William Goodger, a first-year family practice resident, while under the supervision of a third-year surgical resident, Dr. Cynthia Glass.<sup>6</sup> These two residents were the only physicians present during the surgery. Dr. Glass instructed Dr. Goodger to perform the circumcision using the “guillotine technique.”<sup>7</sup>

Although the cutting was typically performed with a scalpel, Dr. Glass instructed Dr. Goodger to cut Jeffery’s foreskin with an Electrosurgical Unit (“ESU”).<sup>8</sup> The ESU consisted of a surgical pencil that operated by applying a high frequency electrical current to the cutting site.<sup>9</sup> The unit had two modes, one for cutting and one for coagulation.<sup>10</sup> Jeffery’s circumcision began with the ESU in the cutting mode with a setting of one on the power dial, but then was raised to two-and-one-half when the initial setting seemed to fail to make a cut.<sup>11</sup> Thereafter, Dr. Glass instructed Dr. Goodger to cease cutting after he had cut approximately one-third of the distance across the foreskin.

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1. ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 32 (2002).

2. *Felice v. Valleylab, Inc.*, 520 So. 2d 920, 922 (La. App. 3d Cir. 1987).

3. *Id.*

4. BLACK’S MEDICAL DICTIONARY 398 (38th ed. 1995) (“[Phimosis is] a condition of great narrowing at the edge of the foreskin for which the operation of circumcision . . . may be necessary.”).

5. *Felice*, 520 So. 2d at 922.

6. *Id.* at 923.

7. *Id.* This procedure is described as the following:

In this technique the foreskin of the penis is stretched past the end of the penis and clamped with a hemostat to hold the foreskin in a position to be cut off. After the excess foreskin is cut away, the bleeding is controlled and the edges of the foreskin are sutured together. Generally the cutting in circumcisions is performed with a scalpel.

*Id.*

8. *Id.* at 923, 928.

9. *See id.* at 923 (identifying the theoretical benefits of the ESU as a reduction in bleeding at the surgical cutting site and the elimination of the necessity of “tying-off” the blood vessels).

10. *Id.* at 923.

11. *Id.*

Dr. Glass apparently saw that something was wrong because the child's penis had retracted and was very pale. Then she noticed that the child's penis had sustained a full thickness burn,<sup>12</sup> evidently due to excess electrical current running through his tissue.<sup>13</sup> Jeffery was sent home from the hospital, but began to run a high fever. Jeffery's external penile tissue eventually sloughed off, leaving the unfortunate child with no visible penile tissue.<sup>14</sup>

At trial in the malpractice case brought in the wake of the Felice surgery, Dr. Glass testified that "she had been trained to perform a circumcision with a scalpel in medical school and that she had not been instructed on the use of an ESU in circumcisions,"<sup>15</sup> and that "[s]he had always performed circumcisions with a scalpel until one week before the Felice surgery."<sup>16</sup> The week before the Felice surgery, however, Dr. Glass and another resident had "discussed the possible benefits of using an ESU for a circumcision."<sup>17</sup> The court noted:

Dr. Glass never inquired of her supervising doctors as to whether the use of an ESU was proper for circumcision surgery. She did not inspect the literature or the manual to see if there would be any dangers in the use of ESU in circumcision. Dr. Glass merely decided to try it and see what effect the ESU would have upon the surgery, since she considered it an improvement upon well-established technique. Dr. Glass also admitted that she had never held the ESU "surgical pencil" in her hand to cut the foreskin in a circumcision. She twice had instructed two residents on a procedure she had never performed herself. Dr. Glass also admitted that it was a precept of medicine that any modification of a learned technique would never be done without a full appreciation of all the risks involved in the modification.<sup>18</sup>

One issue in the Jeffery Felice case was the potential vicarious liability of Dr. Glass's employer. That issue depended on whether the resident, Dr. Glass, had been negligent, a question that ultimately depended in large part on the standard of care to which surgical residents should be held.<sup>19</sup> That question is the subject of this Article.

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12. *Id.*

13. *Id.* Dr. Glass then removed the rest of the foreskin with scissors, sutured the incision by hand, and applied an ointment to the burned area. *Id.*

14. *See id.* ("Put in simpler terms, his penis was gone.")

15. *Id.* at 928.

16. *Id.*

17. *Id.* After this discussion, but before the Felice surgery, the doctor instructed a resident to use the ESU to perform a circumcision and the surgery had no ill effects.

18. *Id.*

19. The court decided this question by holding that, for the purposes of the

The circumstances of the Felice tragedy illustrate the disaccord underlying the question of the standard of care by which the professional conduct of medical residents is to be judged. This tension springs from the need to accommodate two potentially antagonistic, or at least dissonant, goals. On the one hand, patients' health and lives are at risk because they are treated by residents every day. A significant quantum of the health care in the United States is delivered by medical school graduates who are engaged in post-graduate residency programs (including those graduates traditionally referred to as "interns"). But, moving from the microcosm to a longer term perspective, the health and safety of all of us depend on residents' learning. Residency programs are vital components in the education and training of physicians for the independent practice of medicine. This is particularly true for the growing majority of physicians today who undertake a longer residency in preparation to practice a medical specialty.<sup>20</sup> Respected physician and essayist Dr. Oliver Wendell Holmes once remarked that

The most essential part of a student's instruction is obtained . . . not in the lecture-room, but at the bedside. Nothing seen there is lost; the rhythms of disease are learned by frequent repetition; its unforeseen occurrences stamp themselves indelibly in the memory . . . . The bedside is always the true centre of medical teaching.<sup>21</sup>

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vicarious liability of the employer of a third-year resident in surgery who held herself out as limiting her practice to surgery, the resident should be held to the standard of a specialist, namely a surgeon. *Id.* at 928-29. The court also affirmed the trial court's finding that Dr. Glass was negligent in modifying the circumcision technique, the state was vicariously liable, and the medical school was independently negligent in its supervision of Dr. Glass during her residency training. *Id.*; see also *infra* Part II.A.2 (addressing the standard of care for licensed residents). Neither resident was a defendant in this case. *Felice*, 520 So. 2d at 924-29.

20. See *infra* notes 71, 74 (citing GAO reports which document the prevalence of medical specialties in the United States).

21. OLIVER WENDELL HOLMES, *Scholastic and Bedside Teaching*, in IX THE COMPLETE WRITINGS OF OLIVER WENDELL HOLMES, MEDICAL ESSAYS, 1842-1882 273, 276 (Riverside ed. 1911) [hereinafter DR. HOLMES WRITINGS]. Dr. Holmes was a respected medical lecturer and essayist who was also the father of Justice Oliver Wendell Holmes. He also noted the "great hospitals . . . are the true centers of medical education." HOLMES, *The Young Practitioner*, in DR. HOLMES WRITINGS, *supra*, at 374. In comparing the clinical education at the bedside with the classroom, Holmes commented:

When I compare this direct transfer of the practical experience of a wise man into the mind of a student,—every fact one that he can use in the battle of life and death,—with the far off, unserviceable 'scientific' truths that I and some others are in the habit of teaching, I cannot help asking myself whether . . . there is not a possibility that we may sometimes attempt to teach too much.

HOLMES, *Scholastic and Bedside Teaching*, in DR. HOLMES WRITINGS, *supra*, at 284.

This tension is candidly exemplified in the personal account of Dr. Atul Gawande from the perspective of a physician in training as a surgical resident:

In medicine, we have long faced a conflict between the imperative to give patients the best possible care and the need to provide novices with experience. Residencies attempt to mitigate potential harm through supervision and graduated responsibility. And there is reason to think patients actually benefit from teaching. Studies generally find teaching hospitals have better outcomes than non-teaching hospitals. Residents may be amateurs, but having them around checking on patients, asking questions, and keeping faculty on their toes seems to help. But there is still no getting around those first few unsteady times a young physician tries to put in a central line, remove a breast cancer, or sew together two segments of colon. No matter how many protections we put in place, on average these cases go less well with the novice than with someone experienced.

We have no illusions about this. When an attending physician brings a sick family member in for surgery, people at the hospital think hard about how much to let trainees participate. Even when the attending insists that they participate as usual, a resident scrubbing in knows that it will be far from a teaching case. And if a central line must be put in, a first-timer is certainly not going to do it. Conversely, the ward services and clinics where residents have the most responsibility are populated by the poor, the uninsured, the drunk, and the demented.<sup>22</sup>

To underscore the point, Dr. Gawande relates his actions after his own eleven-day-old child suddenly went into congestive heart failure one Sunday morning from what turned out to be a defect in his aorta.<sup>23</sup> Following a successful surgical repair of the cardiac defect, and nearing the time for the child's discharge from the hospital, Dr. Gawande was forced to select a pediatric cardiologist to follow the

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22. GAWANDE, *supra* note 1, at 24; cf. Gregory L. Larkin, Walter Kantor & John J. Zielinski, *Doing unto Others? Emergency Medicine Residents' Willingness to Be Treated by Moonlighting Residents and Nonphysician Clinicians in the Emergency Department*, 8 ACAD. EMERGENCY MED. 886, 888-90 (2001) (reporting that more than 72.9% of emergency medical residents responding to a survey during their final year in residency training would not agree to let an unsupervised resident treat them in an emergency department for a serious condition, and nearly forty percent would refuse to allow a solo resident to care for even a moderate injury or illness); see generally Samuel Keim & Carey Chisholm, *Moonlighting and Emergency Medicine: Raising the Standard*, 7 ACAD. EMERGENCY MED. 927, 927 (2000) (commenting that perhaps proponents of moonlighting by residents to augment their experience may really mean "that they value this additional work experience, but not with their patients nor at their own hospital").

23. GAWANDE, *supra* note 1, at 31.

child and decide on his later treatment and surgeries. When approached by the cardiac fellow who had spent the most time with the child, Dr. Gawande opted instead to have the child attended in the future by a senior member of the hospital's cardiology staff.<sup>24</sup> "I know this was not fair,"<sup>25</sup> Dr. Gawande admitted. But "[m]y son had an unusual problem. The fellow needed the experience . . . [but t]his was *my child*."<sup>26</sup>

The law of medical malpractice is one mechanism for protecting patients. It does so by its liability rules that deter substandard conduct and provide compensation for victims. The measure by which a health care provider's professional conduct is assessed is set by the standard of care. Our question is how the standard of care rules for residents should be formulated to strike a sensible balance between the goals of protecting patients while permitting the essential clinical education of residents. Should medical residents be held to the level of expertise expected of reasonably competent general physicians, to specialists in the area of their residency, to a more subjective standard reflecting the level and stage of training of the particular resident physician in question, or in accordance with some other rule?

These questions are important. Resident physicians are commonly named as defendants in connection with injuries suffered by patients,<sup>27</sup> and vicarious liability claims against hospitals depend on whether their employee-residents have committed tortious conduct. These questions have been given short shrift by the courts. Analysis of the underlying conflicting interests has too often been desultory, inconsistent,<sup>28</sup> and insensitive to the competing demands of

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24. *Id.* at 32. Dr. Gawande elaborated:

"You know, there is always an attending backing me up," the young fellow said. I shook my head . . . I know this was not fair. My son had an unusual problem. The fellow needed the experience. Of all people, I, a resident, should have understood. But I was not torn about the decision. This was my child. Given a choice, I will always choose the best care I can for him. How can anybody be expected to do otherwise? Certainly, the future of medicine should not rely on it.

*Id.*

25. *Id.*

26. *Id.*

27. See Allen Kachalia & David M. Studdert, *Professional Liability Issues in Graduate Medical Education*, 292 JAMA 1051, 1052 (2004) (referencing malpractice insurance data which covered multiple teaching hospitals and more than 8,000 physicians and finding that residents were named in twenty-two percent of malpractice claims between 1994 and 2003).

28. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 81-82 (N.J. 2002) (noting that few jurisdictions have confronted the question of potential liability when the patient receives misleading or inadequate information regarding a physician's credentials or experience, or what potential causes of action might



immediate patient safety (through sound medical care at the moment) and the long-term demands of patient safety in general (through doctors highly trained in clinical practical medicine during their crucial residencies).

Part I of this Article provides an overview of medical residency programs. Part II briefly examines the approaches of courts to the question of the standard of care of medical residents. In Part II, I will also discuss the potential use of the doctrine of informed consent to address the matter of the relationship between residents and patients. Part III proposes a different approach. Rather than mediate the matter of treatment by medical residents exclusively through either the standard of care or the doctrine of informed consent (or some other information-based theory of liability), I propose a more elegant solution that melds the two doctrines. It may be summarized as follows. When medical residents (both not-yet-licensed and licensed ones) fully disclose their status, including their experience, training, education, and credentials, to their patients, then their performance should be judged by a standard of care commensurate with their actual level of post-graduate medical training, education, and experience. Licensed residents should in addition, and as a minimum, be held to the standard of a licensed general practitioner. A resident (either licensed or not-yet-fully-licensed) who either affirmatively misstates or fails to disclose his status should not be permitted to avail himself of the standard that is commensurate with his limited experience and training. If such resident affirmatively misrepresents his credentials and experience, then at a minimum, he should at least be held to the standard commensurate with the professional background that he claims to possess.

When a resident fails to appropriately disclose his status, a not-yet-fully-licensed resident should be held to the standard of care expected of a fully-licensed physician who has completed his internship. A non-disclosing licensed resident actively participating in a graduate medical program to prepare him for a medical specialty should be held to the standard of the specialty covered by his residency program when serving in the capacity of a specialist, unless he can prove that the patient's reasonable expectations were of some less demanding standard, in which case he should be held to a standard commensurate with those expectations.

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apply); Justin L. Ward, Comment, *Medical Residents: Should They be Held to a Different Standard of Care?*, 22 J. LEGAL MED. 283, 288 (2001) (stating that there are not that many federal and state decisions on the issue and that the existing decisions are inconsistent).

I believe that the suggested approach is a sensible compromise between the competing safety and autonomy interests of the immediate patients treated by residents and the longer term interests of the health care system and its patients in being attended by well-trained physicians, particularly specialists. If residents wish to be judged by a more forgiving, experienced-based standard of care, then a sincere and reasonable effort to inform their patients about their level of experience seems a suitable counterpoise.

I should insert a caveat here. Many tort claims arising out of injuries caused by allegedly substandard medical care by residents are also commonly asserted against one or more other health care providers. Those additional potential defendants may include the attending-supervising physician and the sponsoring hospital-employer of the resident, and may be based on theories of direct liability for inadequate supervision or monitoring of the resident and/or vicarious liability when a legally-sufficient relationship is deemed to exist between a resident who was a cause of a patient's injury and another potential defendant-health care provider.<sup>29</sup> The potential liability of these other physicians or hospitals that may be exposed to potential liability in connection with injuries inflicted at least in part by residents is beyond the scope of this Article.

Rather, the focus here is on the narrower question of the standard of care applicable in assessing whether the professional conduct of a medical resident was negligent. Of course, the outcome of the question of whether a resident was negligent may often be relevant to claims against those other health care providers who may be sued in connection with injuries contributed to by residents. Thus, for example, in order to support a vicarious liability claim against a sponsoring hospital employer of a resident, one precondition is a finding that the resident-employee had committed tortious, liability-producing conduct.

#### I. POST-GRADUATE MEDICAL EDUCATION AND TRAINING— RESIDENCIES

A “resident” or “resident physician” is “[a]n individual at any level in a graduate medical education program, including subspecialty programs.”<sup>30</sup> The term “resident physician” evolved to reflect the fact

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29. See Kachalia & Studdert, *supra* note 27, at 1053-55 (discussing the relationship between the attending physician and the sponsoring institution and the physician's potential liability with regards to resident physician care).

30. AM. MED. ASS'N, MEDICAL GLOSSARY, <http://www.ama-assn.org/ama/pub/cate-gory/2376.html> (last visited Nov. 12, 2005). See WEBSTER'S THIRD NEW

that in the early 1900s, residents' relationships to hospitals "[a]ll provided a similar experience of literally *living* and working in the hospital, tending to the moment-by-moment affairs of patients and observing the practice habits of eminent physicians of the day for several years."<sup>31</sup>

For present purposes, the term "resident" will refer to any physician who has graduated from medical school, and is participating in a post-graduate, hospital-based training and education program. Residents include both *not-yet-licensed* physicians (formerly referred to as "interns"<sup>32</sup>) who are completing a shorter period of post-graduate training and education (usually one to three years) required in order to obtain a license to independently practice medicine,<sup>33</sup> and *licensed* physicians who are continuing on in their graduate medical education and training in order to become qualified (board certified) in their chosen medical specialty (and sometimes in a further subspecialty). There are currently about 100,000 resident physicians engaged in this type of graduate medical education in the United States.<sup>34</sup> A majority of these physicians not only are or will become licensed but will continue in a program in order to become qualified in a medical specialty, reflecting the fact

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INTERNATIONAL DICTIONARY 1931 (3d ed. 1931) (defining "residency" as a period of advanced medical training and education which typically follows graduation from medical school and includes supervised practice and instruction in a specialty in a hospital setting). Other terms sometimes used to refer to some of these individuals "include interns, house officers, house staff, trainees, or fellows." *Id.* The designation "fellow" is sometimes used "to denote physicians in subspecialty programs (versus residents in specialty programs) or in graduate medical education programs that are beyond the requirements for eligibility for first board certification in the discipline." *Id.*

31. RITA KWAN & ROBERT LEVY, AM. MED. STUDENT ASS'N, A PRIMER ON: RESIDENT WORK HOURS 3 (6th ed. 2005) (emphasis added), *available at* [http://www.amsa.org/rwh/RWHprimer\\_6thEdition.pdf](http://www.amsa.org/rwh/RWHprimer_6thEdition.pdf).

32. See AM. MED. ASS'N, HOW DO YOU BECOME A PHYSICIAN?, <http://www.ama-assn.org/ama/pub/category/14365.html> (last visited Nov. 12, 2005) ("Some refer to the first year of residency as an 'internship'; the AMA no longer uses this term.").

33. Dr. Reuter notes:

Although physicians receive their M.D. degrees at the completion of medical school, most states require at least one year of clinical training before granting an unlimited license to practice medicine. Thus, the first year of residency is really an extension of medical school, in which the resident acquires additional knowledge and begins to make independent medical decisions.

Reuter, *supra* note 40, at 485-86. See also JAMA Patient Page, *Your Doctor's Education*, 9 J.A.M.A. 1198 (2000) ("After medical school, doctors must complete 1 to 3 years of residency training to be eligible to take the examination for their medical license").

34. Sarah E. Brotherton, Paul H. Rockey & Sylvia I. Etzel, *US Graduate Medical Education, 2003-2004*, 292 JAMA 1032, 1033 (2004) ("As of December 31, 2003, there were 99,964 resident physicians enrolled in ACGME-accredited and combined specialty GME programs, the highest ever recorded by the National GME Census.").

that more than two-thirds of physicians today are currently practicing in a medical specialty<sup>35</sup> or subspecialty.<sup>36</sup>

The principal accrediting organization for residency programs in the United States is the Accreditation Council for Graduate Medical Education ("ACGME").<sup>37</sup> It was established in 1981 out of a perceived need in the medical community for an independent accrediting organization for graduate medical education programs.<sup>38</sup> The ACGME is a private, non-profit organization that accredits about 8,000 residency programs relating to 119 specialties and subspecialties.<sup>39</sup> A residency program, in its modern incarnation, has been defined as follows:

A residency program is a period of education and training that physicians undergo after they graduate from medical school in order to learn how to care for patients in their chosen specialty. Most residency programs last from three to seven years, during which residents care for patients under the supervision of physician faculty and participate in educational and research activities. When physicians graduate from a residency program, they are

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35. See *id.* at 1033 (noting that "[t]he number of subspecialty programs increased 13% during the past 6 years").

36. The percentage of medical residents choosing a subspecialty instead of primary care has increased in recent years. See Myrie Croasdale, *Subspecialties Flourishing as IM Residents Shun Primary Care*, 48 AM. MED. NEWS 1, 1 (2001) (reporting on internal medicine residents opting to pursue a subspecialty).

37. See Accreditation Council for Graduate Med. Educ., *The ACGME at a Glance*, [http://www.acgme.org/acWebsite/newsRoom/newsRm\\_acGlance.asp](http://www.acgme.org/acWebsite/newsRoom/newsRm_acGlance.asp) (last visited Nov. 12, 2005) (identifying 101,810 full-time and part-time residents and 8,037 accredited residency programs for the academic year 2004-05).

38. See *id.* (acknowledging the Liaison Committee for Graduate Medical Education as its forerunner).

39. *Id.* Its mission is to improve the quality of patient care by improving and maintaining the quality of graduate medical education for physicians in training throughout the United States. *Id.* ACGME has "27 residency review committees (one for each of the 26 specialties and one for a special one-year transitional year general clinical program)," with each committee "compris[ing] 6 to 15 volunteer physicians appointed by the ACGME's member organizations and the appropriate medical specialty boards and organizations." *Id.* Its governance has been described as follows:

The members of the ACGME Board of Directors are appointed in equal number by the American Association of Medical Colleges, American Board of Medical Specialties, American Hospital Association, American Medical Association and Council of Medical Specialty Societies. The Board also includes two resident members, three public members and a federal representative appointed by the Department of Health and Human Services . . . . The ACGME governance structure also includes a Council of Review Committee Chairs, consisting of the chairs of the 27 residency review committees and the Institutional Review Committee, and a Council of review Committee Residents, comprising resident members of the review committees.

ACGME Fact Sheet, *infra* note 40.

eligible to take their board certification examinations and begin practicing independently.<sup>40</sup>

The accreditation standards of the ACGME Common Program Requirements address a number of specific areas. These include, for example, provisions relating to supervision of residents,<sup>41</sup> restrictions on duty hours,<sup>42</sup> provisions for adequate free time,<sup>43</sup> restrictions on

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40. Accreditation Council for Graduate Med. Educ., ACGME Fact Sheet, [http://www.acgme.org/acWebsite/newsRoom/newsRm\\_factSheet.asp](http://www.acgme.org/acWebsite/newsRoom/newsRm_factSheet.asp) (last visited Nov. 12, 2005) [hereinafter ACGME Fact Sheet]; see also Stewart R. Reuter, *Professional Liability in Postgraduate Medical Education*, 15 J. LEGAL MED. 485, 485-86 (1994). Dr. Reuter describes residents as follows:

Residents are physicians in transition. They have graduated from medical school and have the basic skills to practice medicine; yet, they still have much to learn to practice at the more complex level of the specialist. Even physicians entering family practice and general internal medicine serve residency programs and become board certified in these specialties.

The first year of postgraduate education is either transitional (also called preliminary, rotating, or flexible) or categorical. In the former, first-year residents rotate through various specialties, usually medicine, surgery, obstetrics, and pediatrics, broadening their general medical knowledge. Trainees selecting a transitional year generally move on to one of the specialties that requires a preliminary clinical year but does not have an integrated categorical year, such as radiology, pathology, or anesthesiology. Transitional years are relatively unregulated by national accrediting organizations and the content is largely at the discretion of the teaching hospital or the medical school that supervises the teaching hospital.

The categorical year, on the other hand, is really the first year of a residency program in one of the more direct patient care specialties, such as medicine, surgery, pediatrics, or obstetrics-gynecology. Also, medical school graduates who want to enter surgical subspecialties serve a preliminary year of general surgery residency and then move to ophthalmology, orthopedics, urology, and the like. Residencies are three to seven years long and lead, following a qualifying examination, to board certification in the specialty.

*Id.*

41. The requirements provide:

VI. Resident Duty Hours and the Working Environment

A. Supervision of Residents

1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.

ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., COMMON PROGRAM REQUIREMENTS 7 (2004), available at [http://www.acgme.org/acWebsite/dutyHours/dh\\_dutyHoursCommonPR.pdf](http://www.acgme.org/acWebsite/dutyHours/dh_dutyHoursCommonPR.pdf).

42. The requirements state, in part:

VI. Resident Duty Hours and the Working Environment

B. Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of

on-call activities,<sup>44</sup> and assurances against moonlighting that interferes with the program.<sup>45</sup> Resident work hours have also been addressed by a few state statutes.<sup>46</sup>

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patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.

2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.

*Id.* (emphasis in original). These ACGME mandated restrictions on resident work hours became effective on July 1, 2004. ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., NEW INSERTIONS INTO THE COMMON PROGRAM REQUIREMENTS FOR ALL CORE AND SUBSPECIALTY PROGRAMS [hereinafter ACGME, NEW INSERTIONS], available at [http://www.acgme.org/acWebsite/dutyHours/dh\\_Lang703.pdf](http://www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf) (last visited Nov. 12, 2005). For an overview of this new policy, see Manda J. Seaver, *ACGME's New Requirements: An Overview*, 12 AM. ASS'N NEUROLOGICAL SURGEONS BULL. 11 (2003), available at <http://www.aans.org/bulletin/pdfs/summer03.pdf> (highlighting six substantive restrictions). For background on the situation prior to the latest ACGME standards on duty hours, see Scott Turner, *Medical Residency: An Exercise in Sleep Deprivation*, 26 GEORGE STREET J. (2001), [http://www.brown.edu/Administration/GeorgeStreet\\_Journal/vol26/26GSJ06h.html](http://www.brown.edu/Administration/GeorgeStreet_Journal/vol26/26GSJ06h.html) (noting that ACGME resident work hour standards in the past too often were not observed). For pending legislation in Congress addressing work hours of post-graduate trainees (fellows, residents, and interns), see Patient and Physician Safety and Protection Act of 2005, S. 1297, 109th Cong. (2005), H.R. 1228, 109th Cong. (2005).

43. See ACGME, NEW INSERTIONS, *supra* note 42, III.B.4, at 8 ("Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.").

44. The ACGME guidelines state:

VI. Resident Duty Hours and the Working Environment

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.

2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. [as further specified by the RRC]

3. No new patients may be accepted after 24 hours of continuous duty. [as further specified by the RRC]

4. *At-home call* (or *pager call*) is defined as a call taken from outside the assigned institution.

a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

In addition to any supplemental requirements developed by each specialty,<sup>47</sup> the ACGME Common Program Requirements also include a condition that each residency program “require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner.”<sup>48</sup> These core competencies are described as follows:

Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;
2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;
3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.<sup>49</sup>

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c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.  
*Id.* VI.C., at 8. Not long ago, residents, provided most on-call services at teaching hospitals. Reuter, *supra* note 40, at 517.

45. See ACGME, NEW INSERTIONS, *supra* note 42, VI.D.1, at 8 (providing *inter alia* that “[b]ecause residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program”).

46. For background on the New York statutory regulation of resident work hours, see Alan S. Boulos & A. John Popp, *Resident Work Hour Restrictions: The New York Experience*, 12 AM. ASS’N NEUROLOGICAL SURGEONS BULL. 16, 16 (2003), available at <http://www.aans.org/bulletin/pdfs/summer03.pdf> (identifying New York as ahead of the curve for placing restrictions on resident work hours).

47. ACGME, NEW INSERTIONS, *supra* note 42, at 1.

48. *Id.* at 6.

49. *Id.* at 6-7.

Residents' training is to a substantial extent clinical and practice-based.<sup>50</sup> This is reflected in the core competencies providing for application of medical knowledge "to patient care" and for needed educational experiences in "practice-based learning and improvement."<sup>51</sup> It is these core competencies and the clinical focus of residency training that are most relevant for our purposes.

Medical residents may not be in the position to offer the level of care to patients that an experienced physician, particularly a specialist, could provide.<sup>52</sup> There are a number of factors contributing to this reality. By definition, residents lack clinical experience on a relative basis.<sup>53</sup> Medical education and experience-

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50. One doctor's experiences in a surgical residency program are informative:

And it works. There have now been many studies of elite performers-international violinists, chess grand masters, professional ice-skaters, mathematicians, and so forth-and the biggest difference researchers find between them and lesser performers is the cumulative amount of deliberate practice they've had. Indeed, the most important talent may be the talent for practice itself. K. Anders Ericsson, a cognitive psychologist and expert on performance, notes that the most important way in which innate factors play a role may be in one's *willingness* to engage in sustained training. He's found, for example, that top performers dislike practicing just as much as others do. (That's why, for example, athletes and musicians usually quit practicing when they retire.) But more than others, they have the will to keep at it anyway.

I still have no idea what I did differently that day. But from then on, my lines went in. Practice is funny that way. For days and days, you make out only the fragments of what to do. And then one day you've got the thing whole. Conscious learning becomes unconscious knowledge, and you cannot say precisely how.

GAWANDE, *supra* note 1, at 20-21.

51. Some specialties elaborate. Thus, for example, the Resident Review Committee for internal medicine has adopted the following program guideline: "Residents must have direct patient responsibility, including participation in diagnosis, management, and admission decisions across the broad spectrum of medical, surgical, and psychiatric illnesses, such that the residents learn how to determine which patients require hospitalization." ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN INTERNAL MEDICINE 21 (2004), *available at* [http://www.acgme.org/acWebsite/downloads/RRC\\_progReq/140pr703\\_u704.pdf](http://www.acgme.org/acWebsite/downloads/RRC_progReq/140pr703_u704.pdf).

52. See, e.g., A. Antoine Kazzi et al., *Emergency Medicine Residency Applicant Educational Debt: Relationship with Attitude Toward Training and Moonlighting*, 7 ACAD. EMERGENCY MED. 1399, 1405 (2000) (reporting that emergency medicine residents acknowledge "a higher risk of adverse outcome when practicing prior to completion of EM training").

53. Thus, Dr. Gawande writes:

No matter how accomplished, surgeons trying something new got worse before they got better, and the learning curve proved longer, and affected by a far more complicated range of factors, than anyone had realized. It's all stark confirmation that you can't train novices without compromising patient care.

This, I suspect, is the reason for the physician's dodge: the "I just assist" rap; the "We have a new procedure for this that you are perfect for" speech; the "You need a central line" without the "I am still learning how to do this." Sometimes we do feel obliged to admit when we're doing something for the



based training are most accurately thought of as parts of a continuum,<sup>54</sup> from medical students to board certified specialists and subspecialists, and then throughout one's medical career. Dr. Stewart Reuter describes the learning curve during residency this way:

Residencies are really preceptorships, in which the students learn by caring for patients under the watchful eye of a university faculty member or an attending private practitioner. The ACGME requires graduated, progressive responsibility by the residents as they move from year to year of residency. Thus, a first-year surgery resident primarily assists a board certified teaching surgeon. However, as they advance into their third and fourth years of training, surgical residents begin to perform simple operations by themselves. By their fifth year, they may perform complex operations without the immediate supervision of the faculty surgeon. In a pathology residency, the first-year resident probably interprets all slides side-by-side with a faculty member, progressing to a situation in the fourth year in which the resident interprets pathological materials semi-independently, with a faculty member available nearby for consultation in case the resident is uncertain about a diagnosis.<sup>55</sup>

Moreover, although the ACGME continues to address the problem of resident hours in their accreditation standards,<sup>56</sup> the reality may be

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first time, but even then we tend to quote the published success rates—which are virtually always from experienced surgeons. Do we ever tell patients that because we are still new at something, their risks will inevitably be higher, and that they'd likely do better with others who are more experienced? Do we ever say that we need them to agree to it anyway? I've never seen it. Given the stakes, who in their right mind would agree to be practiced upon?

GAWANDE, *supra* note 1, at 30.

54. This continuum of learning transcends medical school and even the residency experience, and continues throughout one's professional medical life. It has been described by one doctor nearing the end of his residency as he reflected on the insights shared by his father:

Only now, as I get glimpses of the end of my training, have I begun to think hard about my father's success. For most of residency, I thought of surgery as a more or less fixed body of knowledge and skill which is acquired in training and perfected in practice. There was, as I envisioned it, a smooth, upward-sloping arc of proficiency at some rarefied set of tasks (for me, taking out gallbladders, colon cancers, bullets, and appendices; for him, taking out kidney stones, testicular cancers, and swollen prostates). The arc would peak at, say, ten or fifteen years, plateau for a long time, and perhaps tail off a little in the final five years before retirement. The reality, however, turns out to be far messier. You do get good at certain things, my father tells me, but no sooner than you do, you find what you know is outmoded. New technologies and operations emerge to supplant the old, and the learning curve starts all over again. "Three-quarters of what I do today I never learned in residency," he says.

GAWANDE, *supra* note 1, at 25.

55. Reuter, *supra* note 40, at 487.

56. See ACGME, NEW INSERTIONS, *supra* note 42, VI.B, at 7 (delineating duty hour guidelines to ensure residents receive adequate rest).

that residents do not get enough sleep.<sup>57</sup> Not only are current duty hour guidelines still pretty high,<sup>58</sup> there is also a problem with compliance with ACGME norms.<sup>59</sup> Hospitals may sometimes be less than enthusiastic about restricting the work hours of their resident-employees because “any duty schedule changes could involve millions of dollars in increased labor costs. And teaching hospitals already face fiscal constraints due to decreased reimbursements for medical education.”<sup>60</sup> There may also be resistance in some quarters in the medical profession to restrictions on resident work hours based on the perceived tradition in medicine.<sup>61</sup> Surveys suggest that many medical residents moonlight,<sup>62</sup> primarily for financial reasons,<sup>63</sup> which

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57. See Turner, *supra* note 42 (noting in connection with ACGME work hour standards prior to the 2003 change that ACGME standards “go unobserved too often,” and that if residents do not get sufficient sleep, it “may be unsafe for patients”).

58. See ACGME, NEW INSERTIONS, *supra* note 42, VI.B.2, at 7 (discussing eighty-hour work weeks).

59. Turner, *supra* note 42 (noting that ACGME resident work hour standards in the past too often were not observed); see also KWAN & LEVY, *supra* note 31, at 8 (noting that some residents still work 114 hours a week despite the ACGME regulations); Craig Horowitz, *The Doctor Is Out*, NEW YORK METRO.COM, Nov. 3, 2003, [http://www.newyorkmetro.com/nymetro/health/features/n\\_9426/index.html](http://www.newyorkmetro.com/nymetro/health/features/n_9426/index.html) (reporting compliance failures in some states that have adopted specific regulations that limit the number of hours residents may work in hospitals). For accounts of the fascinating background of the impetus in the famous Libby Zion case for the New York resident work hour rules, see KWAN & LEVY, *supra* note 31, at 4 (crediting Libby Zion’s death with sparking national attention to the issue of resident work hours); Horowitz, *supra* (discussing Sidney Zion’s litigation with the hospital in connection with the death of his daughter, Libby Zion).

60. Turner, *supra* note 42; see David M. Gaba & Steven K. Howard, *Fatigue Among Clinicians and the Safety of Patients*, 347 NEW ENG. J. MED. 1249, 1254 (2002) (“Since residents provide cheap labor, nearly all options for reducing their work hours are expensive—an estimated \$1.4 billion to \$1.8 billion per year nationwide.”).

61. See KWAN & LEVY, *supra* note 31, at 16 (noting that “many physicians opposed the regulation of resident work hours on the grounds that it would create ‘time-clock medicine’ by forcing residents to focus on their timecard rather than patient care”); see also Turner, *supra* note 42 (“The medical profession has a mantra: A fatigued doctor who is familiar with a case is better than a fresh physician who doesn’t know a thing about the patient.”); Dongwood John Chang & Susan Bell, *The Impact of Residents’ 80-Hour Workweek on Neurological Training and Patient Care*, 12 AM. ASS’N NEUROLOGICAL SURGEONS BULL. 1, 7-8 (2003), available at <http://www.aans.org/bulletin/pdfs/summer03.pdf> (documenting concerns that the ACGME’s restrictions will create a “shift worker” mentality, thereby eroding professionalism and limiting educational opportunities).

62. Moonlighting refers “to sporadic or part-time, unsupervised EM practice by residents in EDs or urgent care settings.” Kazzi et al., *supra* note 52, at 1400 (discussing moonlighting in the context of emergency medicine residents).

63. See Jeffrey N. Glaspy, O. John Ma, Mark T. Steele, & Jacqueline Hall, *Survey of Emergency Medicine Resident Debt Status and Financial Planning Preparedness*, 12 ACAD. EMERGENCY MED. 52, 53 (2005) (reporting that fifty-eight percent of emergency medicine residents who responded reported that moonlighting would be necessary in response to their financial needs and that more than a third presently moonlight in order to supplement their income); Gaba & Howard, *supra* note 60, at 1253 (“Incentives to moonlight are strong for residents because many have enormous

might exacerbate challenges resulting from long work hours and lack of sleep.

There are also concerns that even when work hour guidelines are followed, residents may still lack adequate sleep because of the lifestyle activities while away from the hospital.<sup>64</sup> Not only are there problems with inadequate levels of sleep, but also with erratic schedules and sleeping patterns of residents. Residents must contend with circadian disruptions, a challenge said to be severe for residents in training.<sup>65</sup> Inadequate sleep may affect the level of performance of residents already challenged by their inexperience.<sup>66</sup> Studies in sleep laboratories report that for residents, “both at base line and after on-call duty, levels of daytime sleepiness are similar to or higher than those in patients suffering from narcolepsy or sleep apnea.”<sup>67</sup> Fatigue and exhaustion may also foster resentment toward patients.<sup>68</sup>

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educational debts.”); Kazzi et al., *supra* note 52, at 1402, 1404 (noting that moonlighting among residents is common, and is important source of income due to low salaries, long delays into financial stability, and education debt); MI Langdorf et al., *National Survey of Emergency Medicine Resident Moonlighting*, 2 ACAD. EMERGENCY MED. 308 (1995) (reporting findings that nearly half of residents surveyed stated that they moonlighted in some way). The topic of moonlighting is specifically addressed in the current ACGME guidelines. See ACGME, NEW INSERTIONS, *supra* note 42, VI.D, at 8-9 (including internal moonlighting as part of the resident’s eighty-hour weekly limit). The practice of moonlighting by residents has also come under criticism by specialty segments in the profession. See Keim & Chisholm, *supra* note 22, at 927 (reporting the Society for Academic Medicine and the Council of Emergency Medicine Residency Directors’ position on moonlighting as “not an activity that is consistent philosophically with the missions of residency training nor academic emergency medicine”); see also Carey Chisolm & Brigitte Baumann, SAEM Board of Directors, *SAEM Position Statement on the Qualifications for Unsupervised Emergency Department Care*, 7 ACAD. EMERGENCY MED. 929 (2000); Samuel Keim, CORD Board of Directors, *CORD Position Statement on Moonlighting*, 7 ACAD. EMERGENCY MED. 929 (2000).

64. Andrew W. Gefell, *Dying to Sleep: Using Federal Legislation and Tort Law to Cure the Effects of Fatigue in Medical Residency Programs*, 11 J.L. & POL’Y 645, 650-52 (2003); Horowitz, *supra* note 59.

65. Gaba & Howard, *supra* note 60, at 1253 (discussing the circadian effects of clockwise shift rotation).

66. See Gaba & Howard, *supra* note 60, at 1249, 1254 (noting that “[f]atigue is a common complaint of house staff, and many trainees (forty-one percent) say they have made errors that they attribute to fatigue”). Gaba and Howard report that “[i]n the United States, medical professionals, especially residents, are working far beyond the limits that society deems acceptable in other sectors,” a practice that “is incompatible with a safe, high-quality health care system.” *Id.* at 1254. One national survey conducted in 1991 found that forty-one percent of residents attributed a cause of their most serious mistake to fatigue. KWAN & LEVY, *supra* note 31, at 7. Numerous studies have shown that “[w]ell-rested physicians consistently outperform their sleep-deprived counterparts in tests of memory, concentration, mathematical skills, visual attention, electrocardiogram interpretation, and anesthesia monitoring.” *Id.* at 6-7 (footnotes omitted).

67. See Gaba & Howard, *supra* note 60, at 1249 (finding that sleep studies clearly demonstrate that fatigue increases depression, anxiety, confusion, and anger, as well as impairs psychomotor ability).

68. See KWAN & LEVY, *supra* note 31, at 6 (observing that residency programs often

Ironically, although compliance with limitations on resident work hours may afford greater opportunities for sleep, some senior physicians complain that limitations on residents' presence at the hospital may foster less preparation or engagement by residents in cases, thereby undercutting the residents' educational experience,<sup>69</sup> and one might suspect, the continuity of patient care. There is also a question of how effectively or consistently senior physicians fulfill their responsibility to supervise residents in connection with patient care activities.<sup>70</sup>

So here it is in a capsule. Residents provide a lot of the health care in the United States. For the first time they number over 100,000 strong.<sup>71</sup> They may also pull a laboring oar in hospital emergency rooms.<sup>72</sup> The federal government is a major financial engine sustaining robust residency training programs.<sup>73</sup> Moreover, the quantum of medical services provided by residents is likely to increase in the future since statistical evidence suggests that an ever greater percentage of recent medical school graduates are pursuing

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disillusion residents and cause them to lose sight of the altruistic reasons many initially pursued medicine).

69. See Horowitz, *supra* note 59.

70. See Reuter, *supra* note 40, at 489 ("[H]ouse staff are frequently either marginally supervised or unsupervised as they care for patients, particularly at night and in busy emergency room situations . . . . The combination of inexperience, stress, and poor supervision result in a significant number of negligent acts by house staff."). *Id.*

71. See Brotherton, Rockey & Etzel, *supra* note 34, at 1076 (noting that the increase in the number of residents is probably a function of two factors: the overall increase in the number of physicians, and the tendency of physicians to enter medical specialties); see generally U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, COMM. ON HEALTH, EDUC., LABOR, AND PENSIONS, U.S. SENATE, PHYSICIAN WORKFORCE—PHYSICIAN SUPPLY INCREASED IN METROPOLITAN AND NONMETROPOLITAN AREAS BUT GEOGRAPHIC DISPARITIES PERSISTED 2 (2003) [hereinafter GAO REPORT TO THE CHAIRMAN], available at [www.gao.gov/new.items/d04124.pdf](http://www.gao.gov/new.items/d04124.pdf). This report stated the following:

The number of physicians in the United States increased about 26 percent from 1991 to 2001, twice as much as the nation's population. The average number of physicians per 100,000 people rose from 214 in 1991 to 239 in 2001 and the mix of generalists and specialists in the national physician workforce remained about one-third generalists and two-thirds specialists.

*Id.*

72. Even the courts seem resigned to this reality. See *Rush v. Akron Gen. Hosp.*, 171 N.E.2d 378, 380 (Ohio Ct. App. 1957) (stating that "there is nothing sinister in the employment by hospitals of interns to render emergency treatment to any patient of the hospital").

73. See GAO REPORT TO THE CHAIRMAN, *supra* note 71, at 5 ("The bulk of federal dollars to support physician education is through Medicare's graduate medical education (GME) payments to teaching hospitals, which totaled an estimated \$7.8 billion in 2000, the latest year for which data were available."). The distributions are made to the teaching hospital based on the number of physicians trained and Medicare's portion of the patients in the hospital. *Id.*

specialties and subspecialties.<sup>74</sup> But residents are not only delivering medical services, they are also in learning mode. There is tension inherent in a resident's role because in order to learn they must practice, meaning their "practice" involves "practice." We have here two goals, education and patient care, reified contrapuntally in medical residents.

## II. OVERVIEW OF VARIOUS APPROACHES IN THE COURTS

### A. *Standard of Care for Post-Graduate Medical Learners*

The standard of care in medical malpractice cases is based on two core principles in negligence law: first, that negligence liability is fault-based (rather than strict liability) and therefore requires proof that the defendant's conduct was substandard, and second, that a person's conduct should be evaluated according to objective criteria, rather than by a subjective assessment.<sup>75</sup> I have previously described the professional standard of care as follows:

[T]his objective standard in malpractice has usually been defined in terms of a professionally oriented standard that encompasses the teachings and practices of the medical profession. Yet the courts and legislatures have differed on the form that such a professionally oriented standard should take, and on the extent to which they should defer to the practices of the medical profession in defining the relevant standard. Under one common traditional construct, the standard of care for physicians was defined . . . in terms of "custom" or customary practices and medical lore. Under a customary practice orientation, the focus was upon what had customarily been done. The standard of care for malpractice purposes has increasingly been addressed by statute. Although few statutes have expressly defined the standard in terms of custom or customary practice, numerous statutes contain language that seems (if taken literally) to focus on a standard based on what conduct or course has traditionally been followed, and thus are at least

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74. See *id.* at 7 (estimating that, in 2001, the number of generalists was 87 per 100,000 people, and the number of specialists was 150 per 100,000 people, thus generalists represented  $87 \div 239 = 36.4\%$  of physicians whereas specialists were  $150 \div 239$ , or 62.8%). The GAO's classification system significantly understates the prevalence of specialists because it categorized physicians whose specialty information was listed as family practice, general practice, general internal medicine, and general pediatrics as generalists rather than specialists. *Id.* at 17-18.

75. See Joseph H. King, *Reconciling the Exercise of Judgment and the Objective Standard of Care in Medical Malpractice*, 52 OKLA. L. REV. 49, 49 (1999) ("[O]bjective means according to some external referent or test . . . . By contrast, a subjective evaluation would have an internal perspective, evaluating a person's conduct in terms of his individual capabilities.").

consistent with a customary practice perspective. A number of statutes articulate the standard in a way that, at least facially, seems more demanding and normative than the customary practice formulation. Instead of custom or habit, the standard of care is couched in terms suggesting a level of care expected of reasonable members of the defendant's profession and specialty. A number of cases, while retaining a professionally based perspective, have expressly rejected custom as a conclusive test . . . . Frequently, the professionally based standards have been defined not only in terms of professional practices (whether tied to customary or reasonably expected practices) but also with a geographic frame of reference, although some states have, to varying degrees, adopted a national standard. Moreover, the applicable professional standards are usually those that existed at the time the alleged negligent conduct occurred.<sup>76</sup>

As noted above, some state statutes address aspects of medical malpractice liability, including the standard of care. Although these provisions vary in their particularity, usually the standard of care provisions have been sufficiently general to essentially leave the question of the standard of care for residents largely up to the courts, albeit sometimes under the cover of "statutory construction." For present purposes, this Article will not attempt to survey the multiform state statutory provisions.

Although the standard of care for physicians and other professional health care providers has generally been governed by negligence law and accordingly largely depends on the existence of substandard conduct as determined by objective criteria, there has always been a certain "precariousness" in the fault-based and objective principles within the medical malpractice context.<sup>77</sup> This wavering and tentativeness is also evident in cases addressing the question of the appropriate formulation for the standard of care for medical residents. Really, this should come as no surprise. Negligence law has long been solicitous of children, for example, cutting them some slack to reflect the fact that children are often learning their way and are incapable of exercising the same level of knowledge and care as adults in similar circumstances.<sup>78</sup> At the same

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76. *Id.* at 51-54 (footnotes omitted). For background, see generally Joseph H. King, *In Search of a Standard of Care for the Medical Profession: The 'Accepted Practice' Formula*, 28 VAND. L. REV. 1213 (1975).

77. See King, *supra* note 75, at 50.

78. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 10 (Proposed Final Draft No. 1 2005) (stating that unless the child is under five or engaging in adult activities, the child is subject to the standard of children "of the same age, intelligence, and experience . . ."); see generally DAN B. DOBBS, *THE LAW OF TORTS* § 124 (2000) (explaining in detail the negligence standards applicable to

time, however, children who engage in so-called adult activities are often held to the same standard as that expected of an adult under similar circumstances.<sup>79</sup> This ambivalence is also apparent in the cases dealing with medical residents, who in a sense are also learners. With residents, the lines are less clearly delineated and the courts in less agreement.

The case law with respect to the standard of care for residents has been sparse<sup>80</sup> and in general less than lucid. There are a number of explanations for this state of affairs. First, although residents are increasingly named in malpractice cases,<sup>81</sup> the most visible target defendants continue to be the attending or supervising physicians (or more experienced on-call physicians) and hospitals that sponsor or employ the resident.<sup>82</sup> This has tended to divert or at least blur the focus from the matter of precisely how residents' professional conduct should be assessed. Second, there is sometimes ambiguity or lack of precision with the terminology referring to residents. At one time, the medical community commonly used the term "resident" to refer to doctors who had been licensed and were engaged in training to become board certified specialists, while the term "intern" was used to refer to not-yet-fully-licensed medical school graduates who were in training required as a precondition to obtaining a medical license to practice medicine independently. Today, reflecting the lead of the AMA, a single monolithic term, resident, is the recommended usage to refer to all physicians engaged in graduate medical education and training, thus including both licensed residents and not-yet-fully-licensed residents ("interns"). To avoid confusion, I will organize the following overview of the cases into two main categories: not-yet-fully-licensed<sup>83</sup> residents (who were formerly called "interns"), and licensed residents (who have thus completed

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children).

79. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 10 (stating that children are treated as adults when engaging in dangerous adult activities, such as operating a motor vehicle).

80. See *Jistarri v. Nappi*, 549 A.2d 210, 214 n.3 (Pa. Super. Ct. 1988) (noting at the time that there was a "dearth of case law on the standard of care to be applied to a resident"). Even so, the court was able to come up with examples of cases in which courts have applied each of the broad standards. *Id.*

81. See *Kachalia & Studdert*, *supra* note 27, at 1052 (noting that statistics from a malpractice insurer that covers multiple teaching hospitals showed that "resident physicians were named in 22% of claims between 1994 and 2003").

82. See *id.* at 1053-55.

83. I hedge here with the "fully" qualification to allow for the possibility that a medical graduate may be authorized to engage in a limited practice for a time prior to completing his internship, which may be a prerequisite to becoming "fully" licensed so he might engage in *independent* practice of medicine.

their so-called "internship" and are pursuing training to become a specialist).

1. *Not-yet-fully-licensed residents*

There appear to be fewer malpractice cases involving not-yet-licensed residents than licensed residents. This should come as no surprise since not-yet-fully-licensed residents are less numerous than licensed residents because the training required for licensure is usually one to three years,<sup>84</sup> whereas the overall residency training typically spans a number of years, typically three to seven. In addition, first-year, not-yet-fully-licensed residents are subject to more direct and continuous supervision, and generally undertake more routine, less complex medical procedures.

For a representative fact pattern, we can turn to the case of *Rush v. Akron General Hospital*<sup>85</sup> where a not-yet-fully-licensed resident serving in a hospital emergency room<sup>86</sup> treated a patient who had been pushed through a glass door. This resident allegedly closed the patient's wounds without probing them. As a result, he therefore failed to detect two pieces of glass (one 3 1/4 inches long) lodged in the patient's shoulder. Here the resident was not sued individually, thus the court was called upon to decide whether the resident physician was negligent, thereby subjecting his hospital-employer to vicarious liability.<sup>87</sup> That question in turn required that the court consider the underlying legal question of the standard of care by which this doctor's conduct in the emergency room should be evaluated. The *Rush* court adopted a fairly subjective formulation, one tied to the care that interns ordinarily possess under similar circumstances,<sup>88</sup> but as we shall see, the cases are divided.

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84. See JAMA Patient Page, *supra* note 33.

85. 171 N.E.2d 378, 381 (Ohio Ct. App. 1957).

86. He was assigned to the hospital emergency room on a 24-hour tour of duty. *Id.* at 380.

87. See *id.* at 381. On the merits, following a verdict for the plaintiff, the trial judge entered a judgment for the defendant notwithstanding the verdict which was affirmed on appeal. *Id.* (finding that "the evidence does not show the intern to have exercised any lesser degree of skill, care, and diligence than that required of a general practitioner working in this community; and, as a consequence malpractice was not proved").

88. See *id.* at 381 (holding that interns were expected to possess and exercise "such skill and use such care and diligence in the handling of emergency cases as capable medical college graduates serving hospitals as interns ordinarily possess under similar circumstances," and explaining that "[i]t would be unreasonable to exact from an intern, doing emergency work in a hospital, that high degree of skill which is impliedly possessed by a physician... in the general practice of his profession, with an extensive and constant practice in hospitals and the community").



About the only safe generalization about the standard of care for not-yet-fully-licensed residents is that they are not entitled to a free pass merely because of their status as not-yet-licensed residents. In *Mercil v. Mathers*,<sup>89</sup> a claim was brought by the estate of a woman who died shortly after giving birth. Dr. Powell, a first-year, not-yet-licensed resident,<sup>90</sup> who assisted with the delivery, was among the defendants. The trial court granted summary judgment in favor of Dr. Powell and certain other defendants, and the jury returned a verdict in favor of the remaining defendants. Plaintiff appealed, challenging the trial court's decision to dismiss the claim against Dr. Powell. The Minnesota Court of Appeals agreed and reversed for a new trial. Dr. Powell argued that because of his not-yet-licensed resident status he could not be liable.<sup>91</sup> The Court of Appeals disagreed with this conclusion, responding:

Dr. Powell's status as a first-year unlicensed family practice resident does not shelter him from all legal duty, as the trial court ruled . . . . Although doctors cannot be licensed until they complete their first year of residency, they can treat patients during that time. If medical personnel provide treatment to patients, they have some duty towards those patients. The general standard of care provides that a doctor must "use that degree of skill and learning which is normally possessed and used by doctors in good standing in a similar practice . . . . This flexible standard can accommodate a doctor's status as an unlicensed resident."<sup>92</sup>

The court elaborated:

Although Dr. Powell's level of responsibility was not the same as that of the obstetricians, he clearly bore some duty towards the decedent. Resolution of any question of negligence in such a case should not have been handled by dismissing Dr. Powell before trial. Rather, the jury should have been given the opportunity—aided by the expert testimony that was proffered—to determine if Dr. Powell was negligent under the standard of care applicable to an unlicensed first-year resident.<sup>93</sup>

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89. No. C3-93-140, 1994 WL 1114 (Minn. Ct. App. Jan. 4, 1994), *rev'd on other grounds*, 517 N.W.2d 328 (Minn. 1994).

90. Note that this is a "first-year resident" in the current sense of the AMA definition, i.e., an "intern" under the old terminology. See discussion *supra* note 30 (explaining the changes in terminology pertaining to medical residents).

91. *Mercil*, 1994 WL 1114, at \*4. This was apparently what the trial court meant when it said that Dr. Powell "was basically an observer and helper . . . clearly under the direction of other [d]efendant physicians." *Id.*

92. *Id.* (internal citations omitted).

93. *Id.* at \*5; see *Phelps v. Physicians Ins. Co. of Wis.*, 698 N.W.2d 643, 655 (Wis. 2005) (stating that even under a more subjective formulation, as discussed *infra* in text accompanying notes 97-101, a not-yet-fully-licensed resident did not enjoy immunity or automatically escape liability).

Thus, residents, even residents who are not-yet-fully-licensed, are not immune from legal scrutiny of their professional conduct or from concomitant potential tort liability. But, this, of course, leaves the question, by what legal standard is resident conduct to be tested?

The sparse case law has yielded divergent opinions on the standard of care. Some cases hold not-yet-fully-licensed residents to the standard of care applicable to licensed non-specialists, or in other words general practitioners.<sup>94</sup> Cases following this approach seldom articulate a clear rationale for their rule. One suspects these cases reflect an overriding concern with patient safety. Perhaps they are analogous to the same animus that explains why children engaging in adult activities are often held to an adult standard.<sup>95</sup>

Other courts have applied a formulation to not-yet-fully-licensed residents that is somewhat more subjective. Although the language of these courts varies, the underlying rule requires such residents to exercise that level of knowledge and care expected of other practitioners at a *similar stage* in their post-medical school education and training.<sup>96</sup> A recent example of this similar-stage, same-class-

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94. See, e.g., *Gonzalez v. United States*, 600 F. Supp. 1390, 1392 (W.D. Tex. 1985) (applying Texas law and stating that the intern was subject to the standard of care for a "physician," presumably meaning a non-specialist or general practitioner physician); *Centman v. Cobb*, 581 N.E.2d 1286, 1289 (Ind. App. 1991) (holding that not-yet-licensed resident, or "interns," are held to the standard of care of physicians, and stating that thus, "[r]egardless of whether Drs. Cobb and Garner were also called interns or first-year residents, they were practitioners of medicine required to exercise the same standard of care applicable to physicians with unlimited licenses to practice"); *Davis v. Oakland Gen. Hosp.*, No. 204523, 1999 WL 33438841, at \*1 (Mich. Ct. App. July 9, 1999) (stating that "[i]nterns and residents are nonspecialists," and suggesting that they are held to the standard of general practitioners); *Bahr v. Harper-Grace Hosp.*, 497 N.W.2d 526, 528 (Mich. App. 1993) (stating that since interns and residents were not specialists, they were held to the same geographic frame of reference as general practitioners), *rev'd on other grounds*, 528 N.W.2d 170 (Mich. 1995).

95. See *infra* notes 230-232 and accompanying text (discussing the standard for children engaged in dangerous activities).

96. See, e.g., *Mercil*, 1994 WL 1114, at \*4-5 (stating in a claim against a not-yet-licensed resident, or in other words an intern, that the general standard of care requiring a doctor to exercise the skill and learning which is "normally possessed and used by doctors in good standing in a similar practice," and that "[t]his flexible standard can accommodate a doctor's status as an unlicensed resident" who is to be held to the standard of care of an unlicensed, first-year resident) (internal citations omitted), *rev'd on other grounds*, 517 N.W.2d 328 (Minn. 1994); *Rush v. Akron Gen. Hosp.*, 171 N.E.2d 378, 381 (Ohio Ct. App. 1957) (holding that interns were expected to possess and exercise the degree of skill and care in emergency cases as capable medical college graduates and explaining that it would be unreasonable to expect from an intern, doing emergency work in a hospital, the same level of skill which is possessed by a physician in the general practice of his profession); *Phelps*, 698 N.W.2d at 655 (holding in connection with a malpractice claim against a not-yet-fully-licensed, first-year resident, that such resident was subject to the standard of care expected of unlicensed first year residents).

based rule is found in *Phelps v. Physicians Insurance Company*.<sup>97</sup> The parents brought a malpractice claim against a not-yet-licensed, first-year resident,<sup>98</sup> and the hospital, seeking to recover damages for the death of their unborn son. The Wisconsin Supreme Court held that not-yet-licensed residents should be held to the standard of care expected of an unlicensed first-year resident.<sup>99</sup> The court emphasized that its rule was “based on the unique restrictions” imposed on such residents and their “unique status.”<sup>100</sup> The court also took pains to emphasize that its standard did not mean “a grant of immunity”<sup>101</sup> for such residents.

2. *Licensed residents and other licensed physicians engaged in graduate medical education*

For present purposes, “licensed residents” will refer to physicians who have not only completed their traditional medical school education, but have also completed the training—usually consisting of an at least one-year “internship”—required to become fully licensed to practice medicine.<sup>102</sup> Licensed residents and fellows<sup>103</sup> are generally participating in a formal graduate medical education (“GME”) residency program through a sponsoring hospital in order for them to become “board certified” in a recognized medical specialty or subspecialty. Most courts would hold such residents to at least the same level of care as that demanded of licensed general

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97. 698 N.W.2d 643.

98. *Id.* at 647. The court of appeals stated that the defendant “was not a licensed physician” but “an unlicensed medical-college graduate who was undergoing his postgraduate training of 12 months in a facility approved by the Medical Examining Board, as a precondition to licensure.” *Phelps v. Physicians Ins. Co. of Wis.*, 681 N.W.2d 571, 582 (Wisc. Ct. App. 2004), *rev’d on other grounds*, 698 N.W.2d 643.

99. *Phelps*, 698 N.W.2d at 655.

100. *See id.* (stating that although the resident could refer to himself as an “M.D.,” his authority and freedom of action was limited and more restricted than that of a fully licensed practitioner). Specifically, the court noted that the defendant had no authority to provide primary obstetrical care or to act as the primary attending physician. *Id.* Rather, his primary duty was to assess and report findings and differential diagnoses to upper level physicians. *Id.*

101. *Id.* The court noted that such residents might still be found negligent in accordance with the provision of “sophisticated health care services appropriate to their ‘in training’ status” or where for example, “they undertook to treat outside the scope of their authority and expertise, or they failed to consult with someone more skilled and experienced when the standard of care required it.” *Id.* at 656. And, indeed, in the instant case the court refused to disturb a finding by the trial court that the resident had been negligent in failing to move the pregnant patient to Labor and Delivery and to contact more senior staff or the attending physician. *Id.* at 656-57.

102. *See supra* notes 30-33, 83-84 (explaining medical residency).

103. On “fellow” status, *see supra* note 30.

practitioners.<sup>104</sup> That said, we still have the question of whether that is all, or may such residents also be held to a more demanding standard.

Consider the following illustration:

[A] patient . . . [complains of] chest pain and is seen by a first-year [cardiology] resident physician. The resident physician reads the patient's electrocardiogram (ECG) to the best of his ability—in fact, the interpretation is at least as good as one would expect of a resident physician at this level—but his reading misses a subtle finding that the average attending [cardiologist] would not have missed. Believing that the patient does not have a cardiac etiology of pain, the resident physician sends the patient home without treatment. He does not consult an attending physician; the ECG reading seems straightforward so that it is not obvious that supervision should be sought in the situation. The patient later dies of a myocardial infarction. In this case, has the resident physician met his duty of due care of appropriately interpreting the ECG?<sup>105</sup>

If the resident were sued in a wrongful death claim for medical malpractice, how should a jury be instructed on the relevant standard of care to which such a resident should be held? As summarized below, the cases have not agreed on the answer. Moreover, in some jurisdictions, the issue of whether a practitioner is deemed a specialist may affect the geographic frame of reference of the standard of care. This is because whether or not some jurisdictions apply a version of locality rule in connection with the standard of care may depend on whether the defendant was a general practitioner or specialist.<sup>106</sup>

At least three different positions are evident in the cases. Some courts hold licensed residents to the standard of care applicable to *licensed generalists* (general practitioners), or in other words to licensed, non-specialist standards.<sup>107</sup> This approach can be illustrated

104. Ward, *supra* note 28, at 289; see Kachalia & Studdert, *supra* note 27, at 1052; see also Reuter *supra* note 40, at 490 (noting that residents are usually held to at least the standard of general practitioners “even though most do not obtain a license to practice medicine until the completion of their first year”).

105. Kachalia & Studdert, *supra* note 27, at 1052 (as modified in brackets).

106. See, e.g., Bahr v. Harper-Grace Hosp., 497 N.W.2d 526, 527 (Mich. App. 1993) (stating that since interns and residents were not specialists, they were held to the same geographic rule that applied to general practitioners), *rev'd on other grounds*, 528 N.W.2d 170 (Mich. 1995). For background, see generally BARRY R. FURROW ET AL., HEALTH LAW 265 (2d ed. 2000).

107. See McBride v. United States, 462 F.2d 72, 74 (9th Cir. 1972) (applying Hawaii law and holding that a resident who had completed one-and-a-half years of a cardiology residency program was not to be evaluated by “an after-the-fact assessment of what one could expect from a doctor with comparable training and practice,” but instead apparently by the standard applicable to a general licensed physician staffing

by the wrongful death case of *McBride v. United States*.<sup>108</sup> A patient who had been treated at the hospital three days earlier for chest pain, returned again, experiencing severe chest pain. He was seen in the emergency room by a licensed resident who had completed his one-year “internship” and had in addition also completed about one-and-a-half additional years of his residency program in cardiology. Based on his examination and the patient’s electrocardiogram, the resident (although recommending hospitalization) acquiesced in the patient’s preference not to be hospitalized, and did not insist that he be hospitalized. The patient died shortly after reaching home.

At trial, the resident admitted that he had misinterpreted the decedent-patient’s EKG, but the Chief of Cardiology at the hospital testified that many residents would not have recognized the abnormal EKG tracings.<sup>109</sup> Plaintiffs introduced expert testimony that “general practitioners” would have read the EKG accurately.<sup>110</sup> The trial judge’s comments suggested that he believed the resident’s conduct should be evaluated on the basis of what one would expect of a “young resident” with similar training.<sup>111</sup> In reversing, the court of appeals held that the standard of care does not vary according to the doctor’s “individual knowledge or education,” and should not depend on “an after-the-fact assessment of what one could expect from a doctor with comparable training and practice.”<sup>112</sup> Rather the court suggested that a resident who had completed one-and-a-half years of a cardiology residency program should instead be subject to the standard applicable to a general licensed physician (presumably a general practitioner) staffing an emergency room.<sup>113</sup>

A number of other courts have taken a different approach. These courts essentially hold that the standard of care for licensed residents is based on a sliding scale. Residents are evaluated in accordance

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an emergency room); *Davis v. Oakland Gen. Hosp.*, No. 204523, 1999 WL 33438841, at \*1, 5 (Mich. App. July 9, 1999) (stating that interns and residents are “nonspecialists” and, thus, are held to the standard applicable to general practitioners); *Bahr*, 497 N.W.2d at 527 (stating that since interns and residents were not specialists, they were held to the same geographic frame of reference as general practitioners), *rev’d on other grounds*, 528 N.W.2d 170; *Baccari v. Donat*, 741 A.2d 262, 264 (R.I. 1999) (holding the resident to the “same duty of care as other physicians” with “unlimited licenses,” which presumably meant a general practitioner although the opinion is not entirely clear on that).

108. 462 F.2d 72.

109. *See id.* at 74.

110. *Id.*

111. *Id.* at 74 & n.2 (contending that the resident’s performance should be viewed “against the backdrop of his lack of special training and experience”).

112. *Id.* at 74.

113. *Id.* (reversing the trial court’s dismissal because it was based on an incorrect standard).

with others in the same type of residency program and at the same stage.<sup>114</sup> Take, for example, the case of *Sullins v. University Hospital of Cleveland*.<sup>115</sup> The sixty-two-year-old patient had been admitted to the hospital for the treatment of rheumatoid arthritis. Because of her past exposure to tuberculosis and reactor status, the attending physician requested an infectious disease consultation. This consultation was provided by defendant, Dr. Woolley, an infectious disease fellow in training at the hospital. The patient lapsed into a coma and died several days later. Plaintiffs alleged that the fellow was negligent in undertaking the consultation on his own and in failing to timely diagnose the patient's condition, which turned out to be tuberculosis meningitis.

A jury returned a verdict in favor of the hospital in the claim against it for the alleged negligence of the fellow, Dr. Woolley, a verdict based on a failure to find that Dr. Woolley was negligent.<sup>116</sup> In affirming, the court of appeals approved an instruction by the trial court that "the existence of a fellow physician-patient relationship imposes on the fellow physician the duty to act as would a fellow physician of ordinary skill, care and diligence at the same stage of his training under like or similar circumstances."<sup>117</sup> Elaborating, the

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114. See, e.g., *Reeg v. Shaughnessy*, 570 F.2d 309, 314-15 (10th Cir. 1978) (applying Oklahoma law and stating that with respect to a physician who had completed three years of a four-year residency in general surgery, "it would have been improper to hold [a general practitioner] to a standard of an orthopedic surgeon, inasmuch as he was not board certified in that specialty" and had not held himself out as an orthopedist, but he "was properly held to a higher standard of care than that required of a general practitioner" given "his additional training and expertise"); *Sullins v. Univ. Hosp. of Cleveland*, No. 80444, 2003 WL 195076, at \*5 (Ohio Ct. App. Jan. 28, 2003) (approving an instruction by the trial court that "the existence of a fellow physician-patient relationship imposes on the fellow physician the duty to act as would a fellow physician of ordinary skill, care and diligence at the same stage of his training under like or similar circumstances," and stating that "[f]or doctors in training (interns, residents or fellows), the standard of care is that of a doctor of ordinary skill, care and diligence at the same stage of his training, under like or similar circumstances"); *Maurer v. Trs. of Univ. of Pa.*, 614 A.2d 754, 758 (Pa. Super. Ct. 1992) (stating in dicta that "[t]he standard of care to be applied to a resident is an intermediate one, higher than that for a general practitioner but less than that for a fully trained specialist"); *Jistarri v. Nappi*, 549 A.2d 210, 214 (Pa. Super. Ct. 1988) (holding that the trial court did not err when it instructed the jury to apply to the orthopedic resident "a standard of care higher than that for general practitioners but less than that for fully trained orthopedic specialists"); *Fullerton v. Sacred Heart Med. Ctr.*, No. 19579-I-III, 2003 WL 21154151, at \*3-4 (Wash. App. May 20, 2003) (holding with respect to a third-year radiology resident that the trial court correctly instructed the jury "that radiology residents have a duty to comply with the standard of care for the profession or class to which they belong," and noting that the standard in the state was measured against a "yardstick of reasonable prudence"), *rev. denied*, 87 P.3d 1184 (Wash. 2004).

115. 2003 WL 195076.

116. *Id.* at \*4.

117. *Id.* at \*5.

court of appeals framed the standard of care as follows: “For doctors in training (interns, residents or fellows), the standard of care is that of a doctor of ordinary skill, care and diligence at the same stage of his training, under like or similar circumstances.”<sup>118</sup>

Some other cases have held licensed residents to a specialist standard of care.<sup>119</sup> This approach is well illustrated by the case of *Powers v. United States*.<sup>120</sup> The patient underwent cervical fusion

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118. *Id.* The *Sullins* rule was recently extended to the persons in training to practice dentistry and dental specialties. See *Tarellari v. Case W. Res. Univ. Sch. of Dentistry*, No. 84892, 2005 WL 1120007, at \*3 (Ohio Ct. App. May 12, 2005) (holding that for a third-year undergraduate student of general dentistry and for a dentist in his second-year of graduate studies in endodontics, the standard of care is that of third-year students of general dentistry and second-year graduate students of endodontics respectively).

119. See *Powers v. United States*, 589 F. Supp. 1084, 1099-1101 (D. Conn. 1984) (suggesting that in a Federal Tort Claims Act case applying Connecticut law, a first-year orthopedic resident did “specialize in orthopedics” and was subject to the standard of care of other physicians “in the same line of practice” and in “similar cases” in the relevant geographic frame of reference with respect to the postoperative evaluation and care of the patient, and further holding even though the resident “lacked the experience necessary to recognize the severity of [the patient’s] condition and the need for immediate corrective action,” his “failure to attempt additional diagnostic or surgical procedures at this stage constituted a breach of the standard of care”); *Harrigan v. United States*, 408 F. Supp. 177, 185 (E.D. Pa. 1976) (holding that for the purposes of the federal government’s liability based on the alleged negligence by a licensed resident in urology, a resident “acting within his specialty in urology” is held to the standard of care applicable to specialists); *Valentine v. Kaiser Found. Hosp.*, 15 Cal. Rptr. 26, 33 (Cal. Dist. Ct. App. 1961) (approving instruction holding resident to the standard and “duty of possessing that degree of learning and skill ordinarily possessed by specialists of good standing practicing,” and stating that although defendant-resident “had only completed one-third of his residency, it would not seem at all unreasonable to hold him to a higher standard of skill than that required of the general practitioner”), *overruled on other grounds*, *Siverson v. Weber*, 372 P.2d 97 (Cal. 1962); *Parmelee v. Kline*, 579 So. 2d 1008, 1016 (La. Ct. App. 1991) (holding that a first-year neurology resident who was limiting her practice to neurosurgery and was holding herself out as a specialist in that area was classified as a specialist for purposes of determining the appropriate standard of care); *Felice v. Valleylab, Inc.*, 520 So. 2d 920, 928 (La. App. 3d Cir. 1987) (holding that for the purposes of the vicarious liability of the employer of a third-year resident in surgery who held herself out as limiting her practice to surgery, she was held to the standard of a specialist, namely a surgeon); *St. Germain v. Pfeifer*, 637 N.E.2d 848, 852 (Mass. 1994) (implying that a first-year orthopedic resident, presumably a licensed resident, should be held to the same standards as other “more senior physicians,” which seems to imply a specialist standard although the opinion is not clear, an indecisiveness underscored in a later case discussed *infra* note 131); *Pratt v. Stein*, 444 A.2d 674, 708 (Pa. Super. Ct. 1982) (stating that for the purpose of the vicarious liability of the hospital-employer of a licensed resident, a resident “should be held to the standard of a specialist when the resident is acting within his field of specialty”); *Baccari v. Donat*, 741 A.2d 262, 264 (R.I. 1999) (holding a resident to the “same duty of care as other physicians” with “unlimited licenses,” which presumably means to a specialist standard, although the opinion is not explicit nor clear on this). For more recent cases applying Pennsylvania law and reaching a different conclusion, see *supra* note 114 (applying an apparent intermediate standard).

120. 589 F. Supp. 1084 (applying Connecticut law).

surgery at a Veterans Association hospital. An experienced orthopedic surgeon supervised three licensed residents during the surgery. One of these residents, Dr. Biondino, was a first-year orthopedic resident who testified that the surgery was his first time performing a cervical fusion procedure for this type of problem. Nevertheless, he was, according to the court's assessment of the operative report, "functionally . . . the surgeon."<sup>121</sup> In fact, Dr. Biondino and another resident operated on the patient's neck at the fusion site while the supervising surgeon and another resident operated on the patient's leg to harvest bone for the bone graft. Also, Dr. Biondino was primarily responsible for the post-operative care of the patient for about a month.<sup>122</sup> The patient suffered severe morbidity from the surgery, including partial paralysis of the upper extremity.<sup>123</sup> Apparently, his spine was fused at an excessively forward angle so that his spinal cord became impinged.<sup>124</sup>

The court found that the surgical fusion was performed negligently and that the postoperative care of the patient "did not measure up."<sup>125</sup> Importantly, although the court's language was ambiguous, it suggested that the inexperienced surgical resident, Dr. Biondino, was being held to the standard of care applicable to a specialist—an orthopedic surgeon. The court noted that the first-year orthopedic resident did "specialize in orthopedics"<sup>126</sup> and was subject to the standard of care of other physicians "in the same line of practice"<sup>127</sup> and "exercised in similar cases" in the relevant geographic frame of reference.<sup>128</sup> Thus, the court found that the performance of the cervical fusion surgery failed to satisfy the standard of care. And, with respect to the postoperative evaluation and care of the patient, even though Dr. Biondino "lacked the experience necessary to recognize

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121. *Id.* at 1091. The senior attending orthopedic surgeon, Dr. Raycroft, "testified that at the time of the operation he mistakenly believed that Dr. Biondino was a third-year orthopedic resident. He was not aware that Dr. Biondino was only a first-year orthopedic resident until the time of trial." *Id.*

122. *Id.* at 1095.

123. *Id.* The defendant-resident Dr. Biondino attempted to explain the patient's worsening condition on a psychological basis as hysteria. *Id.* at 1094-95. The court rejected that contention, choosing to rely instead on objective evidence that the ill-fated surgery caused the patient's condition. Those objective bases included not only five electromyography tests measuring nerve root damage by electrodes, but also included the patient's submitting to a sodium amytal interview which indicated the paralysis was real and not caused by psychological or hysterical factors. *Id.* at 1097.

124. *Id.* at 1096.

125. *Id.* at 1100-01 (stating that "the surgeons who performed the plaintiff's fusion failed to adequately take into account his unique, pre-fusion spinal condition").

126. *Id.* at 1101.

127. *Id.* at 1099.

128. *Id.* at 1100.



the severity of [the patient's] condition and the need for immediate corrective action,"<sup>129</sup> his "failure to attempt additional diagnostic or surgical procedures at this stage constituted a breach of a standard of care."<sup>130</sup>

There are also a fair number of cases involving treatment administered by licensed medical residents in which the nature of the standard of care is unclear. Sometimes the courts deliberately refuse to decide the legal issue.<sup>131</sup> And, in other cases, the court's language is unclear on precisely what the applicable legal formulation for the standard of care is for licensed residents. Thus, in *National Bank of Commerce v. Quirk*,<sup>132</sup> medical malpractice claims were brought for alleged spinal cord injuries to a newborn as a result of treatment during and following pregnancy and delivery. The plaintiffs sued ten physicians employed by the University of Arkansas for Medical Sciences. Two of those physician-defendants were licensed medical residents in radiology who were alleged to have misread an MRI. They both moved for summary judgment, contending that the plaintiffs had failed to present expert testimony showing that their conduct had deviated from the standard of care for residents in training.<sup>133</sup>

On appeal, the Supreme Court of Arkansas affirmed the trial court's grant of summary judgment in favor of these two residents. The Court variously stated that the plaintiffs were required to prove the "applicable" or "required" standard of care, and that they had not done so, noting that the testimony of one physician expert related to the standard of care "for the staff radiologist," and that he "admitted

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129. *Id.* at 1101.

130. *Id.*

131. See, e.g., *Jarry v. Corsaro*, 666 N.E.2d 1012, 1013 (Mass. App. Ct. 1996). In *Jarry*, at some point during her hospitalization, the child, Anastasia, suffered brain damage from lack of oxygen which resulted in a seizure disorder and mental retardation. In the subsequent medical malpractice action, the jury determined that the residents had not been negligent. Plaintiffs appealed, alleging "that the trial judge erred in instructing the jury that Drs. Kessler and Lee were to be held to the standard of care of a general practitioner." *Id.* Plaintiffs contended that, "as second and first-year residents respectively, [they] should have been held to a higher standard of care because they (a) had received additional training in pediatric care, and (b) held themselves out as specialists." *Id.* at 13-14. The Massachusetts Court of Appeals bypassed this argument and issue in a footnote, noting "that this case presents the question of the standard of care required of residents and interns when treating patients," but that "neither this court, nor the Supreme Judicial Court, has dealt squarely with the appropriate standard for residents beyond their first year of residency." *Id.* at 1014 n.4. The court declined to address the issue because the plaintiffs had failed properly to preserve the issue for appeal.

132. 918 S.W.2d 138 (Ark. 1996).

133. *Id.* at 149.

he did not know what the standard of care was for a resident.”<sup>134</sup> The Court then added vaguely that the plaintiffs had “not cited any evidence in the record to support the theory that residents should be held to the same standard as other licensed doctors.”<sup>135</sup>

The problem with this statement is that whether residents should be held to a particular standard is a *legal* issue for the court to decide before the parties seek to establish *factually* whether that legal standard of care, *as formulated by the court*, was violated. Thus, the Court implied that residents were held to the same standard as other “residents in training,” but did not explicitly or unequivocally decide the question.<sup>136</sup>

### 3. *Restatements*

The current position of the Restatement of Torts on the question of the standard of care for medical residents is ambiguous and does not offer much guidance. The matter seems to have been consigned to a silent interregnum between the Restatement (Second) and the proposed final draft of the latest segment of the Restatement (Third) of Torts: Liability for Physical Harm<sup>137</sup> that is under active consideration by the American law Institute (“ALI”). The black letter of Section 299A of the Restatement (Second) approved in 1965, which relates to “Undertaking in Profession or Trade,” provided that “[u]nless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities.”<sup>138</sup> Section 299A, however, does not address the question of the standard of care of a learner who is silent and makes no representations about possessing a specified level of skill or knowledge.

The black letter language of the new Section 12 of the Restatement (Third) is couched in more general terms, and states that “[i]f an actor has skills or knowledge that exceed those possessed by most others, these skills or knowledge are circumstances to be taken into account in determining whether the actor has behaved as a

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134. *Id.* at 150.

135. *Id.*

136. *Id.* at 149-50.

137. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM (Proposed Final Draft No. 1 2005).

138. RESTATEMENT (SECOND) OF TORTS § 299A (1965).

reasonably careful person.”<sup>139</sup> The comments to Section 12 take a different, somewhat more nuanced approach, stating:

A somewhat special case concerns learners or beginners. Just as the law holds teenagers who choose to engage in adult activities to adult standards despite their inexperience, so adults who choose to engage in particular activities can properly be held to general standards, even when they are learners. Yet while an actor's status as a learner is in general ignored, there can be relationships between that actor and the other actor that attach significance to this status. When, for example, the defendant, while learning to drive, receives a lesson from the plaintiff, and when the defendant's inexperienced operation of the car causes an accident that injures the plaintiff, the defendant's status as a beginner is taken into account in considering the defendant's negligence and hence the defendant's liability. That status is ignored, however, if the defendant is sued by a pedestrian injured in the same accident.<sup>140</sup>

Although both the broad language of Section 12 and the accompanying Reporters' Notes suggest that it could be applicable to professional liability,<sup>141</sup> the new Section 12 apparently was not intended to address professional liability. This limitation is evident from the deliberations of the ALI at the meeting at which Section 12 was discussed, during which it became apparent that Section 12 was intended to address exclusively nonprofessional negligence.<sup>142</sup> The remarks of Professor Michael Green, one of the Reporters for the new Third Restatement of Torts, concur that Section 12 was not

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139. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 12.

140. *Id.* § 12 cmt. b.

141. See Norman L. Epstein, 2001 Proceedings, 78th Annual Meeting, American law Institute 93 (Apr. 14, 2001). Justice Epstein stated:

The Reporters' Note to Comment *a* makes a statement that this section “can be easily applied to cases involving the liability of professionals,” and in fact, the broad language that the black letter uses would include professionals, because there is nothing in it that indicates that it would not. It is a broad, generic provision, as I now read it.

*Id.*

142. During the Institute's discussion of section 12, Justice Epstein cautioned:

It seems to me that the liability of professional persons and tradespersons as well is so substantial that it deserves a particular and explicit statement in the Restatement, so that we should either do this now . . . or we ought to explicitly recognize that we are not treating it at this point and will treat it later. I understand it is treated in the Law Governing Lawyers with respect to attorney malpractice, but it does not appear to be explicitly treated in any other way, except generically in this provision as it is now stated. It deserves a separate statement, and for that reason I move that we either treat it in a separate section or subdivision of this section or explicitly state that we are not doing so now but will address it at some future time.

*Id.* at 93-94.

applicable to professional medical negligence.<sup>143</sup> Accordingly, it appears that the standard of care for professional medical negligence will therefore continue for the time being to be covered by Section 299A of the Second Restatement, presumably at least until the matter is explicitly addressed by a new section.<sup>144</sup>

Turning then to Section 299A of the Second Restatement, we find the following language:

Unless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities.<sup>145</sup>

143. The Proceedings state, as elaborated by my bracketed language which is needed for Green's comment to make sense:

Professor Green: Let me just add, there is a connection between this section, § 12, and the section in the Second Restatement that is referred to in that Reporters' Note, § 299A, but I think what we can do here . . . is to make it clear that this speaks to the nonprofessional malpractice situation [and not to the professional medical malpractice situation] for which § 299A exists and remains until the project that Lance refers to comes into being and conclusion.

*Id.* at 94; *see also Temporary Summary Note to Section 12*, 24 FALL ALI REP. 6, 6-7 (2001), which states (again with bracketed rationalizing language added):

In response to a motion that the problem of professional and tradespersons' negligence, treated in § 299A of the Restatement Second, be addressed in a subdivision of this section, in a separate section, or at some future time, the Reporter agreed to consider stating that this section [Section 12] speaks to the nonprofessional malpractice situation for which § 299A was fashioned and that § 299A continues to reflect the position of the Institute.

144. The Proceedings state:

Justice Epstein: The problem with doing it that way is that § 299A is going to disappear from view, except as a matter of history. If what we are going to present is the Restatement Third of Torts, then § 299A, if it is not brought forward in some way, is something historical but is not included.

Now if you are suggesting an explicit statement that § 299A remains the position of the Institute until it is addressed further, then that may be a little awkward, but I think that would do the job, and, if that is what you are suggesting, that would address my concerns.

Professor Green: Well, you are really raising an important question of Institute policy that I don't think any Reporters have it within their scope to address. I can say that I think it has been the understanding of the Reporters who have worked on various projects of the Third Restatement . . . that whenever the day was done on the Third Restatement there would be many provisions in the Second Restatement that remained and still spoke as authoritatively as they ever did and would not be superseded by the Third Restatement. That was our understanding, and I think this draft that you see here is consistent with that understanding. Now that may or may not be able to be effectuated, but that is the assumption[.]

*Id.* at 94-95.

145. RESTATEMENT (SECOND) OF TORTS § 299A (1965).

This Section, which is applicable to physicians,<sup>146</sup> explains that “[i]n the absence of any such special representation, the standard of skill and knowledge required of the actor who practices a profession or trade is that which is commonly possessed by members of that profession or trade in good standing.”<sup>147</sup> Another comment suggests that a person who represents that he has superior skill or knowledge beyond that common to his profession be judged accordingly.<sup>148</sup> A person may also, however, in the absence of a contrary representation,<sup>149</sup> “make it clear that he has less than the minimum of skill common to the profession or trade; and in that case he is required to exercise only the skill which he represents that he has.”<sup>150</sup>

It is not clear whether this representing-the-standard-down option was intended to be available to professionals, or only to laypersons who have undertaken to perform a task normally reserved for professionals.<sup>151</sup> In any case, the net effect of this convoluted stroll through the Restatements is that the Restatement does not offer much guidance on the problem. This is especially true where a person—such as a medical resident—remains silent and says nothing to the patient about his status.

*B. Informed Consent and Other Information-Based Liability Theories*

Most malpractice cases arising out of treatment by health care providers who possess less experience or training than others rendering similar medical services focus on the actual performance of the treatment in question. Therefore, the question of the standard

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146. *Id.* § 299A cmt. b (stating that “[i]t applies to any person who undertakes to render services to another in the practice of a profession, such as that of physician or surgeon, dentist, pharmacist, oculist, attorney, accountant, or engineer”).

147. *Id.* § 299A cmt. e.

148. *Id.* § 299A cmt. d. On the importance of representation, the Restatement sets forth the following:

An actor undertaking to render services may represent that he has superior skill or knowledge, beyond that common to his profession or trade. In that event he incurs an obligation to the person to whom he makes such a representation, to have, and to exercise, the skill and knowledge which he represents himself to have. Thus a physician who holds himself out as a specialist in certain types of practice is required to have the skill and knowledge common to other specialists.

*Id.*

149. *See id.* (clarifying that “[t]he rule stated in this Section applies only where there is no such special representation”).

150. *Id.*

151. The example used to illustrate this principle did not involve a physician. The comment states: “Thus a layman who attempts to perform a surgical operation in an emergency, in the absence of any surgeon, and who makes it clear that he does not have the skill or knowledge of a surgeon, is not required to exercise such skill or knowledge.” *Id.*

of care for treatment purposes figures centrally in such cases. In recent years, a second theory of liability has sometimes emerged in this setting. This new kid on the block is the doctrine of informed consent. This doctrine requires that a treating physician disclose the material risks of the contemplated medical procedure to his or her patient in order that the patient's consent to the treatment be "informed."<sup>152</sup> Failing that, liability may be imposed on a non-disclosing doctor for the material risks of the medical procedure that eventuate. The jurisdictions are divided on whether the required disclosures should be determined in accordance with professionally based standards of what a reasonable medical practitioner would be expected to disclose, or by lay standards based on what information a reasonable patient would deem material.<sup>153</sup> The profession-based standard of disclosure usually results in a more limited scope of the required disclosures because the duty to disclose then depends on expert testimony on whether the applicable professional practices call for the types of disclosure alleged by a plaintiff.

Although of comparatively recent vintage, the doctrine of informed consent has become widely established in the United States.<sup>154</sup> The doctrine has not been without its skeptics, both during its emergence,<sup>155</sup> and continuing to the present.<sup>156</sup> There has also

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152. See DOBBS, *supra* note 78, § 250, at 652-53 (exploring the principles underlying informed consent doctrine including autonomy, self-determination, "fundamental American values," and medical ethics).

153. See *id.* at 655 (characterizing the medical standard of disclosure, established via expert testimony of the professional standard, as the older "camp" supported by case law and/or statutes in slightly more than half of states and tracing the origin of the standard based on reasonable patient expectations to three 1972 decisions); FURROW ET AL., *supra* note 106, at 313-14 (explaining the physician-based standard and reasonable patient standard); Emmanuel O. Iheukwumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373, 380-91 (2002) (comparing cases that adopted the reasonable physician standard with those that adopted the reasonable patient standard and concluding that despite a nationwide trend towards the patient standard, the physician standard has retained its resiliency).

154. See Iheukwumere, *supra* note 153, at 375-80 (tracing the evolution of the doctrine); Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 315 (2002) (stating that "[i]n the latter half of the twentieth century, the legal requirement of informed consent became well-established in all fifty states"). In 2000, Georgia became the fiftieth state to accept the doctrine of informed consent. *Id.* at 315 n.11.

155. See Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 148 (1977) (questioning the level of disclosures physicians make to patients and observing that "disclosure and consent...are obligations alien to medical practice"); Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265, 334 (1983) (observing that "informed consent as envisioned by the courts is a relatively rare phenomenon in the clinical settings that we have examined"); Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justifiable Causation*, 1988 U. ILL. L. REV. 607, 648 (1988) (criticizing informed choice as a

been some resistance in the medical profession to the spirit of informed consent.<sup>157</sup>

The doctrine continues to evolve. Some commentators have even suggested that rather than attempt to expand the scope of informed consent, a newly packaged autonomy interest should be recognized to protect the patient's right of informed decisionmaking.<sup>158</sup> One

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"sanctionless tort" based on the authors' contention that decision causation is not justiciable in practice); Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749, 751 (1986) (declaring that "the law has been far richer in its rhetorical devotion to the ideal of patient self-determination than in its provision of effective legal redress to victimized patients"); cf. Alexander M. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 367 (1974) (cautioning about the danger of the informed consent process turning into "a charade, a symbolic but contentless formality").

156. See Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 398, 427 (1990) (concluding based on observations and interviews that the informed consent procedures that most doctors use "while sometimes meeting the letter of the informed consent doctrine, rarely [meet] what should be its spirit, i.e., providing adequate information and attempting to ensure that patients understand the information so they can make knowing and voluntary decisions about medical care" and lamenting that, in practice, "[p]atients are not protected; physicians are burdened with requirements that mean little; the law and society's principles concerning individual autonomy and decisionmaking are effectuated in name only"); Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 81 (1994) (describing informed consent as "a charade"); Morris, *supra* note 154, at 316 (asserting that "[d]eference to doctors has replaced the duty of disclosure"); William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1705 n.8 (1999) (questioning whether informed consent truly empowers patients or merely gives "the illusion of self-determination").

157. This has been true for a long time. Consider the words of Doctor Oliver Wendell Holmes: "Your patient has no more right to all the truth you know than he has to all the medicine in your saddlebags. . . . He should get only just so much as is good for him." HOLMES, *The Young Practitioner*, in DR. HOLMES WRITINGS, *supra* note 21, at 388. Professor Cathy Jones identifies reasons that medical professionals commonly give for objecting to the duty of informed consent:

[P]atients neither understand nor remember what they are told, in large part because the information to be conveyed is too technical for patients to grasp and is knowable and understandable only by physicians after years of schooling and training; testing patients' understanding of what they have been told is too time consuming and too expensive in terms of the physician's additional duties to this patient and others; patients want physicians to make decisions for them; [and] physicians can convince almost any patient to do what the physician thinks is best for the patient.

Jones, *supra* note 156, at 407.

158. Morris, *supra* note 154, at 370-71 (urging acceptance of proposals made by various torts scholars "to replace the informed consent doctrine with a new tort that recognizes and protects the patient's dignitary interest in informed medical decisionmaking"); see, e.g., Capron, *supra* note 155, at 350, 404 (suggesting a new ground for recovery, building upon negligence and battery theories with its own rules of conduct, causation, and damages); Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 276 (1985) (urging adoption of a "new model for the allocation of authority between doctors and patients" by "direct creation of an independent interest in medical choice" thereby

incipient development under informed consent relates to attempts to extend the scope of the duty of disclosure beyond the medical risks inherent in the medical procedure to encompass risks peculiar to the physician in question. Although a number of courts have in recent years extended the scope of the duty to disclose to encompass a duty to disclose alternatives to the contemplated medical procedure<sup>159</sup> and the risks of refusing the suggested procedure,<sup>160</sup> only quite recently have courts begun to address the question of whether an attending physician must disclose risks peculiar to him.

Thus far, few cases have addressed the question of the duty to disclose risks peculiar to the physician (as opposed to risks inherent in the proposed medical procedure). Most of these cases have involved situations in which the physician allegedly suffered from physical or mental impairments that might affect his capacity to provide medical services<sup>161</sup> or from an infectious disease such as HIV.<sup>162</sup> In addition, several cases have expanded the duty to disclose to encompass potentially conflicting financial or research interests that may conflict with the patient's interests and the fiduciary responsibilities that the physician owes to protect his patient's health

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"[c]reating direct legal protection for patient autonomy"); Weisbard, *supra* note 155, at 763 (proposing a "new legal cause of action . . . [imposing] an affirmative obligation on physicians to facilitate the patient's exercise of this right to the extent reasonably possible," with damages assessed for "dignitary harms"); cf. Alan Meisel, *A "Dignitary Tort" as a Bridge Between the Idea of Informed Consent and the Law of Informed Consent*, 16 LAW, MED. & HEALTH CARE 210, 211 (1988) (recommending that the informed consent doctrine be broadly conceived as protecting the patient's dignitary interests); Twerski & Cohen, *supra* note 155, at 609, 654-64 (suggesting that "courts should identify and value the decision rights of the plaintiff which the defendant destroyed by withholding adequate information," and compensate for their invasion rather than focusing exclusively on whether the lack of disclosure was deemed to have caused some physical injury).

159. DOBBS, *supra* note 78, at 659 n.9; see FURROW ET AL., *supra* note 106, at 324-25 (summarizing current law as requiring doctors to disclose alternative diagnostic tests or treatments).

160. See FURROW ET AL., *supra* note 106, at 324-26.

161. See, e.g., *Hawk v. Chattanooga Orthopedic Group, P.C.*, 45 S.W.3d 24, 35 (Tenn. Ct. App. 2000) (finding the fact that defendant-surgeon suffered from Raynaud's Syndrome affecting the use of his hands relevant to patient's informed consent claim arising from the results of hip replacement surgery).

162. See, e.g., *Faya v. Almaraz*, 620 A.2d 327, 333 (Md. 1993) (finding that jury should have been allowed to consider whether failure of surgeon to disclose HIV-positive status constituted a breach of duty); *Estate of Behringer v. Med. Ctr. at Princeton*, 592 A.2d 1251, 1278-83 (N.J. Super. Ct. Law Div. 1991) (holding that defendant-medical-center properly barred plaintiff from performing surgery and imposing a requirement of informed consent because his work posed a "reasonable probability of substantial harm" under informed consent principles even if the statistical risk of HIV transmission from doctor to patient was small); see also Iheukwumere, *supra* note 153, at 396-400 (analyzing three cases addressing a physician's duty to disclose his or her HIV infection status to a patient).



and autonomy interests.<sup>163</sup> Fewer cases still have involved claims based on the patient's lack of information about his physician's level of experience and training, the context most relevant to the topic of residents.

Of cases that have involved this narrow type of claim, a majority have, for one reason or another, declined to extend the scope of the duty to disclose that far.<sup>164</sup> Thus, for example, in *Whiteside v. Lukson*,<sup>165</sup> Dr. Lukson, the defendant surgeon performed a laparoscopic cholecystectomy on the patient. Prior to this, he had participated in a two-day class on how to perform a cholecystectomy laparoscopically.

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163. The most notable example is the decision of the Supreme Court of California in *Moore v. Regents of the University of California*, 793 P.2d 479 (Cal. 1990). In *Moore*, plaintiff-patient was suffering from hairy-cell leukemia, treatment for which entailed removal of his spleen and withdrawal of extensive amounts of blood and aspiration of bone marrow tissue. 793 P.2d at 481. Plaintiff alleged that his attending physician failed to disclose that he had formed the intent and made arrangements to conduct research on plaintiff's cells to develop and exploit financially. *Id.* The court held that the duty to obtain informed consent includes the duty to disclose personal research or economic interests unrelated to the patient's health. *Id.* at 483. *Cf.* *Shea v. Esenstein*, 208 F.3d 712, 716-17 (8th Cir. 2000) (applying Minnesota law and recognizing a claim based on alleged negligent misrepresentation for failure to disclose financial incentives under HMO contract that related to referrals to specialists).

164. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 83 (N.J. 2002) (noting "[c]ourts generally have held that claims of lack of informed consent based on a failure to disclose professional-background information are without merit," but also recognizing a potential informed consent claim when a doctor allegedly affirmatively misstates his professional experience, and declining to decide whether a doctor has a duty to disclose); *Ditto v. McCurdy*, 947 P.2d 952, 958-59 (Haw. 1997) (relying on a state statute and holding that defendant-physician who was board certified as an otolaryngologist (ear, nose, throat specialist), facial surgeon, and cosmetic surgeon and who allegedly disfigured the patient during breast augmentation surgery, did not have duty to disclose to the patient that he was "not a plastic surgeon and that he did not have hospital privileges"); *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (holding that "evidence of a physician's personal characteristics and experience is irrelevant to an informed consent claim" regardless of whether the patient inquired about the physician's experience, but noting by way of caveat that its holding "should not . . . be read to stand for the proposition that a physician who misleads his patient is immune" and that a plaintiff may have a cause of action for misrepresentation where a physician "allegedly provides inaccurate information regarding his experience"), *modified by* 40 PA. CONST. STAT. ANN. § 1303.504 (d)(2) (West 2002) (stating that a physician may be liable under informed consent principles if he knowingly misrepresents his "professional credentials, training or experience"); *Mitchell v. Kayem*, 54 S.W.3d 775, 781 (Tenn. Ct. App. 2001) (stating that, for the purposes of an informed consent claim by a patient operated on for papillary carcinoma and alleging that her surgery caused hypoparathyroidism and vocal cord paralysis, although the defendant may be required to disclose alternative courses of treatment, "different courses of treatment" did not include the choice of a more experienced surgeon and a different hospital, and that, in any event, plaintiff was required to prove decision causation); *Whiteside v. Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) (holding that "a surgeon's lack of experience in performing a particular surgical procedure is not a material fact for the purposes of . . . informed consent").

165. 947 P.2d 1263.

The class included “hands-on participation in performing the procedure on three pigs.”<sup>166</sup> When the defendant sought the plaintiff’s informed consent for the surgery, the defendant had never performed a cholecystectomy using this laparoscopic technique on a person and he did not inform the plaintiff of this fact.<sup>167</sup> During surgery, Dr. Lukson misidentified and consequently damaged the plaintiff’s bile duct, with resulting complications. Even applying the “reasonable patient” standard of disclosure, the court held that “a surgeon’s lack of experience in performing a particular surgical procedure is not a material fact for the purposes of . . . informed consent.”<sup>168</sup>

A few courts have, however, begun to recognize a duty of disclosure that at least in some circumstances may include information about the defendant’s level of experience and training.<sup>169</sup> The most notable

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166. *Id.* at 1264.

167. Apparently, by the time he performed surgery on the plaintiff, the defendant had performed this laparoscopic procedure on two other patients. *Id.*

168. *Id.* at 1265.

169. See, e.g., *Barriocanal v. Gibbs*, 697 A.2d 1169, 1172 (Del. 1997) (holding in a case in which defendant-surgeon allegedly clipped decedent’s carotid artery instead of the aneurysm during surgery on a cerebral aneurysm, with fatal consequences, that the trial court erroneously excluded expert testimony that defendant’s “failure to inform his patient of his lack of recent aneurysm surgery . . . fell below the applicable standard of care”); *infra* text accompanying notes 170-173 (discussing *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996)); cf. *Dingle v. Belin*, 749 A.2d 157, 169-70 (Md. 2000) (holding in a case in which fourth year resident allegedly dissected plaintiff’s bile duct instead of the cystic duct during gall bladder surgery, that, as a matter of his contractual undertaking, the attending surgeon could be subject to potential liability for allegedly breaching his contractual understanding with the patient regarding the allocation of tasks between the attending surgeon and the resident, but finding that the trial court’s failure to submit the question to the jury was harmless error based on jury’s findings of fact); *Howard*, 800 A.2d at 83 (recognizing a potential informed consent claim when a doctor allegedly affirmatively misstates his professional experience by “significant misrepresentations,” but declining to decide whether a doctor has a duty to disclose). The *Dingle* court noted that given the “expanding era of more complex medical procedures, group practices, and collaborative efforts among health care providers . . . the identity of the persons who will be performing aspects of the surgery” and “who, precisely, will be conducting or superintending the procedure or therapy” must be discussed and resolved, at least if raised by the patient. 749 A.2d at 166.

In *Howard*, the plaintiff underwent unsuccessful back surgery leaving plaintiff in a quadriplegic state. The plaintiff claimed that the defendant-surgeon had misrepresented his experience and credentials by stating that he was board certified at a time when he was merely board-eligible, and only became board certified more than two years after the plaintiff’s surgery. *Howard*, 800 A.2d at 76 n.1. Plaintiff also alleged that the defendant had told him and his wife that he had performed about sixty corpectomies in each of the eleven years that he had been performing such procedures, whereas the defendant had performed approximately “a couple dozen” during his career. *Id.* at 76-77. The court held that a “significant” or “serious” misrepresentation concerning “the quality or extent of a physician’s professional experience . . . can be material to the grant of intelligent and informed consent.” *Id.* at 83. The court thus expressly extended the scope of informed

decision recognizing a potential to disclose this type of physician-experience information is *Johnson v. Kokemoor*,<sup>170</sup> a decision by the highly respected Justice Shirley Abrahamson. In *Johnson*, the plaintiff-patient was stricken with partial (“incomplete”) quadriplegia resulting from neurosurgery to clip a large cerebral posterior basilar bifurcation aneurysm. The plaintiff alleged that she was not provided with sufficient information about the level of experience of the defendant-surgeon in connection with the especially challenging nature of surgery for the specific type of cerebral aneurysm involved.

The Supreme Court of Wisconsin held, for the purposes of informed consent, that the trial court properly exercised its discretion in admitting evidence regarding the defendant’s lack of experience, the difficulty of the proposed surgery, the fact that different physicians have “substantially different success rates” with the same medical procedure, the comparable risks<sup>171</sup> of surgery performed by the defendant versus surgery performed at a tertiary care facility (in this case, the Mayo Clinic), and evidence that the defendant should have advised the plaintiff of the option of undergoing surgery at a tertiary care facility. The court reasoned that this type of information fell within the general obligation of physicians to disclose “viable alternatives” to the proposed treatment.<sup>172</sup>

The Wisconsin Supreme Court in *Johnson* strove assiduously to contain the potential reach of its holding, saying that “[i]t is a rare exception when the vast body of medical literature and expert opinion agree that the difference in experience of the surgeon performing the operation will impact the risk of morbidity/mortality as was the case here.”<sup>173</sup> The reality remains, however, that there may be significant differences in outcomes between residents and more

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consent doctrine to cover the alleged misstatements, and noted that “[s]tripped to its essentials, plaintiff’s claim is founded on lack of informed consent.” *Id.* at 84. But, the court declined to decide whether, under its prudent patient standard, “personal credentials and experience” may be a required part of an informed consent disclosure, noting that “[o]ur case law never has held that a doctor has a duty to detail his background and experience as part of the required informed consent disclosure; nor are we called on to decide that question here.” *Id.* at 82.

170. 545 N.W.2d 495 (Wis. 1996).

171. The court’s holding here applied at least when “defendant elected to explain the risks confronting the plaintiff in statistical terms.” *Id.* at 508.

172. *Id.* at 498, 501 n.17 (relying on both case law and statute).

173. *Id.* at 510 (quoting from Brief for Petitioner at 40); see also *Prissel v. Physicians Ins. Co. of Wis.*, No. 02-1729, 2003 WL 22998133, at \*8 (Wis. Ct. App. 2003) (requiring (and not finding in the record) proof that the morbidity and mortality rate expected of the defendant-physician when assisted by a physician’s assistant was higher than the rate expected of another cardiovascular surgeon when assisted by another surgeon).

experienced and established specialists. But, that said, it does not follow that taking an informed consent route to address that reality is a sensible course. In fact, it would raise a host of complexities.

In addition to the mixed reaction of the courts to extending the scope of the duty to disclose a physician's level of experience, there would be complications that are inherent in the informed consent doctrine. Would the *Johnson* holding mean that virtually any surgeon within ninety miles of the Mayo Clinic must essentially apprise his patients of the option of going to the Mayo Clinic? In other words, where is the stopping point once we start down that informed consent road? Moreover, the fact that residencies are a learning continuum that defy statistical generalization, or perhaps any meaningful relative generalizations at all, would limit the range of experience-based risk information that one could confidently impart. What do the "success rates" really tell us? Might these rates be skewed by how one defines "morbidity"? And, from what period of time is a physician's performance average to be derived?

And, even more complexity resides here in the physician-specific information claims when causation is considered. At least two core causation dimensions are implicated in informed consent cases.<sup>174</sup> First, in what has been termed "decision causation,"<sup>175</sup> the failure to disclose must have been *outcome-determinative* to the decision of a reasonable person (under the prevailing rule) to undergo the procedure. This means essentially that, had the required information been disclosed, a reasonable patient in the plaintiff's position would have chosen a different course of action.<sup>176</sup> This causation

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174. See Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87, 121-22 (1976) (outlining the practical obstacles to showing (1) that the plaintiff would reasonably have rejected the proposed treatment if informed and (2) that the injury would not have occurred if the patient had reasonably made an informed choice for an alternative treatment); Alan Meisel & Lisa D. Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 438-39 (1980) (comparing the "rarely acknowledged" issue of injury causation with the more widely examined issue of decision causation); Aaron D. Twerski & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 NW. U. L. REV. 1, 9 (1999) (defining "decision causation" and "injury causation" and noting that decision causation requires the patient to prove he would have reasonably declined his doctor's advice if fully informed even though most "reasonable patients generally follow the nonnegligent recommendations of their reasonable doctors").

175. Meisel & Kabnick, *supra* note 174; see also Twerski & Cohen, *supra* note 155, at 617 & n.38, 643; Twerski & Cohen, *supra* note 174, at 9.

176. This proof would most likely be governed by a reasonable person test. See DOBBS, *supra* note 78, at 657 (explaining that the reasonable patient standard is "unique to medical informed consent cases" and limits the doctor's duty of disclosure, but has been widely accepted). Thus, here, plaintiff would have to also prove that a reasonable person in his position, if receiving adequate disclosure,

component is much easier to satisfy when the omitted information relates to risk information tied to the specific treating physician.<sup>177</sup>

The problem lies with the second companion causation dimension that has been referred to as “injury causation.”<sup>178</sup> This 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 contemplates 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.”<sup>179</sup> For present purposes, the plaintiff would presumably also have to show that the harm complained of would not have materialized had he been adequately informed about the relative experience level of his physician because the performance of another health care provider whom he would have reasonably chosen would have avoided the harmful consequences.<sup>180</sup>

would have decided differently.

177. Twerski & Cohen, *supra* note 174, at 12. The authors note:

In these cases, the question is not whether the patient would have consented to the procedure in question (as opposed to some other procedure with a different risk matrix, or as opposed to the risk of undergoing no procedure at all). Rather, the question is whether the patient would have consented to the procedure to be performed by *this* provider with *this* provider’s level of risk, as opposed to being performed by another provider with *that* provider’s lower level of risk. Disputes concerning the identity of the provider do not, by their nature, necessarily inhabit the same narrow bounds as cases concerning the procedure itself. Rather, decision causation in this context can, and often will, be in the realm of “easy” cases.

*Id.*

178. Meisel & Kabnick, *supra* note 174, at 438; *see also* Twerski & Cohen, *supra* note 155, at 617 & n.38; Twerski & Cohen, *supra* note 174, at 9.

179. Twerski & Cohen, *supra* note 174, at 9; *see* Meyers v. Epstein, 282 F. Supp. 2d 151, 156 (S.D.N.Y. 2003) (applying New York law and analyzing claim alleging that surgeon who performed surgery was not the one to whom consent had been given under informed consent principles, and holding that damages for the harm from complications of the surgery were not recoverable unless plaintiffs “can show that the results of the surgery would have been different had it been performed by [a surgeon to whom consent was given]”); *see also* Epstein, *supra* note 174, at 121. Epstein elaborates:

The second causal question raised in informed consent cases concerns what might have happened to the patient if appropriate disclosures had led him to refuse the proposed treatment. While it might be tempting to hold the physician responsible for the harm caused by the treatment, that position is quite unsound if it does not take into account the harm that would have occurred in any event.

*Id.* at 121-22.

180. *See* Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 85 (N.J. 2002) (discussing the injury causation dimension of the causation requirement in informed consent case arising out of alleged misinformation regarding the surgeon’s credentials and experience); Prissel v. Physicians Ins. Co. of Wis., No. 02-1729, 2003 WL 22998133, at \*10-11 (Wis. Ct. App. 2003) (noting the requirement of causation in a case based on an alleged failure to disclose physician-specific risk and requiring not only decision causation, but also that the plaintiff prove that the morbidity and

Presumably, then, the plaintiff having undergone a specific medical procedure must *not only* prove that had he been adequately informed about the relative inexperience of the defendant-physician, he reasonably<sup>181</sup> would have opted to have the procedure performed by a different health care provider (perhaps at a different medical facility), the plaintiff must also establish that the harm he is complaining of was caused by the treatment he actually received *and* that this harm is greater than what he would have suffered had he been warned and had he chosen a different health care 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.

As a response to this causation perturbation, Twerski and Cohen suggest that the “lost chance doctrines provide a doctrinal umbrella for assessing liability.”<sup>182</sup> In *Johnson*, for example, the comparison could be made in various ways. Perhaps the most likely basis would compare the usual morbidity and mortality rate of fifteen percent to the estimate for one with the “defendant’s relatively limited experience” of close to thirty percent. Then, under a loss of chance analysis we might calculate: thirty minus fifteen equals a loss of a fifteen percent chance of avoiding the adverse result.

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mortality rate expected for the defendant when assisted by a physician’s assistant was higher than the rate expected of another cardiovascular surgeon when assisted by another surgeon, and also that the patient’s injury was a materialization of that increased risk). The court in *Howard* said:

[T]o satisfy the damages element in a claim based on a lack of informed consent, a plaintiff typically has to show a causal connection between the inadequately disclosed risk of the procedure and the injury sustained. If that risk materialized and harmed plaintiff, damages for those injuries are awarded. Here, if successful in his claim based on lack of informed consent, plaintiff may receive damages for injuries caused by an inadequately disclosed risk of the corpectomy procedure.

800 A.2d at 85 (citations omitted). Unfortunately, the court’s language was very general and did not detail precisely what the plaintiff must prove to satisfy this element. As such, it failed to address the complex nuances of injury causation in this setting. See *infra* notes 181-183 and accompanying text.

181. This proof would most likely be governed by a reasonable person test. See DOBBS, *supra* note 78, at 657 (explaining that the reasonable patient standard is “unique to medical informed consent cases” and limits the doctor’s duty of disclosure, but has been widely accepted). Thus, here, plaintiff would also have to prove that a reasonable person in his position, if receiving adequate disclosure, would have decided to have the procedure performed by a different health care provider (perhaps at a different medical facility).

182. Twerski & Cohen, *supra* note 174, at 23. This also seems to have been what Marjorie Schultz had in mind generally when elaborating on her proposal for a new model directly creating a new independent interest in medical choice. Schultz, *supra* note 158, at 287 (contending that “the loss of an uncertain chance of a preferable outcome . . . can be valued as a matter of assessing damage”) (citing Joseph H. King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353 (1981)).

Although I am a champion of the principle of the loss of a chance doctrine in other contexts,<sup>183</sup> that doctrine may not be suitable here in the informed consent setting. First, the statistical comparisons may be flawed because the circumstances of individual patients on which they are based may not be commensurable. The statistical sample from the experienced-physician cohort may be too small to be meaningful or the relevant information may be unavailable. Also, since residencies are a learning continuum, individual statistical generalization may not be feasible. Moreover, the statistics for the defendant-resident would be speculative, unscientific, and in any event, based upon too small a sample (almost by definition since our defendant is inexperienced) to be meaningful. Second, there would also be problems with defining “success rates” and “morbidity,” as well as selecting the period of time from which a physician’s performance average would be derived. The definition of success or failure may be different for the defendant and the other provider to which he is compared. The definitions for adverse outcomes may be too broad, dissimilar, or general to make any comparison meaningful.

The AMA’s own professional opinions have not contributed clear direction in this matter. At one time they provided that “[i]f a resident or other physician is to perform the operation under the guidance of the surgeon, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement contained in the consent.”<sup>184</sup> Those guidelines then added that if the surgeon employed “merely assists the resident . . . in performing the operation, it is the resident . . . who becomes the operating surgeon . . . [and that] [i]f the patient is not informed as to the identity of the operating surgeon, the situation is ‘ghost surgery.’”<sup>185</sup>

However, the current opinion states: “If a resident or other physician is to perform the operation under non-participatory supervision, it is necessary to make a full disclosure of this fact to the

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183. For an article associated with the development and judicial acceptance of the “loss of a chance” theory in medical malpractice law, see King, *supra*. For additional elaboration on the conceptual nuances of the loss of a chance doctrine, see Joseph H. King, “Reduction of Likelihood” Reformulation and Other Retrofitting of the Loss-of-a-Chance Doctrine, 28 U. MEMPHIS L. REV. 491, 546-54 (1998). See generally Lars Noah, *An Inventory of Mathematical Blunders in Applying the Loss-of-a-Chance Doctrine*, 24 REV. LITIG. 369 (2005) (discussing some of the pitfalls and potential errors in application of the doctrine).

184. American Medical Association Judicial Council Opinion 8.12 (1982), *quoted in* Dingle v. Belin, 749 A.2d 157, 168 n.3 (Md. 2000).

185. American Medical Association Judicial Council Opinion 8.12.

patient, and this should be evidenced by an appropriate statement contained in the consent. Under these circumstances, it is the resident or other physician who becomes the operating surgeon.”<sup>186</sup> Thus, the change represents deliberate silence by the Judicial Council of the AMA on the potential duties of disclosure when a resident undertakes to perform medical procedures in the presence of the attending physician (since then it would presumably be participatory supervision rather than “non-participatory supervision”).

Some commentators have raised the possibility of vindicating the patient’s interest in information regarding the physician’s education and experience by invoking other theories of liability, such as some aspect of a misrepresentation theory.<sup>187</sup> The misrepresentation route raises a host of complications and is problematic. In the first place, the “misrepresentation” or “fraud” moniker may mean different things depending on the eye of the beholder. It might, for instance, be invoked not as a discrete theory of liability, but rather as a means of attempting to invalidate a patient’s consent in order to support a claim by the patient for battery.<sup>188</sup> Or, misrepresentation might be asserted as a freestanding theory of liability.<sup>189</sup> Adding to the confusion, some commentators seem to meld the two ideas, battery

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186. Substitution of Surgeon without Patient’s Knowledge or Consent, AM. MED. ASS’N, AMA CODE OF MEDICAL ETHICS § E-8.16 (1994), <http://www.ama-assn.org/ama/noindex/category/11760.html> (follow “Accept” hyperlink; then follow “Code of Medical Ethics” hyperlink; then follow “E-8.00 Opinions on Practice Matters” hyperlink; then follow “E-8.16 Substitution of Surgeon without Patient’s Knowledge or Consent” hyperlink).

187. See Heyward H. Bouknight, III, Note, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 60 WASH. & LEE L. REV. 1515, 1560 (2003) (recommending a misrepresentation-based “fraud” cause of action premised upon a “legally enforceable expectation” that a physician will reply honestly to a patient “who specifically inquires about his doctor’s experience”). One court has noted the multifarious legal theories that might be invoked, at least when an attending physician allegedly fails to abide by an understanding regarding the allocation of responsibilities between attending physicians and residents. See *Dingle*, 749 A.2d at 170. The *Dingle* court stated:

The lack of a clear understanding prior to the procedure may well engender a later finding that informed consent was not obtained. A violation of an understanding so reached may constitute the lack of informed consent, negligent delegation, and a breach of the contract, not to mention the risk of a claim of misrepresentation or fraud. It would be prudent, of course, for the written consent form presented to the patient either to set forth any special understanding in this regard or note affirmatively that there is no such understanding.

*Id.*

188. See RESTATEMENT (SECOND) OF TORTS § 892B(2) (1979) (clarifying that consent induced by a substantial mistake resulting from misrepresentation is not effective consent for the unanticipated invasion or harm).

189. See Bouknight, *supra* note 187, at 1545.



and misrepresentation.<sup>190</sup> The misrepresentation characterization, as either a prong of a battery claim or a freestanding misrepresentation cause of action, seems a singularly blunt instrument with which to address the matter of nondisclosures by medical residents.

A battery characterization or allegation may raise a number of complications. That route would present the question of whether such claims should nonetheless be governed exclusively by the informed consent doctrine irrespective of attempts to characterize it as a battery.<sup>191</sup> That in turn could depend on whether a resident merely failed to disclose or misstated his experience and background, or more seriously, failed to reveal or misstated his involvement in the patient's surgery or other treatment.<sup>192</sup> The Restatement provides that consent may be invalidated by a mistake "concerning the nature of the invasion . . . or the extent of the harm to be expected"<sup>193</sup> if that mistake is known to the defendant or is induced by the defendant's misrepresentation. A key question would presumably be whether the defendant either knew of the patient's "mistake," or induced it.

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190. See *id.* (referring in the same paragraph to fraudulent misrepresentation as a "stand-alone tort" and allowing the plaintiff "to bring an action for battery").

191. Cf. *supra* note 179 (discussing *Meyers v. Epstein*, 282 F. Supp. 2d 151, 156 (S.D.N.Y. 2003)). But, the same judge in an earlier opinion in the same case said that "informed consent cases are inapposite." *Meyers v. Epstein*, 232 F. Supp. 2d 192, 196 (S.D.N.Y. 2002).

192. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 81 (N.J. 2002); *Bundrick v. Stewart*, 114 P.3d 1204, 1209 (Wash. Ct. App. 2005); see also *infra* note 195 (discussing the *Meyers* opinions). In *Howard*, the Supreme Court of New Jersey rejected a battery characterization where the defendant-surgeon had allegedly misstated the level of his specialty board certification and the number of times he had performed corpectomies. In doing so, the court distinguished this situation from a true "ghost surgery" situation in which a different physician performs the surgery than the one to whom the patient specifically consented and contemplated would perform it. 800 A.2d at 81. The court specifically noted that a battery claim might lie "where there has been 'ghost surgery' or where no consent has been given for the procedure undertaken." *Id.*

In *Bundrick*, the patient suffered a massive infection resulting from improper suture placement during an attempt to repair the mesentery lining of her bowel during tubal reanastomosis surgery. She alleged, inter alia, that a medical battery had occurred based on the allegation that a third-year resident participated in the surgery without her consent. The court implied that the resident might have owed a duty to the patient to disclose the fact that he would be participating in the plaintiff's surgery, saying that the resident "had no right to participate without [the patient's] consent." 114 P.2d at 1209. The court, however, went on to affirm the judgment against the plaintiff on the medical battery claim, relying on the "broad" consent signed by the patient consenting to "all medical treatment or . . . services performed or prescribed by/or at the direction of the attending physician," as sufficient. *Id.* (citation omitted) (emphasis added). The jury had been instructed that "[a] patient may refuse to consent to a particular doctor . . . [and a] health care provider has a duty to honor such a refusal of consent if the patient has informed the health care provider of the refusal." *Id.* (citation omitted). The jury then found that the patient did not refuse consent to the participation of the resident. *Id.*

193. RESTATEMENT (SECOND) OF TORTS § 892B(2) (1979).

Furthermore, the courts would have to decide whether mere silence constituted misrepresentation, which in turn might ultimately entail deciding the fundamental question of whether or when a resident owed a duty to disclose such information to the patient. The apparent perceived overlap between misrepresentation, or at least negligent misrepresentation, and informed consent further clouds the analysis.<sup>194</sup>

Likewise, invoking a freestanding misrepresentation theory would involve its own parade of entanglements.<sup>195</sup> Should a distinction be drawn based on whether a defendant-resident affirmatively misstated his experience or merely failed to disclose it?<sup>196</sup> And, if the physician merely failed to disclose information about his credentials, training, or experience, the outcome would depend in part on whether the court imposed a duty to disclose under the circumstances.<sup>197</sup> Moreover, proof of reliance would most certainly be required.<sup>198</sup>

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194. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 504 n.29 (Wis. 1996) (noting that an overlap exists between negligent misrepresentation and informed consent, and that "allegations made and evidence introduced by the plaintiff might have fit comfortably under either theory").

195. See, e.g., *Meyers*, 232 F. Supp. 2d at 196-201 (discussing the complex torts, damages, causation, and proximate causation aspects of malpractice and fraud claims against a surgeon to whom consent had been given, and a battery claim against another surgeon who allegedly performed the surgery); *Meyers*, 282 F. Supp. 2d at 155 (analyzing a claim alleging that surgeon who performed surgery was not the one to whom consent had been given under informed consent principles and holding that damages for harm from the complications of the surgery were not recoverable unless plaintiffs "can show that the results of the surgery would have been different had it been performed by [surgeon to whom consent was given]"). The court had initially allowed the malpractice claim against the surgeon and the battery claim against the resident surgeon who allegedly performed the surgery to proceed. See *Meyers*, 232 F. Supp. 2d at 199-201.

196. The complex issue of whether or when there is a duty to disclose in the context of fraudulent misrepresentation claims for pecuniary losses unrelated to personal injury is addressed in the Restatement. See *RESTATEMENT (SECOND) OF TORTS* § 551 (1977). The sheer uncertainty of it all is especially evident in section 551(e) (assigning a duty to exercise reasonable care to disclose facts to the other party before the transaction is consummated, including "facts basic to the transaction, if he knows that the other is about to enter into it under a mistake as to them, and that the other, because of the relationship between them, the customs of the trade or other objective circumstances, would reasonably expect a disclosure of those facts").

197. See *Ditto v. McCurdy*, 947 P.2d 952, 959 (Haw. 1997) (holding that an instruction to the jury on fraud was erroneous because that defendant-physician who was board certified as otolaryngologist, facial surgeon, and cosmetic surgeon and who allegedly disfigured the plaintiff in breast augmentation surgery, did not have duty to disclose to the patient that he was "not a plastic surgeon and that he did not have hospital privileges").

198. See *RESTATEMENT (SECOND) OF TORTS* § 310 (1965) (dealing with liability for conscious misrepresentation involving a risk of physical harm); *RESTATEMENT (SECOND) OF TORTS* § 311 (1965) (dealing with liability for negligent misrepresentation involving a risk of physical harm); § 546 (dealing with the causation requirements for fraudulent misrepresentation resulting in exclusively

Little wonder, then, that a majority of the few cases to consider the question have resisted using the misrepresentation theory to remedy the problem of inadequate patient information regarding a physician's education, training, and experience.<sup>199</sup>

Occasionally, a case will even invoke breach of contract as a possible theory of liability. For example, in one case, a fourth-year resident dissected a patient's bile duct instead of the cystic duct during a gall bladder surgery.<sup>200</sup> The court held that an attending surgeon could potentially be liable for allegedly breaching his contractual understanding with the patient regarding the allocation of tasks during surgery between the attending surgeon and the resident.<sup>201</sup>

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pecuniary loss unrelated to personal injury); RESTATEMENT (SECOND) OF TORTS § 552 (1977) (dealing with reliance requirement for negligent misrepresentation resulting in exclusively pecuniary loss unrelated to personal injury). For discussion of the four dimensions of reliance generally, see Joseph H. King, *Limiting the Vicarious Liability of Franchisors for the Torts of their Franchisees*, 62 WASH. & LEE L. REV. 417, 444-45, 448-60 (2005) (discussing the reliance requirement for apparent agency for the purposes of vicarious liability).

199. *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 82 (N.J. 2002) (citing cases that have rejected a claim of fraud cause of action where physicians allegedly misrepresent or fail to disclose background credentials). The *Howard* court followed the reasoning of these cases and held that even allegations that the defendant surgeon affirmatively misrepresented his credentials and experience could not be pursued as a fraud or deceit-based claim. *Id.* In rejecting such a fraud claim under the circumstances, the New Jersey Supreme Court reasoned that not only might such an approach increase the possibility of an award of punitive damages, but the court also suggested its discomfort with fraud claims arising solely from the physician-patient relationship. *Id.* The court did, however, expressly extend the scope of the informed consent doctrine to cover these misstatements and noted that the plaintiff's claim was essentially founded on lack of informed consent. *Id.* at 84; see also *Ditto*, 947 P.2d at 959 (holding that since defendant-physician who allegedly disfigured the plaintiff during breast augmentation surgery did not have a duty to disclose to the patient that he was not a certified plastic surgeon and did not have hospital privileges, instructing the jury on fraud was erroneous); *Paulos v. Johnson*, 597 N.W.2d 316, 320 (Minn. Ct. App. 1999) (finding that where a plaintiff claimed that he was erroneously advised that the defendant-physician was a board-certified plastic surgeon, that a fraudulent misrepresentation claim could not lie).

Notably, at least one case has held that whereas an informed consent cause of action is not available, a claim for misrepresentation might be available if a physician provides inaccurate information about his experience and training prior to performing a medical procedure. See *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (holding that "evidence of a physician's personal characteristics and experience is irrelevant to an informed consent claim" but stressing that the court's holding "should not . . . be read to stand for the proposition that a physician who misleads a patient is immune from suit," because a plaintiff may have a cause of action for misrepresentation where a physician "allegedly provides inaccurate information regarding his experience"), modified by 40 PA. CONST. STAT. ANN. § 1303.504(d)(2) (West 2002) (stating that a physician may be liable under informed consent principles for knowingly misrepresenting his professional credentials, training or experience).

200. See *Dingle v. Belin*, 749 A.2d 157, 159 (Md. 2000).

201. *Id.* at 169-70 (finding, however, that a breach of contract claim could not survive because an issue that was central to the plaintiff's contract claim was

Even if a new theory of liability were created to sidestep the causation-of-physical-harm hurdles<sup>202</sup> or to augment the traditional informed consent doctrine,<sup>203</sup> such an approach would be problematic. The courts would still have to grapple with the problem of how to value any new interest independent of the physical dimension of the treatment. This is the soft spot in proposals to create a new dignitary theory of liability to supplement the traditional informed consent remedy.

For example, Shultz, Twerski, and Cohen, who were early proponents for recognizing a brand-new autonomy interest in information necessary for informed medical decisionmaking,<sup>204</sup> seem vague on precisely how damages for invasions of the proposed dignitary interest would be valued. Shultz writes:

Identification of an intangible interest in choice could also allow recovery for less traditional categories of harm. Courts could evaluate consequences of a substantial but not necessarily “physical” or “injurious” (as socially judged) harm . . . . For example, although emotional distress damages would constitute a particularly likely result of invasions of this interest, courts could restrict such recoveries.<sup>205</sup>

We are not told, however, precisely how the courts are to limit recoveries. Similarly, Twerski and Cohen state:

Not all choice deprivations are of equal magnitude. When valuing the denial to the plaintiff of his right to exercise options, one must consider the range of options available and their possible benefits and detriments. The greater the range of benefits available through alternate choice, the greater the harm done to the choice-making process . . . . Once more, the focus on the undesirable result rather than on the uninformed nature of the decision-making process has diverted attention from the actual damages that flow from a crippled decision-making process.<sup>206</sup>

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submitted to the jury at trial, where the jury found in the defendant’s favor).

202. See *supra* notes 174-183 and accompanying text (addressing the challenge that results for plaintiffs in meeting the dual-causation standard, particularly the “injury causation” prong).

203. See *supra* note 158 and accompanying text (exploring the theory proposed by various scholars that the informed consent doctrine either be broadly conceived to protect the patient’s dignitary interests or be replaced by a tort that would protect the patient’s right to autonomous decisionmaking).

204. See *supra* note 158.

205. Shultz, *supra* note 158, at 290 (citations omitted).

206. Twerski & Cohen, *supra* note 155, at 658-59; see Weisbard, *supra* note 155, at 763 (suggesting that damages for dignitary harms should be based on a statutory schedule ranging from \$1,000 to \$10,000, perhaps allowing for greater recovery for punitive damages in unusual circumstances).

We are left with sparse guidance as to how such dignitary interests are to be measured. Then, we would face the ethereal labor of attempting to convert the non-economic effects of a perceived invasion of a patient's autonomy or dignitary interests into money (read damages), despite the fact that the two are incommensurable.<sup>207</sup>

I prefer not to attempt to force the problem of resident-based medical errors into an informed consent/loss-of-chance vessel or into a newly minted but undefined freestanding autonomy cause of action. A more sensible approach would be to meld a duty to disclose one's resident status with the standard of care rule used to evaluate the defendant's overall performance of the medical procedure. That approach is discussed in the following section.

### III. THESIS AND PROPOSAL

#### A. *Proposed Standard of Care Rule*

Rather than address the problem of treatment by medical residents exclusively through either the standard of care or the doctrine of informed consent (or some other information-based theory of liability), I propose the following more elegant solution that melds the two doctrines: When medical residents (both not-yet-licensed and licensed ones) fully disclose their status, including their experience, training, education, and credentials, to their patients, then their performance should be judged by a standard of care commensurate with their actual level of post-graduate medical training, education, and experience. Licensed residents should, in addition and as a minimum, be held to the standard of a licensed general practitioner. A resident (either licensed or not-yet-fully-licensed) who either affirmatively misstates or fails to disclose his status will not be permitted to avail himself of the standard commensurate with his limited experience and training. If such resident affirmatively misrepresents his credentials and experience, then he should at least be held to the standard commensurate with the professional background that he claims to possess.

Now for the tough part. When a resident fails to disclose, I propose the following approach: When a resident fails to disclose his status, not-yet-fully-licensed residents should be held to the standard

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207. I have addressed this problem more broadly in another publication. See Joseph H. King, *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163 (2004) (suggesting that damages for pain and suffering should not be recoverable in personal injury tort claims, with the trade-off that the scope of economic damages and attorney's fees be broadly conceived).

of care expected of a fully licensed physician who has completed his internship. A non-disclosing licensed resident, actively participating in a graduate medical program to prepare him for a medical specialty, should be held to the standard of the specialty covered by his residency program when serving in the capacity of a specialist, unless he can prove that the patient's reasonable expectations were of some less demanding standard, in which case he will be held to a standard commensurate with those expectations. As a practical matter, then, a non-disclosing licensed resident would usually be held to the specialty of his residency program when he is serving in the role of a specialist or in the scope of that specialty. For example, a non-disclosing surgical resident would be held to the standard of care of a specialist-surgeon when performing surgery or managing a post-operative patient's care. On the other hand, that same resident may not be held to the specialist-surgeon standard when helping to conduct physical exams that the hospital offered to the local high schools as a public service.

Thus far, I have been addressing the conduct of medical residents while actively engaged within the scope of their duties in their graduate medical-education residency programs. Residents sometimes moonlight<sup>208</sup> at hospital emergency rooms and elsewhere, and may be functioning outside of the scope of their formal residency-training program. I would also apply my suggested rule in this scenario as well. Therefore, in the absence of disclosure to the patient of their residency status, it would have to be decided whether such moonlighting residents were serving in a generalist or in a specialist capacity (unless the resident could show that the patient's reasonable expectations were of some less demanding standard).<sup>209</sup>

Under the preceding proposal, alleged malpractice against a medical resident would proceed as a traditional claim for negligent performance of professional medical services. That being so, the burden of proof would be on the plaintiff to prove that the defendant-resident violated the standard of care—as defined in accordance with the proposed rule—and if so, to prove the harm caused by that alleged substandard care.

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208. See *supra* notes 62-63 and accompanying text (explaining the concept of moonlighting among residents and the substantial criticism that accompanies this practice).

209. See generally Keim & Chisholm, *supra* note 22, at 927 (declaring that “[w]e believe patients who are cared for by a moonlighting physician have the right to expect that their physician practices according to the standard of care for EM [Emergency Medicine],” adding that “[m]oonlighting weakens the fabric of our profession, and continues to propagate the myth that ‘anyone can work in an ER’”).

The confusing state of the law regarding the standard of care for residents has inspired a number of suggestions by others for reform. These typically address the matter exclusively through the standard of care,<sup>210</sup> through manipulation of the doctrine of informed consent,<sup>211</sup> or by the use of some other theory of liability, such as misrepresentation.<sup>212</sup> In general, I do not believe such proposals strike a suitable balance between competing interests, nor are they sufficiently predictable in their operation.<sup>213</sup>

### B. Rationale

In addressing the standard of care for residents, we must confront the contending interests and the difficult underlying ethical dilemma

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210. See, e.g., Reuter, *supra* note 40, at 492 (stating that residents “should be held to a progressively higher standard as their knowledge, experience, and practice progressively increase through their residency training”). Reuter goes on to say that “[f]irst-year residents should be held to the standard of practice of a generalist[,] . . . final-year residents should be held to the standard of a specialist[,] . . . and [h]ouse staff in the middle of their training period should be held to an intermediate standard.” *Id.* I believe, however, that residents should not be permitted to avail themselves of the sliding scale standard of care unless they have fully disclosed their status and level of education and experience to their patients. See also Ward, *supra* note 28, at 295-96 (suggesting a two-step approach to determine the appropriate standard of care for residents). If a resident held himself out as a specialist, Ward advocates that the court hold the resident to the same standard of care as a specialist in the field in which the resident was practicing. *Id.* at 296. But, if the court determined that the resident did not hold himself out as a specialist, it should “move to step two to determine if the procedure in question is ordinarily performed only by specialists.” *Id.* Further, “[i]f the procedure in question is usually undertaken only by specialists, then the court would hold the resident to the same standard as a specialist.” *Id.*

The Ward proposal suffers from several shortcomings. First, it depends initially on a determination of whether a resident held himself out as a specialist. But what if a resident says nothing? When will a resident be deemed to have held himself out? I prefer a rule that places an incentive on the resident to disclose affirmatively his status and background, which ideally would foster a dialogue with the patient if the resident’s background is important to the patient. Moreover, under Ward’s proposal, residents who hold themselves out as specialists would automatically be held to that standard. I prefer affording residents who fully disclose their status the benefit of a sliding scale standard expected of a person with a similar level of post-graduate professional education, training, and experience.

Under Ward’s proposal, if a defendant did not hold himself out as a specialist, then he would be held to the standards of a general practitioner unless he performed a procedure that is usually undertaken only by specialists. But whether a procedure is usually undertaken only by specialists would be difficult to determine. Also, what is meant by “specialist”—only those who are board certified? Board eligible? There might also be a question of which specialty the resident should be considered under because sometimes multiple specialties undertake the same medical procedure. This approach leaves many questions and ambiguities.

211. *Supra* notes 158, 182 and accompanying text.

212. *Supra* note 187 and accompanying text.

213. For a more detailed assessment, see *supra* note 210 (addressing standard of care proposals); *supra* notes 173-183 (discussing an informed consent approach); *supra* notes 187-197 (analyzing a variety of misrepresentation proposals).

that they create. On the one hand, we have the individual patients whose safety, health, and rights to self-determination are at stake. Medicine, like any professional activity, improves with experience. In fact, Professors Twerski and Cohen tell us that for all medical procedures studied, the data consistently show an inverse relationship between the number of procedures performed per provider and the rates of unfavorable outcomes, as measured by risk-adjusted mortality or complication rates and thus suggest that “‘practice makes proficiency.’”<sup>214</sup> Accordingly, “[a]ny contention that a reasonable patient would consider his or her physician’s level of experience immaterial to a procedure, particularly an invasive procedure, is clearly contradicted by real life experiences.”<sup>215</sup> But the health of us all depends on the education, training, and experience of residents so that they may assume their crucial roles among the most qualified medical specialists in the world.<sup>216</sup> And it is essential that the individual resident gains needed experience.<sup>217</sup> Thus, the immediate microcosmic interests of individual patients may be arrayed against

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214. Twerski and Cohen, *supra* note 174, at 13 n.30 (quoting Don Colburn, *Practice Makes Proficiency in Bypass Surgery, Study Says*, WASH. POST, Nov. 18, 1997, at WH-5).

215. Iheukwumere, *supra* note 153, at 413-14; see Gregory L. Larkin et al., *Great Expectations: Patient/Customer Preferences for Resident Physicians (RPs) & Physician Extenders (PEs) in the Emergency Department (ED)*, 6 ACAD. EMERGENCY MED. 384a [Abstract], (1999) (reporting that 65.3% of emergency room patients want to know the level of training of the health-care providers that are caring for them).

At least one state has addressed the patient’s disclosure interests by statute. See VA. CODE ANN. § 54.1-2961(E) (2003). This statute requires that the Board of Medicine adopt guidelines providing for:

[T]he obtaining of informed consent from all patients or from the next of kin or legally authorized representative, to the extent practical under the circumstances . . . after such patients or other persons have been informed as to which physicians, residents, or interns will perform the surgery or other invasive procedure.

*Id.* The statute mentions that the guidelines should also include:

[P]olicies to avoid situations, unless the circumstances fall within an exception in the Board’s guidelines or the policies of the relevant hospital, medical school or other organization operating the graduate medical education program, in which a surgeon, intern or resident represents that he will perform a surgery or other invasive procedure that he then fails to perform.

*Id.*

216. The courts have acknowledged the importance of this interest. See, e.g., *Owens v. Thomae*, 904 So. 2d 207, 210 (Miss. Ct. App. 2005) (stating that established physicians engaged in the training of residents are fulfilling the state’s strong interest in educating medical students, interns, and residents that will be society’s future doctors).

217. See *Rush v. Akron Gen. Hosp.*, 171 N.E.2d 378, 380 (Ohio Ct. App. 1957) (commenting that the intern’s primary reward is the practical medical and surgical instruction that he gains from assisting or watching the more experienced physicians treat a spectrum of patient and illnesses).



the longer term macrocosmic ones; namely the education of the medical profession.<sup>218</sup>

In the individual patient we hear the echo of that Kantian admonition—we must not treat any person as a means, but rather always as ends.<sup>219</sup> Thus, Kant's classic construct states: "Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end."<sup>220</sup> He refers to the autonomy of the will "as the supreme principle of morality."<sup>221</sup> But, as Professor Daniel Markovits reminds us, Kant's "categorical imperative" contains two distinct commands concerning how to treat humanity.<sup>222</sup> Markovits explains:

The principle that one should never use persons merely as means prohibits actions that follow principles or rules . . . that could not possibly be accepted by the persons whom the actions affect. The principle that one should always treat other persons as ends in themselves prohibits actions in pursuit of ends that the persons whom they affect cannot share . . . . The first command—about not using persons merely as means—captures the idea that persons are not simply *available* to one another. Unlike things, persons have independent intellects and wills . . . concerning the world and their places in it. A person who acts against others based on a maxim that they cannot accept in effect denies this: She bypasses their . . . intellects and their wills . . . and so treats them not as persons but merely as things.

The second command—about treating persons as ends in themselves—captures the idea that even though persons are not simply available to one another, they must nevertheless be *open* to one another . . . . A person who acts against others in pursuit of ends that they cannot share, even if she responds to their wills in one way, does so on terms that necessarily set her apart from them

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218. There may also be are other conflicts here. *See, e.g., Dingle v. Belin*, 749 A.2d 157, 169-70 (Md. 2000). The court asserted:

The parties may well have conflicting interests in that regard—the doctor wanting as much flexibility and discretion as possible and the patient, if choosing the physician because of some special confidence in that physician's particular abilities, desiring that the selected physician oversee and personally perform the most difficult part of the procedure.

*Id.*

219. *See* JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 16 (2005) (discussing that this Kantian principle has been of great significance to the field of bioethics, highlighting autonomy as a governing principle in the field).

220. IMMANUEL KANT, *THE MORAL LAW: KANT'S GROUNDWORK OF THE METAPHYSIC OF MORALS* 91 (H.J. Paton trans., Hutchinson Univ. Library 1967) (1785).

221. *Id.* at 101.

222. *See* Daniel Markovits, *Contract and Collaboration*, 113 YALE L.J. 1417, 1424 (2004) (explaining that humanity has been defined by Kant as the capacity to determine ends through rational choice).

and therefore that rule out joint participation in the acts in question.

Someone who violates these two commands refuses to *engage* others as persons, in the first case by declining to address them at all and in the second case by addressing them on terms that they cannot accept. And in refusing to engage them, she estranges herself from them and renders shared participation in a respectful relation—at least in connection with the actions in question—quite literally impossible.<sup>223</sup>

Kant's two commands anticipate the essence of our dilemma: in one sense medical care administered by a resident is a learning experience and thus does treat the patient as a means to educate the resident. On the other hand, the patients—all patients—may share in the “end” of benefiting from highly trained physicians and medical specialists. Dilemmas like this are not unique; indeed, they are inherent in the life of the law.<sup>224</sup> It has always been easier to accept casualties if we did not have to face them.<sup>225</sup> Dr. Gawande captured the sober reality of this dilemma during his residency, reflecting on his own child's hospitalization:

In a sense, then, the physician's dodge is inevitable. Learning must be stolen, taken as a kind of bodily eminent domain. And it was, during Walker's stay—on many occasions, now that I think back on it. A resident intubated him. A surgical trainee scrubbed in for his operation. The cardiology fellow put in one of his central lines. None of them asked me if they could. If offered the option to have someone more experienced, I certainly would have taken it. But that was simply how the system worked—no such choices were offered—and so I went along. What else could I do?<sup>226</sup>

Practice by residents is thus portrayed as a matter of pedagogical, utilitarian expediency. But, although this “coldhearted machinery . . . gets the learning done,”<sup>227</sup> it does not exact its educational costs equally. Dr. Gawande comments:

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223. *Id.* at 1425-26.

224. *See, e.g.,* *Boomer v. Atl. Cement Co.*, 257 N.E.2d 870, 871 (N.Y. 1970) (articulating that the “threshold question” in a nuisance case involving air pollution was “whether the court should resolve the litigation between the parties . . . or whether, seeking promotion of the general public welfare, it should channel private litigation into public societal objectives”).

225. *Cf.* Jennifer Hewett, *Mesmerising, Until the Dead Stare Back*, *SIDNEY MORNING HERALD*, Mar. 27, 2003, available at <http://www.smh.com.au/articles/2003/03/26/1048653747489.html> (noticing that the stark realities of death in the Iraqi war become much more tangible and difficult to accept when the public is able to continuously view such violence in the media).

226. GAWANDE, *supra* note 1, at 32.

227. *Id.*

If learning is necessary but causes harm, then above all it ought to apply to everyone alike. Given a choice, people wriggle out, and those choices are not offered equally. They belong to the connected and the knowledgeable, to insiders over outsiders, to the doctor's child but not the truck driver's. If choice cannot go to everyone, maybe it is better when it is not allowed at all.<sup>228</sup>

Reconciling Kant's commands—if they can be reconciled at all—requires some effort to facilitate disclosure to patients of the status and background of their treating residents.<sup>229</sup>

Both patient and resident may invoke fairness arguments. Patients may claim that they deserve treatment by experienced practitioners and should not be unwitting guinea pigs. Residents may argue that it is unfair to hold them to a standard expected of established practitioners and specialists when they are still very much in a formative, learning mode. Courts have had to face this kind of fairness issue before in deciding standard of care questions.

A similar standard of care problem exists with respect to children. Competing arguments exist there too; children may claim that it is unfair to hold them to an adult standard, and victims may argue that they deserve protection when children are engaging in adult behavior. The law's response has been a compromise. In general, minor children are held to the standard of care expected of other children of like age, intelligence, and experience.<sup>230</sup> But there is an exception when the child who causes injury was engaging in an adult activity.<sup>231</sup> One rationale for the adult-activity exception is instructive for our purposes. It is based on the likelihood that a potential victim will be on notice as to the status of the child. When actors are engaged in adult activities, potential victims may expect that adults will be the relevant actors, and the law vindicates that expectation by

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228. *Id.* at 32-33; see also Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and Patients' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147, 151 (1994) (noting that many hospitals undermine patient interests and deprive them of their autonomy by neglecting to inform them that medical students will be examining them or that residents and interns will perform their surgical procedures while being only supervised by a licensed physician).

229. See Christine M. Korsgaard, *Kant's Formula of Humanity*, in *CREATING THE KINGDOM OF ENDS* 106, 124 (1996) (analyzing that when Kant speaks of rational nature or humanity is an end in itself, he is referring to the human power of rational choice).

230. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 10(a) (Proposed Final Draft No. 1 2005); DOBBS, *supra* note 78, at 293.

231. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 10(c) (stating that a child is held to an adult standard of care when engaging in any dangerous activity that would characteristically be undertaken by adults).

holding such actors, even if children, to the higher adult standard of care.<sup>232</sup>

This analogy is useful for our purposes. If patients lack notice of the true status and relative inexperience of the treating resident, as many patients often do,<sup>233</sup> then the application of a higher standard of care becomes more justified.<sup>234</sup> Hopefully, my disclosure-based standard of care rule could ultimately motivate more vigorous promotion or enforcement of work-hour guidelines, more consistent and transparent supervision of residents, and more clearly delineated lines of responsibility between residents and attending or supervising physicians.

My proposal also offers a predictable rule. Although the proposed rule is grounded on respect for the collective expectations of patients generally, it does not (apart from one limited exception for specialty-

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232. See DOBBS, *supra* note 78, at 301 (stating that “when the older minor creates risk to others who cannot identify the actor as a minor or protect themselves, the adult standard seems the most appropriate one for protecting the reasonable expectations of the other party”); see also David E. Seidelson, *Reasonable Expectations and Subjective Standards in Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent*, 50 GEO. WASH. L. REV. 17, 46 (1981) (concluding that in cases where it is unclear whether a minor should be judged by an adult or a child standard of care, that courts should take into account the reasonable expectations of the other party dealing with the minor). Seidelson continues by adding that where the other party contemplates that the minor is displaying a level of knowledge, skill, or maturity below that of an adult, that the minor should receive the benefit of being judged according to the child standard of care. *Id.*; cf. *Ritchie-Gamester v. City of Berkley*, 597 N.W.2d 517, 525 (Mich. 1999) (adopting a recklessness standard for coparticipants in recreational activities and reasoning that this standard most accurately reflects the actual expectations of participants in recreational activities that carry a risk of inadvertent harm, known to the party at the outset).

233. See GAWANDE, *supra* note 1, at 32 (explaining that very few people have the medical knowledge that would even enable them to ask the right questions and determine the level of experience possessed by each person who is participating in their treatment). One poll conducted by the National Sleep Foundation found that eighty-six percent of respondents indicated that they would feel anxious about their safety if they learned that the doctor that will be performing their surgery had been on duty for twenty-four consecutive hours, but seventy percent reported that they would request another doctor and sixty percent would be unlikely to assume that the procedure would go “well.” NAT’L SLEEP FOUND., 2002 SLEEP IN AMERICA POLL 26 (2002), available at <http://www.sleepfoundation.org/content/hottopics/2002SleepInAmericaPoll.pdf>. What would the public’s response be if asked to consider their reaction if they were told that their doctor was only a resident?

234. See Seidelson, *supra* note 232, at 25 n.34. Seidelson argues:

[T]he basic reason for imposing a professional standard on one who engages in a professional activity is the anticipation of the other party that the ‘professional’ is what he purports to be. When that anticipation does not reasonably exist and the actor is in fact not a professional, for example, when ‘Aunt Minnie’ suggests a home remedy to her nephew - the court is unlikely to impose the professional standard on the actor. Similarly, it seems to me, when the actor’s minority is known, actually or constructively, to the other party, giving the minor the benefit of the child standard will do no violence to the reasonable expectations of the other party.

*Id.*

oriented residents) demand a case-by-case inquiry of individual expectations. Rather, it focuses on the presence, or absence, of disclosure to the individual patient. Hence, under the rule that I propose, the standard of care does not vary according to the expectations of the patient.<sup>235</sup> The proposed approach offers a bright-line rule for deciding whether a resident's conduct is to be evaluated by an experience-based standard or a more demanding standard. Under my test, the question of the applicable standard of care would be determined by the presence or absence of *actual* disclosure to the patient, unless the defendant can prove the patient's reasonable expectations were of some less demanding standard.<sup>236</sup>

By fostering disclosures, my rule is consistent with the fiduciary obligation owed to patients by their treating physicians. Although the physician-patient relationship has been characterized by a number of metaphors,<sup>237</sup> the dominant metaphor is that of a fiduciary relationship.<sup>238</sup> In general, "[t]he law has imposed obligations on

235. Cf. Caroline Forell, *Reassessing the Negligence Standard of Care for Minors*, 15 N.M. L. REV. 485 (1985). In connection with the standard of care for children, Professor Forell rejects tying the application of the "adult activity" exception to a test based on the reasonable expectations of the victim. She reasons:

Even if a uniform reasonable expectations test were adopted, such a test would require a case-by-case determination of whether the plaintiff knew or should have known that the defendant was a minor. There would be no certainty as to which standard applied to any category of activities . . . . The unpredictability of such a test would probably only make this area even more murky and analytically dissatisfying.

*Id.* at 502 n.98. As to which standard of care applies to children, Forell would base her rule on a distinction between dangerous and carefree activities, which she says would be founded on a "fairness" rationale. *Id.* at 506-08.

236. Cf. *Zaverl v. Hanley*, 64 P.3d 809 (Alaska 2003) (describing that the alleged negligence of the patient's surgeon resulted in the death of the patient during surgery). The defendant-surgeon argued that he should be held merely to the standard of a general surgeon, rather than to the standard of a thoracic or vascular surgeon. *Id.* at 817. The court held that the surgeon could be held to the higher standard even if he had not led the patient to have an actual expectation that he would exercise a greater level of skill, as long as he took affirmative steps to hold himself out to the public as such a specialist. *Id.* Although the court found error in the jury instructions, the error was deemed harmless. *Id.* at 817-18.

237. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 242 (1995). Rodwin identified various metaphors for the patient-physician relationship:

[P]arent-child relations (paternalism); seller-purchaser transactions (consumerism); teacher-student learning (education); relations among partners or friends (partnership or friendship); or rational parties entering into negotiations or contracts (negotiation or rational contract). Doctors have also been viewed both as priestly healers and engineers.

*Id.* at 241.

238. See *id.* at 242; see also Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 51 (1993) (observing that medical patients are vulnerable and that such vulnerability imposes a fiduciary obligation on physicians that is justified by the physician's dominant position in the physician-patient relationship). Although Professor Rodwin has also referred to

physicians, often when they have done something to create reliance or a generalized sense of security.”<sup>239</sup> I invoke this fiduciary duty not as a basis for a new standalone cause of action, but as support for my disclosure-mediated standard of care rule.<sup>240</sup> My proposed rule will help to assuage the concern held in the field of medicine that there is a disconnect between the ideal of fiduciary duty and the realism of practice.<sup>241</sup> It would address the problem that patients are not always informed that medical students, residents, and interns are examining them or will be performing their treatment under the supervision of a doctor for the benefit of medical training.<sup>242</sup>

A number of courts have recognized that a physician owes a fiduciary duty to his patients when subject to a potential conflict of interest. Most notably, the Supreme Court of California held that the duty to obtain informed consent includes a duty to disclose personal research or economic interests *unrelated* to the patient’s health.<sup>243</sup> Failure to disclose such potentially conflicting interests may violate the duty to secure informed consent and the fiduciary duty owed by the attending physician to the patient.<sup>244</sup> A fiduciary obligation would

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consumerism as the “reining metaphor,” the autonomy and self-determination interests of patients seem paramount under either the fiduciary or consumerism characterization and both characterizations advocate for an increase in the amount of information available to the consumer-patient. Rodwin, *supra* note 228, at 153.

239. Furrow, *supra* note 238, at 56.

240. *Cf.* Neade v. Portes, 739 N.E.2d 496, 498-500 (Ill. 2000). The plaintiff alleged, in a wrongful death claim, that defendant physician’s failure to order an angiogram for her husband resulted in his failure to diagnose her husband’s impending fatal heart attack. The plaintiff also alleged that the defendant breached a fiduciary obligation by failing to disclose that incentives existing under the defendant’s arrangement with the patient’s health maintenance organization (HMO) put the defendant’s financial well-being in direct conflict with the patient’s physical well-being. *Id.* at 499. In her second count, the plaintiff further claimed that the defendant breached his fiduciary duty by refusing to authorize further testing or refer the patient to a specialist. *Id.* The Supreme Court of Illinois declined to recognize a new, separate cause of action for breach of a fiduciary duty under these circumstances because such a claim duplicated the traditional medical negligence claim, which the court found would sufficiently address the same alleged misconduct. *Id.* at 503. But the court did hold that evidence of the HMO incentive plan might be relevant if the defendant testified in the medical negligence trial on possible issues of credibility and bias on cross-examination. *Id.* at 506.

241. Rodwin, *supra* note 237, at 247 (explaining that although physicians think of themselves as fiduciaries and courts sometimes label physicians as fiduciaries, that such legal fiduciary principles have been applied to physicians only in limited instances, such as obtaining patients’ informed consent prior to treatment).

242. Rodwin, *supra* note 228, at 151.

243. Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990); *see supra* note 163.

244. *Id.* at 485; *see also* Morris, *supra* note 154, at 361 (discussing the importance of being able to trust one’s physician). Morris goes on to say:

If, however, the physician has a financial or other interest that conflicts, or even potentially conflicts, with the physician’s fiduciary duty to the patient’s health, but does not reveal that conflict to the patient, the physician betrays

be kindled in the resident-treatment context because of the potential conflict between, on the one hand, the patient's health and autonomy interests, and, on the other, the resident's interest in advancing his education, society's interest in an educated medical profession, and hospitals' interest in meeting their staffing requirements with the inexpensive cadre of residents. As Barry Furrow has darkly noted, "[t]he tension in the fiduciary disclosure cases is tangible—a physician must rescue a patient from the physician's own mixed motivations and conflicts of interest between the patient's good and his own. The rescuer and the person posing a danger are folded into the same person."<sup>245</sup>

The disclosure rule that I contemplate is animated by a softer glove than if such disclosures were mediated through an unvarnished expansion of the informed consent doctrine, with its slippery slope and manifold causation complexities.<sup>246</sup> As evidenced by the universal adoption of the carrot of Good Samaritan Laws, physicians seem to need encouragement to be Good Samaritans.<sup>247</sup> My approach similarly relies on the promise of a more forgiving, experience-based standard of care to encourage disclosure. Not only does it avoid the casuistries of informed consent, but it also provides residents with a readily available window through which to avail themselves of a more forgiving, experience-based standard of care.

This construct is more true to the spirit of a fault-based system of malpractice. How can these residents be deemed at fault if their performance was consistent with their novice status as participants in graduate medical education? This compromise also reflects a more flexible and all-encompassing idea of duty, one with a necessarily broader spectrum of beneficiaries than exclusively the patient.<sup>248</sup>

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that trust. If the physician knows of his or her own obvious physical infirmities (HIV-positive status, substance abuse) or inexperience that may increase the risk of harm to the patient, but does not disclose them to the patient, the physician betrays that trust.

*Id.* In discussing the holding in *Moore*, Morris reasons:

After all, if a surgeon's HIV-positive status must be revealed because it nominally increases the patient's risk of contracting the AIDS virus, a surgeon's research interest or economic interest that may influence a surgeon to recommend surgery that subjects the patient to all the risks of harm inherent in that operation and all the consequences of that operation, should require a similar disclosure.

*Id.* at 353-54.

<sup>245.</sup> Furrow, *supra* note 238, at 52.

<sup>246.</sup> See *supra* notes 152-160 and accompanying text (addressing the complications that are inherent in the informed consent doctrine in this context).

<sup>247.</sup> Furrow, *supra* note 238, at 52 (discussing statutes that may, in some circumstances, lessen potential liability for physicians who render emergency aid).

<sup>248.</sup> Rodwin, *supra* note 237, at 242. Professor Rodwin asserts:

Professor Marc Rodwin notes the possibility of balancing the inherent competing interests of the patient, physician, hospital, and society within a fiduciary framework, as long as doctors properly disclosed all relevant information to their patients.<sup>249</sup>

C. *"Hell No—I Want a Real Doctor" and Other Perturbations*

The proposed disclosure-facilitating rule admittedly carries with it possible complications. What if the patient, after being told of a resident's status, responds, "Hell no. I want a 'real doctor.'"? Now what? This is why it is important to reach an understanding with patients in advance so that if necessary, other arrangements can be made. Thus, if a patient demurs, the parties should consider trying to reach agreement on one of the following alternatives: an agreed level of resident participation; an understanding that the resident will not care for the patient; or, an understanding that the attending physician should primarily care for the patient without the resident's full participation. If the foregoing accommodations are not acceptable, then the attending physician overseeing the resident may, after providing reasonable notice to the patient affording a reasonable opportunity for care by other providers, want to consider withdrawing from the case if otherwise consistent with rules regarding the duration and termination of the physician patient relationship. In any event, patients should remember that it may, or may not, be true that a predictably (statistically) better outcome would be achieved at a non-teaching hospital as compared to a teaching hospital, even if the latter is staffed in part with residents.

The condition of the patient and the time pressures of emergency care may also be complicating factors. How does a resident disclose to an unconscious patient (or his surrogates) with a life-threatening gunshot wound who is rushed by ambulance to an emergency room?

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[H]ealth policy now focuses on the population rather than individual patients. Given the formidable costs of medical care and the increasing dependence of doctors on organizations that employ and pay for their services, physician loyalty is weakened for patients and strengthened for other parties. These facts suggest that the law may consider the interests of these other groups in the future and that other metaphors may more aptly describe patient-physician relationships. Nonetheless, there is reason to think that the law will continue to address strained physician loyalty within a fiduciary framework. It may impose limits on and stretch the fiduciary metaphor to reconcile obligations of doctors to patients with service to groups and society.

*Id.*

249. *Id.* at 255-56 (explaining that many fiduciaries have to balance varying interests of competing individuals or groups).



Should precious time during the “golden hour”<sup>250</sup> be spent educating accident victims (or their surrogates) about the nature of residency programs and graduate medical education?

There may also be questions about what information should constitute sufficient disclosure to entitle the residents to the more forgiving, experience-based standard of care. The disclosure should not depend on the patient specifically asking—“are you a resident?”<sup>251</sup> Nor should the resident be entitled to assume that everyone knows who the residents are and what the term “resident” means.<sup>252</sup> And, of course, the disclosure should be communicated directly to the patient (or surrogate).<sup>253</sup>

That said, we must remember that there are competing interests here. As Professor Mark Hall has counseled in another context, we must develop rules of medical disclosure that can reconcile legal idealism with economic necessity.<sup>254</sup> Educating residents in order to develop future specialists is essential to our health care system. At the margins, there may also be concerns that as disclosures proliferate to include potential conflicting interests—here, in the educational

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250. The “golden hour” is the sixty minutes following an injury. See E. Brooke Lerner & Ronald M. Moscati, *The Golden Hour: Scientific Fact or Medical “Urban Legend”*?, 8 ACAD. EMERGENCY MED. 758, 758 (2001) (explaining that the term reflects the belief that trauma patients have better outcomes if they receive medical care within an hour of sustaining an injury). The concept of the golden hour appears to have evolved during the Vietnam War, where the survival rate in medical facilities increased by two percent from previous wars and the time between injury and treatment was reduced to one hour, down from approximately five hours in the Korean War. *Id.* at 759.

251. For the classic statement on this in the informed consent context, see *Canterbury v. Spence*, 464 F.2d 772, 783 n.36 (D.C. Cir. 1972). The *Canterbury* Court states: “We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services.” See Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 563 (1997) (citing *Canterbury* and its theory that patients lack a level of sophistication necessary to apply caveat emptor in the arena of medical services, in rejecting a so-called “transparency standard” that obligates patients to ask questions of doctors when further explanation or clarification is needed).

252. See *supra* note 233 and accompanying text (referring to the passage in Gawande’s book, *COMPLICATIONS*, where he discusses how much easier it is to ask the necessary questions about a resident’s involvement in a surgical procedure when one has a medical background and thus an appreciation of who the “players” are in the surgical context).

253. Cf. *Grant v. Douglas Woman’s Clinic*, 580 S.E.2d 532, 534 (Ga. Ct. App. 2003) (stating that a doctor’s notation on the patient’s medical chart that the doctor had “nothing to add” did not constitute reasonable notice to the patient of the doctor’s unilateral decision to withdraw from the relationship and enable the patient to obtain substitute care).

254. See Hall, *supra* note 251, at 515 (discussing the compromise that exists when patients are on medical welfare or a more affordable form of limited, non-comprehensive health insurance because under these systems, patients no longer have complete financial autonomy to order any and all beneficial medical treatment available).

advancement of the resident—not only will patients be stressed and distracted by having to decide how to react, especially when a negative reaction may be perceived as impugning the professional standing of an inexperienced resident, but the overall effect may undermine the level of trust between the patient and the health-care professionals who care for him.<sup>255</sup>

How then might the contemplated resident disclosure be streamlined without it disintegrating into a rote “medical Miranda warning?”<sup>256</sup> Here are some suggestions as to how this might work. Medical workers should consider a global disclosure at the first meeting between the patient and a resident (or his supervising physician) with ongoing responsibilities.<sup>257</sup> Professor Hall has discussed the practical need for what he terms “bundling” of consent. “Bundled consent,” he says, is “how we now view a single decision to be hospitalized or to undergo surgery. These decisions are taken as

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255. See *id.* at 548 (commenting, in connection with disclosures of a physician’s potentially conflicting financial interests, that “[i]t is difficult to see how patient trust could survive ongoing disclosures of this nature, yet it is patient trust that informed consent is designed to foster,” and quoting the experience of one physician in an HMO gatekeeping capacity that “the collective impact of these negative encounters, though each in itself might have been minor, created a climate of suspicion, cynicism, readiness to fight, and a sense of being used that permeated my office in a way that I had not known before”).

256. Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 ARCHIVES INTERNAL MED. 2521, 2522 (1996) (asserting that “[a]s practiced, and certainly as symbolized by consent forms, informed consent is often no more than a medical *Miranda* warning”). The danger of the meaningless, rote disclosures is a special concern once a patient is admitted to a hospital. Professor Cathy Jones explains:

The actual process of informed consent falls even shorter of its theoretical goals, however, once the patient is admitted. At least two reasons contribute to this shortcoming: first, the “status” of the in-patient . . . . The second reason for the further decline in the application of the informed consent procedures once patients are hospitalized is that so much of what occurs in the hospital is “routine” (at least to the providers), and therefore, the providers do not deem formal disclosure and consent requirements to be necessary. The notion of routineness and lack of necessity to make disclosure or seek consent for many procedures performed on patients once they enter hospitals is reinforced by the admitting process.

Jones, *supra* note 156, at 404-06.

257. Hall contends:

Some global disclosure of cost containment incentives, rules, and mechanisms is required at the outset of enrollment, although this presently is not done. If such a disclosure can be accomplished, it would validate at least some subsequent cost containment decisions without the need for doctors to make (non)treatment-specific disclosures at the bedside. This results from either a bundled consent conception or from a waiver of consent conception. For either of these characterizations to hold, however, some meaningful choice must exist at the time of insurance enrollment, a choice that does not presently exist for many—perhaps the majority—of subscribers to managed care plans.

Hall, *supra* note 251, at 582.

entailing consent to hundreds of discrete events of testing, medication, and bodily examination during the course of what may be a rather long and complex episode of treatment.”<sup>258</sup> Bundling is consistent with modern “relational contracting” theory, which contemplates that:

[I]t is unrealistic to impose on patients and physicians the impossible burden of specifying the minutiae of an explicit contractual standard of medical practice. Instead, the law assumes that doctors, when they take on the care of a patient, automatically promise the bundle of unspecified treatment obligations entailed in customary professional practice. Patients cannot assert that they are not governed by the conventional practice standard simply because they lack specific notice of its content. When patients choose generalists over specialists, or choose non-physician allied health professionals or practitioners of holistic medicine, it is taken for granted that a lower or different standard of care applies without the need to specifically warn patients that superior care may be available elsewhere.<sup>259</sup>

Following the initial global disclosure and consent, specific additional disclosures might be appropriate. Medical residents with functional responsibility for a patient should disclose what his responsibilities will be in connection with general management of the patient’s care and with respect to each diagnostic or therapeutic medical procedure for which a separate, discrete disclosure or warning of the risks is required under the applicable rules of informed consent.<sup>260</sup> These disclosures should include information on the residents’ responsibilities for preoperative decisionmaking; actual performance of, or functional responsibilities for, surgical, diagnostic, or other discrete procedures; and the resident’s post-operative management and decisionmaking role.

A question may arise as to whether my test would require the disclosure of comparative performance statistics by the resident. In

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258. *Id.* at 559.

259. *Id.* at 560. Hall elaborates:

This practice is consistent with legal doctrine, which presumes that, by submitting oneself to treatment, a patient consents, absent any objection, to the many minor bits and pieces that make up the entire treatment encounter. This “bundling” concept of informed consent arises by legal implication even though the patient receives no risk/benefit disclosure about each of these component parts.

*Id.* at 553.

260. Recall that my suggested approach is not based on informed consent per se, but rather uses the scope of disclosure rules simply to define the range of appropriate disclosure in order to determine the standard of care that will be applied to medical residents.

general, I would say no. First, given the diversity of backgrounds and experiences among residents and the varied hospital settings in which they serve, it would seldom be feasible to attempt relevant statistical comparisons. Any attempt at statistical comparisons would also be thwarted by the fact that much of what a resident does will presumably have been done under some level of supervision, albeit of decidedly mixed quality, by more senior physicians. Morbidity and mortality outcomes may thus be a function of the quality and level of supervision and involvement by the attending physician overseeing the resident. Thus, performance outcomes may reflect other variables in addition to the capacities of the resident. On a heuristic level, there may also be cognitive biases and limitations that challenge patients' comprehension of statistical information,<sup>261</sup> especially when communicated in the highly stressful treatment environment.

The matter of residents and disclosure remains a quandary, as Dr. Gawande again forthrightly reminds us from the trenches:

We find it hard, in medicine, to talk about this with patients. The moral burden of practicing on people is always with us, but for the most part unspoken. Before each operation, I go over to the pre-operative holding area in my scrubs and introduce myself to the patient. I do it the same way every time. "Hello, I'm Dr. Gawande. I'm one of the surgical residents, and I'll be assisting your surgeon." That is pretty much all I say on the subject. I extend my hand and give a smile. I ask the patient if everything is going OK so far. We chat. I answer questions. Very occasionally, patients are taken aback. "No resident is doing my surgery," they say. I try to reassure. "Not to worry. I just assist," I say. "The attending surgeon is always in charge."

None of this is exactly a lie. The attending *is* in charge, and a resident knows better than to forget that. Consider the operation I

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261. See Hall, *supra* note 251, at 570-71. Hall comments:

Most lay people (and even many doctors) suffer from a number of cognitive biases and limitations in comprehending statistical probabilities, which include: . . . Giving disproportionate weight to memorable, personalized anecdotes—that Uncle Fred died from heart surgery is more important than all the other information; . . . Exaggerating risk information by disassociating it from its base rate of prevalence—harm to forty percent of people with condition X is viewed as a high risk, even though condition X is very rare; . . . Underestimating disjunctive probabilities and overestimating conjunctive ones—where there is a fifty percent chance of harm A and a fifty percent chance of harm B, people fail to perceive that the probability of either A *or* B occurring is seventy-five percent but the probability of A *and* B occurring is only twenty-five percent; and . . . Having different perceptions of the same odds depending on whether they are framed in positive or negative terms—five percent chance of failure vs. ninety-five percent chance of success.

*Id.*

did recently to remove a seventy-five-year-old woman's colon cancer. The attending stood across from me from the start. And it was he, not I, who decided where to cut, how to isolate the cancer, how much colon to take.

Yet to say I just assisted remains a kind of subterfuge. I wasn't merely an extra pair of hands, after all. Otherwise, why did I hold the knife? Why did I stand on the operator's side of the table? Why was it raised to my six-feet-plus height? I was there to help, yes, but I was there to practice, too. This was clear when it came time to reconnect the colon. There are two ways of putting the ends together—by hand-sewing them or stapling them. Stapling is swifter and easier, but the attending suggested I hand-sew the ends—not because it was better for the patient but because I had done it few times before. When it's performed correctly, the results are similar, but he needed to watch me like a hawk. My stitching was slow and imprecise. At one point, he caught me leaving the stitches too far apart and made me go back and put extras in between so the connection would not leak. At another point, he found I wasn't taking deep enough bites of tissue with the needle to insure a strong closure. "Turn your wrist more," he told me. "Like this?" I asked. "Uh, sort of," he said. I was learning.<sup>262</sup>

In addition to disclosures, both globally at the initial meeting and then again prior to the surgery to detail more explicitly the contemplated respective roles of the attending physician or surgeon and the surgical residents, there are a number of possible innovative techniques to facilitate patient comprehension of the information provided.<sup>263</sup> The point is that if a resident wishes to be judged by a more forgiving, experienced-based standard of care, then a sincere and reasonable effort to inform the patient about that resident's level of experience and contemplated involvement seems a suitable counterpoise.

#### CONCLUSION

Medical resident physicians are commonly named as defendants in connection with injuries suffered by patients who received treatment at hospitals, and vicarious liability claims against hospitals and others depend on whether their employee-residents had committed tortious

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262. GAWANDE, *supra* note 1, at 23.

263. See Jones, *supra* note 156, at 411-19 (mentioning that tape recording conversations between the physician and the patient, providing the patient with brochures or videotapes detailing the patient's proposed treatment, and ensuring that another person accompanies the patient in these conversations are among the possible techniques a medical caregiver can use to enhance a patient's understanding).

conduct. This Article explored the question of how the standard of care rules for medical residents should be formulated. More specifically, it asked the question of whether medical residents should be held to the level of expertise expected of reasonably competent generalist physicians, to specialists in the area of their residency, to a more subjective standard reflecting the level and stage of training of the particular resident physician in question, or in accordance with some other rule. These important questions have been given short shrift by the courts.

The question of the appropriate standard of care for medical residents is complicated by the presence of competing interests. This underlying tension springs from the need to accommodate two potentially antagonistic or dissonant goals. On the one hand, patients' health is, and their lives are, at risk because patients are treated by residents every day. A significant quantum of the health care in the United States is delivered by medical-school graduates who are engaged in post-graduate residency programs. But moving from the microcosm to the long-term perspective, the health and safety of us all depends on residents learning their profession in a comprehensive way. Residency programs are vital components in the education and training of physicians for the independent practice of medicine. This is particularly true for the growing majority of physicians today who undertake to practice a specialty. The challenge is to arrive at an approach that strikes a sensible balance between the health, safety, and autonomy of patients, while simultaneously accommodating the need for essential clinical education of residents. Analysis of these underlying conflicting interests has too often been absent, or at best, desultory and inconsistent.

In Part I of this Article, I provided an overview of medical residency programs. Part II briefly examined the approaches of the courts to the question of the standard of care for medical residents, and also a critical assessment of the potential use of the doctrine of informed consent to address the matter of the relationship between residents and patients. Part III proposed a different approach. Rather than mediate the matter of treatment by medical residents exclusively through either the standard of care or the doctrine of informed consent (or some other information-based theory of liability), I proposed a solution that melds the two doctrines.

This solution may be summarized as follows: when medical residents (both not-yet-licensed and licensed ones) fully disclose their status, including their experience, training, education, and

credentials, to their patients, their performance should then be judged by a standard of care commensurate with their *actual* level of post-graduate medical training, education, and experience. Licensed residents should, in addition and as a minimum, be held to the standard of a licensed general practitioner. A resident (either licensed or not-yet-fully-licensed) who either affirmatively misstates or fails to disclose his status will not be permitted to avail himself of the standard commensurate with his limited experience and training. If a resident affirmatively misrepresents his credentials and experience, then he should at least be held to the standard corresponding to the professional background that he claims to possess. When a resident fails to appropriately disclose his status, a not-yet-fully-licensed resident should be held to the standard of care expected of a fully-licensed physician who has completed his internship. A non-disclosing licensed resident actively participating in a graduate medical program to prepare him for a medical specialty should be held to the standard of the specialty covered by his residency program when serving the capacity of a specialist, unless he can prove that the patient's reasonable expectations were of some less-demanding standard, in which case he will be held to a standard commensurate with those expectations.

I believe that the foregoing approach represents a sensible compromise between the competing interests of the safety of those patients that are being treated by residents, and the longer term interests in a health-care system that can offer its patients treatment by well-trained physicians, particularly specialists. The contours of the suggested approach also afford a predictable and workable standard to the courts, physicians, and patients.