

inside...

Residents in a
Liability Context
..... page 3

RISE: Risk
Management
Grant Award
Program
..... page 4

Lessons Learned
..... page 5

Risk Management
and Resident
Education
..... page 6

Continuing
Education
..... page 8



Lifespan Risk Management

www.lifespan.org/risk

167 Point Street
Suite 170
Providence, RI 02903

tel: (401) 444-8273

fax: (401) 444-8963

into risk management

Teaching Residents to Ask for Help

One of the most frequent issues found in claims involving residents is the failure to go up the chain of command.

In this interview, Dominick Tammaro, MD, residency director for the Division of General Internal Medicine, discusses his division's efforts to incorporate this important lesson into residency training and to reduce barriers to asking for help.

Joan Flynn, Director, Risk Management, AMC:

What do you think some of the reasons are for residents being reluctant to go up the chain of command and what do you think can be done to get around those barriers?

Dr. Tammaro:

I think the barriers go from the real simple to the more complex. A simple barrier is not knowing who to call. During the day it is pretty easy: there is no rotation where there is not a more senior resident supervising an intern, a chief resident available to guide that senior resident, and an attending responsible for the admissions. An attending is backing up the chief resident or one of the program directors is available so there are many layers of hierarchy. However, at night, knowing who is on-call can be more of a problem. So we put our division of general internal medicine schedule on our residency website so from any computer in the hospital you click and you can see exactly who the attending is, and what their pager is. That has really helped.

J. Flynn:

Does someone keep that updated if someone begs off?

Dr. Tammaro:

It is always updated. One person in our division has not only the responsibility for doing it but she also has access to the hospital's intranet so if someone says "I'm switching my day with someone" they e-mail it to her. She makes the change right on the website and it gets updated. The second thing I think is that there is still somewhat of a complexity of getting in touch with the attendings at night. There is this sense that I shared when I was a resident that "I'm going to handle this." "I can handle this." Every time a resident calls me at home almost without exception they say, "I'm sorry to bother you." I'm glad they are calling me.

J. Flynn:

It seems that the biggest barrier is the concern that, "I should know how to do this and if I call somebody they are going to think I don't know what I'm doing." So does the intern call the more senior resident and then does it go up the chain of command?

Dr. Tammaro:

Most of the time, everybody works as a team so if there is an issue that an intern has it is really an issue that the intern and the resident have and that is when they call the senior person. In any given

continued on page 2

month, one of our general medicine faculty is assigned to each of those teams.

Each team is on-call for admissions every fourth night. Our practice for a couple of years has been that the on-call attending whose team is doing admissions calls the resident to check in. We are preempting the residents calling us and we find that residents feel free to discuss cases with us that maybe they wouldn't have called us on. Nine times out of ten, the residents have properly identified and dealt with the cases but since they already have us on the phone, they may take the opportunity to double-check their decisions. Sometimes the management of the case gets changed but even if it doesn't, I found that the residents appreciated the check-in by the attending, and it is starting to break down some of the barriers about calling.

J. Flynn:

How about barriers between junior and senior residents?

Dr. Tammaro:

The expectation is that they are working as a team. For example, on nights we have two interns, one for Med A and one for Med B. They are supervised by a senior resident. There is a second-year resident who just does admissions who can use the senior resident for back-up and questions. They are here from 8pm to 8am, so they are often running into each other and discussing patients.

The addition of the Medical Admitting Resident in the Emergency Department (ED) has also helped, as the residents on the units no longer have to juggle the role of admitting ED patients with taking care of patients on the floors.

J. Flynn:

How do you achieve balance between giving residents maximum opportunities to learn while protecting patients from harm?

Dr. Tammaro:

We identify residents that need closer supervision and I communicate that to attendings at the beginning of each month. We have when necessary delayed transition of individuals from an intern to the second year. We had them stay as an intern and when they became a second year resident, they were not permitted to work independently. They worked with the senior resident as their partner. The senior resident would go through the cases with them and would approve the plan or change it with them.

J. Flynn:

What are residents expected to do if they have problems being able to go up the chain of command? Let's say they have a personality conflict with the senior resident. Do you mediate that or is it something they must learn to live with?

Dr. Tammaro:

Absolutely, there is someone to help mediate, and it depends on the type of conflict and the setting. Generally, whoever takes the first step will usually bring it up to one of the chief residents. The chief resident will probably counsel that individual to talk with the other and maybe give him some advice to see how things go. If things aren't resolved to a satisfactory degree or if there are acute issues in terms of things they could do better or if patient safety is at stake, then the chief resident will intervene. Then depending on how things go with the chief resident they will get one of the program directors involved as well. Another individual is also in the loop. Every ward team has a service attending. Often times depending on the service attending, they will get involved and it might be that instead of going to the chief residents, the resident or the intern will either bring it up to the service attending or more often than not it's the service attending that sees a problem and says "we have to sit down and have a discussion." That is often how some of the issues you are

describing get brought to light because it is the service attending who is working with these teams day after day that sees there is an issue that needs to be addressed. We have also increased the number of attendings on weekends—now we have two on Saturdays and two on Sundays—which is better in a lot of ways. It's better supervision because when the residents have a question on a patient because there are two of us, an attending will get to that patient sooner. I'm going to get to that patient and have some advice for that resident. So we are able to provide more time for the supervision of the residents because we are there more.

J. Flynn:

If you were going to give one major bit of advice to residents about how to make sure you are asking for advice or being aware of what your capabilities are and what they aren't what would you say to them?

Dr. Tammaro:

I would say the threshold for calling someone for advice should be low. If the person you call agrees with you, you have confirmed your decisions. If they have something to add, you have improved your care of the patient. ✨

Risk Management staff

is available to provide risk management education to clinical departments, hospital departments, medical staff and meetings at any one of the Lifespan affiliated institutions. Foundation requests should be directed to **Peggy Martin**, Sr. Risk Management Coordinator, Lifespan Risk Services.

E-mail: pmartin2@lifespan.org

Phone: 444-6491

Residents in a Liability Context

—by David Carroll, Esq., Roberts, Carroll, Feldstein & Peirce, Providence

Overall, state Supreme Courts have decided relatively few issues regarding professional liability for resident-level physicians, and the legal literature offers limited comment on residents. In this context, the following discussion of residents' legal concerns is drawn from an amalgam of case law and anecdotal experience. These cover the liability exposure of residents, their employers and supervisors, and their medical record entries.

Professional status

Rhode Island is abundantly clear as to the professional status of residents caring for patients. In *Baccari v. Rhode Island Hospital, et al.*,¹ the Supreme Court of the State of Rhode Island enunciated the standards to which a resident will be held, by stating:

“In this jurisdiction, residents are held to the same duty of care as other physicians.” *Id.* at 264.

The Court went on to state that residents are not held to a lesser duty of care than physicians with unlimited licenses. Thus, a resident physician is held to the standard of a fully licensed physician from the very first minutes of his or her residency. As a fully licensed physician, one is expected to live up to a certain standard of care when treating patients. That standard of care has also been described by the Supreme Court of the State of Rhode Island:

“[A physician must bring to the patient] that degree of care, skill and knowledge which is possessed by the reasonably competent physician in his or her specialty during [the time when the alleged malpractice took place] under like or similar circumstances having due regard for the state of scientific knowledge at that time.”²

Note that the Rhode Island Supreme Court holds residents not to the level of the *average physician*, but to the level of a *reasonable physician*. Accordingly, if a range of reasonable options within the standard of care is available to a resident, the resident is mandated to exercise judgment in selecting one of the reasonable options, but not necessarily

the “average” or most popular one. In other words, even if 6 out of 10 physicians would select a particular course of care and treatment, the resident may select another option if such option was one that a reasonable doctor would adopt.

Vicarious liability

Residents accepted into a hospital's residency program, generally, have contracts with the hospital that specify the length of the residency, compensation, and other specifics about their employment relationship with the hospital. Indeed, such residents are employees of the hospital during the term of the contract. By law, hospitals are responsible for each and every act—or failure to act—of their employees, including resident physicians, as long as such action is within the scope of their employment.

Thus, if a resident, while caring for a patient, does not adhere to the standard of care, the hospital is liable for the action or failure to act of such resident. Under the law, the resident need not actually be named as a party in the lawsuit for the hospital to be found responsible for such resident's activities in caring for a patient. This is called “vicarious” liability.

Residents often wonder if their employer hospital would sacrifice the resident to protect itself in a malpractice case. The simple answer is that, while a resident is acting within the scope of his or her employment with the hospital, the hospital is in legal unity with the resident—the interests of the hospital are identical to those of the resident. Thus, the hospital could not and would not separate itself from the resident in a lawsuit.

Captain of the ship

The medical doctrine of “Captain of the Ship” (i.e., one physician is responsible for the acts of all subordinates) has never been legally adopted by Rhode

Island. In fact, as recently as 1999 the Rhode Island Supreme Court reaffirmed the fact that such doctrine is not automatically accepted in this state. In *Lauro v. St. Joseph Hospital, et al.*,³ the Court indicated an attending (i.e., “captain”) would only be liable if he or she controlled the work or conduct of the personnel who supposedly caused harm to the patient. The decision suggested that, if the plaintiff had proof that an attending controlled *in detail* what another physician did, then the attending could be held responsible for the actions of the physician, who was acting as the attending's agent.

...any physician who has reasonable confidence in the skill and training of a particular resident would not be liable for the resident's care even when that physician is in a supervisory role

Unfortunately, the Court's decision in *Lauro* creates uncertainty about “captaincy” as one can easily envision future cases hinging on a hair-splitting analysis over the degree of detailed control a particular attending exercises over the work or conduct of the resident.

Supervision of residents

Attending physicians frequently ask whether their supervision of residents increases their potential liability, and the answer is yes. That does not mean, however, as discussed above, that the attending is the “captain of the ship” who is responsible for all of a resident's actions. If a resident is specifically carrying out the directives of an attending, it is the attending who is legally responsible because the resident, as the attending's agent, is acting on the attending's behalf. On the other hand, a resident would have separate liability, even if carrying out an attending's orders, if the resident followed those orders, knowing that the orders were contrary to good medical practice.

continued next page

From the attending physician's perspective, any physician who has reasonable confidence in the skill and training of a particular resident would not be liable for the resident's care even when that physician is in a supervisory role. The resident would be liable for his or her own substandard care. Obviously, a resident who on his or her own engaged in activities which exceeded the level of his or her training and experience would be liable if the care was carried out negligently.

Residents' notes

Residents often argue that the note that they put in the hospital chart should be viewed in light of their status and experience, implying a certain leeway should be granted for inexperience. But, as explained above, the courts hold a resident to the level of a fully licensed physician, including medical record documentation. Anecdotal experience indicates that jurors give great weight to the opinions of a resident.

For example, in Rhode Island, a suit was brought against a hospital, a drug company, and a physician alleging that the

drug company did not supply sufficient warnings as to a side effect of the medication prescribed to a patient pregnant with twins. A resident—in the first month of his first year of residency—wrote in the medical record that the twins, who were born following the use of such medication, were compromised by fetal hydantoin syndrome. The hospital note bearing the resident's opinion was submitted to the jury for consideration. Despite hearing compelling expert testimony to the contrary, disassociating the twins' condition from both the syndrome and medication, the jury accepted the diagnostic note of the one-month resident.

Conclusion

While their colleagues, employers, and even patients may perceive residents as physicians "in training," the legal system treats residents as fully competent—and responsible—health care providers. Fortunately malpractice suits are relatively rare; nevertheless, awareness of potential liability in a teaching environment is useful protection for hospitals, residents, and attending physicians. Loss prevention strategies for

hospitals and medical staff begin with proper selection of residents, and the careful assessment of their skills throughout their training. It is also important to provide instruction to attending physicians and residents on teaching and supervising other residents, and creating a non-punitive environment in which all members of the healthcare team feel comfortable asking for assistance or clarification.

In addition, residents need to be realistic about their own skills as they proceed through training. Asking for assistance when uncertain, establishing their own relationships with patients by reviewing and practicing good communication and interpersonal skills, and documenting the care rendered and the rationale for treatment decisions will help them limit their own liability, and the potential liability of those who supervise them and the healthcare facilities where they practice.

1 *Baccari v. Rhode Island Hospital, et al*, 741 A.2d 262 (R.I. 1999).

2 *Sheeley, et al v. Memorial Hospital, et al*, 710 A.2d 161 (R.I. 1998) at 165.

3 *Lauro v. St. Joseph Hospital, et al*, 739 A.2d 1183 (R.I. 1999). ☀

Rhode Island Sound Enterprises Insurance Co., LTD (RISE) Risk Management Grant Award Program

Each year grants are awarded for funding of specific educational/research action projects or a single capital expenditure. They are awarded on an annual basis for one year and must be related to patient safety, and professional or general liability.

A subcommittee of the Lifespan Quality Oversight Committee acting as the Risk Management Grant Advisory Committee has announced the awarding of three grants for 2003.

Proposals approved for funding include:

"Improving the reliability and safety of Emergency Department triage" submitted by Andrew Sucov, MD, Emergency Department, RIH

"Liability prevention for Hasbro Hospital staff: practical strategies for youths with mental health and

substance abuse issues" submitted by Joseph V. Penn, MD, Director of Child and Adolescent Forensic Psychiatry, RIH

"Developing a training curriculum to educate hospital staff and leadership on appropriate use of trained medical interpreters" submitted by William J. Kirkpatrick, LICSW, Clinical Social Work & Interpreter Services, AMC

The Committee extended its congratulations to those whose proposals were accepted and acknowledged its appreciation to all those who submitted proposals for their efforts to identify opportunities to decrease liability exposure.

For information about the grant program and how you can apply, contact Peggy Martin at Lifespan Risk Services, 444-6491 or pmartin2@lifespan.org.

Lessons Learned

—by Alan R. Tate, Esq., Tate & Associates

The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, but should have some relevance to situations that you may encounter.

CASE

A seven-week-old male infant was brought to his pediatrician's office with complaints of increased irritability, decreased PO intake, and a temperature of 100.6 (rectally). The infant was born prematurely at 30 weeks gestation via emergency cesarean section; his mother was Group B Strep positive. At birth, he was admitted to the Special Care Nursery and administered IV Ampicillin and Gentamicin prophylactically for 48 hours, until his cultures returned negative. He remained in the Special Care Nursery for one month, and his discharge diagnoses included prematurity, intrauterine growth retardation, and periventricular leukomalacia.

At the pediatrician's office, a second-year pediatric resident, who was completing his clinic rotation in the office, examined him. Based on the history relayed to him, as well as his examination of the infant which included the finding of a bulging fontanelle, the resident decided that evaluation at the local hospital emergency department (ED) was indicated for a septic work-up to rule out meningitis.

The pediatric resident expected that the infant's condition would result in admission to the hospital. The resident discussed his opinion with the attending pediatrician in the office (who was not the infant's regular physician). The office resident also telephoned the hospital to alert the pediatric resident-on-duty in the ED of the patient's impending arrival.

The ED pediatric resident (in consultation with an ED attending) evaluated the infant. This attending thought the child should either be admitted or be sent home with antibiotics. She discussed this with the pediatric resident, then ended her shift; a second attending took over.

Later that afternoon, the resident who had seen the infant in the pediatric office went to the emergency room and spoke with the pediatric resident in the ED. He was informed that the infant's physical examination was normal, his fontanelle was full but not bulging, laboratory results were within normal limits—although the gram stain results were not yet available. The lumbar puncture was essentially normal.

Subsequently, the ED resident, under supervision of the ED attending, telephoned the pediatrician who had assumed coverage for the group that night—but was not the infant's regular pediatrician—and informed him of the findings. The pediatrician indicated that, since the septic work-up was negative and the infant was afebrile, he should be discharged home without antibiotics.

Accordingly, the child was discharged in the early evening hours. Early the next morning, the infant was found apneic at home and transported to the ED via rescue. He was resuscitated and admitted to the PICU. After 10 days, he died.

A gram stain from the original ED visit was reported on the day of admission as positive for Group B Strep.

DAMAGES

Untimely death.

LIABILITY

The plaintiffs claimed that the infant's fever, the pediatric office resident's finding of a bulging fontanelle, the infant's prematurity, and the mother's positive test for Group B Strep, made the risk of infection high enough to merit having the infant admitted, or discharged with antibiotic coverage.

The ED pediatric resident saw bacterial infection as unlikely because the child was seven weeks of age (perhaps not considering prematurity as a factor). The first ED attending told the infant's mother that her baby was going to be treated with an antibiotic—either as an inpatient or outpatient—based on pending laboratory results. However, after the ED pediatric resident later consulted with the (private) covering pediatrician, the infant was discharged without antibiotics.

RISK MANAGEMENT ISSUES

Gaps in communication among the care team were a vital factor in this case. Several physicians were involved in the care of this infant, none of them his regular pediatrician, and none may have had full understanding of the patient's history, the care plan, and the care actually provided. Who shared what information with whom is not clearly revealed in the record; some providers were unaware of the infant's history of prematurity and the mother's Group B Strep status. Some thought antibiotics would be ordered; others did not. The physician covering for the child's primary pediatric group—who made the decision to discharge the infant from the ED without any antibiotic—was, apparently, unaware of crucial information.

continued next page

Lessons Learned continued from previous page

Several factors contributed to the communication difficulties in this case:

The infant's care was managed by two pediatric residents under the direction of three different attending physicians.

The continuity of the infant's care in the ED was interrupted due to a shift change among the attending physicians. There is no evidence that the resident advised this second attending that antibiotics were not ordered.

Largely because of lack of documentation, it is unclear what information was imparted to each physician: (e.g., the covering pediatrician indicated that he was never told by the pediatric resident of the mother's positive Group B Strep finding, nor of the baby's prematurity) Some physicians were unclear whether the infant would be admitted

or discharged from the ED and whether he would be discharged on antibiotics or not.

This case points out the need for clear communication among mutual caregivers of pertinent history, physical findings, and assessment and treatment plan—both in the record and in conversation. Equally as important as writing it down, is picking it up: even the best documentation will not contribute to good patient care unless providers read it and use it to make subsequent treatment decisions. This is perhaps even more important when physicians see patients with whom they are not familiar.

OUTCOME

A financial settlement was reached prior to institution of a lawsuit.

Risk Management and Resident Education

—*Peggy Berry Martin, MEd, Sr. RM Coordinator, Lifespan Risk Services and Jennifer Doyle, MA, Director of Educational Development & Evaluation, Departments of Graduate Medical Education and Surgery, Beth Israel Deaconess Medical Center, Boston*

A seven-week old infant born at thirty weeks to a mother positive for Group B Strep was seen in both the pediatrician's office and the emergency department. Five attending physicians and two residents made care decisions for this infant. The next day he was found apneic at home and brought back to the ED, was admitted and died. The resident in the ED was the only care provider who had all the information necessary to create and carry out this infant's care plan. (see case discussion above)

Risk management discussions and articles are full of examples of good and substandard patient care, and of physician-patient communication that contributed to good care and some that was inadequate and resulted in less than satisfactory patient outcomes. In any healthcare setting where physicians-in-training care for patients, accurate diagnosis and delivery of good care requires the exercise of skills in communica-

tion and self-reflective practice as well as medical knowledge and technical expertise.

For decades, medical journals have been full of the risks inherent in the academic teaching environment. The "tightly-coupled system" of graduate medical education and delivery of care by residents, has created circumstances "where errors in one part of the system place other components at significant risk."¹ Lawsuits involving residents frequently highlight their inexperience, often compounded by failures in communication with other providers who may have assisted with their patients' care. As such, these cases can become good teaching material, illustrating both good and questionable care and suggesting strategies to prevent similar occurrences.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) endorsed six general competencies for residents in the areas

of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. For the past several years, these general competencies have been incorporated into the ACGME's requirements for accrediting residency programs. Residency programs were required to "define specific objectives for residents to demonstrate learning in the competencies" listed above, by June, 2002. Residency programs were to begin "integrating the teaching and learning of competencies into residents' didactic and clinical educational experiences as needed to ensure learning opportunities."

Currently (between July 2002 and June 2006), programs are expected to "provide learning opportunities (as needed) in all six competency domains."²

While the residency programs in the Lifespan hospitals have for years

provided rich and varied opportunities to learn and demonstrate the required competencies, the Risk Management Department may be overlooked as a source of resident edu-

cation. However, if we look closely at the definitions of the required competencies, it is clear that material from claims, incidents, near misses, and patient complaints—the

stuff that risk management education is made of—is a useful and available resource. The table below lists each competency and available risk management education programs.

ACGME Competency	Some Related RM Topics
<p>Patient Care Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.</p>	<p>How to listen; Delivering bad news; Who can consent to care</p>
<p>Medical Knowledge Residents must demonstrate knowledge about established and evolving biomedical, clinical, cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.</p>	<p>Cognitive factors in cases of failure to diagnose; Helping patients deal with uncertainty</p>
<p>Practice-based Learning and Improvement Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.</p>	<p>Giving and asking for feedback; Documenting in special circumstances; Role of residents in early reporting of adverse events</p>
<p>Interpersonal and Communication Skills Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.</p>	<p>Dealing with challenging patients; How to listen; What is informed consent</p>
<p>Professionalism Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population</p>	<p>Medical decision-making; When and how to use interpreters; Confidentiality of patient information</p>
<p>Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value.</p>	<p>Recognizing systems issues that can lead to physician liability; Safe consulting; Liability in office practice setting</p>

The risk management staff, with an archive of closed cases and years of experience in claims management and loss prevention, is an important source of material for residency programs as they continue to put together teaching opportunities ad-

ressing these competencies. This material will become increasingly important to attending physicians also. The American Board of Medical Specialties has adopted the ACGME competencies as criteria for recertification of practicing physicians.

References

1. Perrow, C. *Normal accidents: living with high-risk technologies*. New York: Basic Books, 1984, quoted in Battles, JB, Shea, CE, "A system of analyzing medical errors to improve GME curricula and programs". *Academic Medicine*, 76(3), Feb 2001, pp. 125-6.
2. ACGME Outcome Project. Retrieved September 10, 2003. <http://www.acgme.org/outcome/comp>



“Case Studies in Risk Management,” A monthly CME program for physicians Second Tuesday of the month, Collis Conference Room, 12 noon to 1pm

Beginning Tuesday, February 10, 2004, Rhode Island Hospital Department of Continuing Medical Education and the Risk Management Department will present a monthly one-hour program for physicians. Case studies from actual and potential claims will be discussed and pertinent loss prevention strategies will be reviewed.

Bring your lunch. Cold drinks and dessert will be provided.

Rhode Island Hospital is accredited by the Rhode Island Medical Society to sponsor intrastate continuing medical education for physicians.

Rhode Island Hospital designates this continuing medical education activity for a maximum of 1 category I credit toward the AMA Physician's Recognition Award.

Each physician should claim only those credits he/she actually spent in the educational activity.

Rhode Island Hospital fully intends to comply with the legal requirements of the Americans with Disabilities Act. If any participant of this conference is in need of accommodation, please contact the Rhode Island Hospital CME office at (401) 444-4260.

This CME activity is also designated for a maximum of 1 category I credit in Risk Management.

Program Dates

February 10
March 9
April 13
May 11
June 8
July 13
August 10
September 14
October 12
November 9
December 14

Insights is published quarterly by Lifespan Risk Management department. Submissions and ideas are welcome and may be submitted to Peggy Martin via e-mail: pmartin2@lifespan.org or fax: (401) 444-8963.

editorial committee chairperson: Peggy Martin

committee members: Paul Adler, Joan Flynn, Rick Almeida, Joseph Melino and Roland C. Loranger

design: Ellen Watt/IGN

Lifespan
Risk Management
167 Point Street
Suite 170
Providence, RI 02903



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