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LAW AND SOCIETY

Yogyakarta, 04 – 07 April 2017

LP3M & Faculty of Law Universitas Muhammadiyah Yogyakarta
2017
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ASSALAMU’ALAIKUM
WARAHMATULLAHI WABARAKATUH,

In the Name of Allah, the most Gracious and the most Merciful. Peace and blessings be upon our Prophet Muhammad (S.A.W).

First and foremost, I felt honoured, on behalf of the university to be warmly welcomed and to be given the opportunity to work hand in hand, organizing a respectable conference. Indeed, this is a great achievement towards a warmers multilateral tie among Universitas Muhammadiyah Yogyakarta (UMY), International Islamic University Malaysia (IIUM), Universiti Islam Sultan Sharif Ali (UNISSA), Universiti Sultan Zainal Abidin Malaysia (UNiSZA), Fatoni University, Istanbul University, Fatih Sultan Mehmet Vakif University and Istanbul Medeniyet University.

I believe that this is a great step to give more contribution the knowledge development and sharing not only for eight universities but also to the Muslim world. Improving academic quality and strengthening our position as the procedures of knowledge and wisdom will offer a meaningful contribution to the development of Islamic Civilization. This responsibility is particularly significant especially with the emergence of the information and knowledge society where value adding is mainly generated by the production and the dissemination of knowledge.

Today’s joint seminar signifies our attempts to shoulder this responsibility. I am confident to say that this program will be a giant leap for all of us to open other pathways of cooperation. I am also convinced that through strengthening our collaboration we can learn from each other and continue learning, as far as I am concerned, is a valuable ingredient to develop our universities. I sincerely wish you good luck and success in joining this program.

I would also like to express my heartfelt thanks to the keynote speakers, committee, contributors, papers presenters and participants in this prestigious event.

This educational and cultural visit is not only and avenue to foster good relationship between organizations and individuals but also to learn as much from one another. The Islamic platform inculcated throughout the educational system namely the Islamization of knowledge, both theoretical and practical, will add value to us. Those comprehensive excellent we strived for must always be encouraged through conferences, seminars and intellectual-based activities in line with our lullaby: The journey of a thousand miles begin by a single step, the vision of centuries ahead must start from now.

Looking forward to a fruitful meeting.

WASSALAMU’ALAIKUM WARAHMATULLAHI WABARAKATUH
Alhamdulillah all praise be to Allah SWT for his mercy and blessings that has enabled the Fakultas Hukum, Universitas Muhammadiyah Yogyakarta in organizing this Inaugral International Conference on Law and Society 6 (ICLAS 6).

This Conference will be providing us with the much needed academic platform to discuss the role of law in the society, and in the context of our two universities, the need to identify the role of law in furthering the progress and development of the Muslims. Muslim in Indonesia and all over the world have to deal with the ubiquity of internet in our daily lives life which bring with it the advantages of easy access of global communication that brings us closer. However, internet also brings with it the depraved and corrupted contents posing serious challenges to the moral fabric of our society. Nevertheless, we should be encouraged to exploit the technology for the benefit of the academics in the Asia region to crat a platform to collaborate for propelling the renaissance of scholarship amongst the Muslims.

This Conference marks the beginning of a strategically planned collaboration that must not be a one off event but the beginning of a series of events to provide the much needed platform for networking for the young Muslim scholars to nurture the development of the Muslim society.

UMY aims to be a World Class Islamic University and intend to assume an important role in reaching out to the Muslim ummah by organising conferences hosting prominent scholars to enrich the development of knowledge. This plan will only materialise with the continuous support and active participation of all of us. I would like to express sincere appreciation to the committee in organising and hosting this Conference.
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Safeguarding Patient Safety: A Need to Re-Examine the Legal Responsibilities of Medical Trainees

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ABSTRACT

Although possessing the basic skills of practicing medicine, the post of 'medical trainees' are considered to be transitory until they metamorphose into fully qualified medical doctors. Thus, the medical training period tends to be crucial as it serves as a platform for the trainees to gain all the required practical knowledge and skills in treating the patients. During this period, medical trainees may be vulnerable to risks of medical errors, particularly, if they are not well supervised and are subjected to perform tasks that are beyond their capability. Many other factors such as heavy workload, fatigue and carelessness could lead to preventable medical errors causing patient safety to become compromised. Medical trainees may also find themselves exposed to law suits although the potential of being individually liable would be rare due to their status which is still considered as equivalent to 'students' under training. Nevertheless, the implications of medical errors may lead to patients' suffering physical injuries and also death in which their supervisors and hospitals may be held vicariously liable for their actions in the court of law. Subsequently, legal and judicial intervention have thus, become more prevalent in cases involving medical trainees as courts in various jurisdictions such as the United States, Canada and England have imposed high standard of care to be adhered to by medical trainees. Therefore, in safeguarding patient safety, it is imperative that medical trainees strive to attain the highest professionalism at all times in respecting the goals of patient safety and the demands of legal standards.

Keywords: Patient Safety, Medical Trainees, Medical Errors

I. Introduction

Medical training period is considered to be a crucial period for the medical trainees to gain the relevant practical experiences in order for them to obtain recognition as fully qualified doctors, which will eventually determine their future in the medical fraternity. In completing this training period, medical trainees have to be prepared physically and mentally to adapt with the new environment and challenges ahead. Strength and endurance are major attributes which they need to possess to complete the tasks given while training at various departments. However, during this period, they may be prone to commit medical errors if they are not supervised properly and given tasks to perform that are beyond their capability. Failure to complete the tasks given to them properly and efficiently may subsequently cause harm to the patient, and patient safety, may thus, be compromised. Thus, it is imperative that medical are fully guided and supervised by their superiors in order to avoid any untoward consequences that may lead to possibilities of a negligence suit.

II. Discussion

2.1 Definition of “Medical Trainees”
The word “trainees” means “someone who is being trained”, “a person undergoing training” [1]. “Medical trainees” means “a registered doctor under training”. In Malaysia, the term medical trainee is replaced with houseman or house officer. “House officer” means a medical practitioner undergoing internship training under the Medical Act 1971. “Housemanship” or “Internship” is the period of resident medical practice before full registration and it is only imposed after graduation. The house officers, need to complete their training for two years to enable them to gain the appropriate knowledge, skill and experience before they are fully registered and recognised as medical officers [2].

On the other hand, the term “medical residents” is much more commonly used compared to “medical trainees” in the United States of America and common law jurisdictions. The term “resident” has been defined as physician who has finished medical school and is receiving training in a specialized area, such as surgery, internal medicine, pathology, or radiology. Board certification in all medical and surgical specialties requires the satisfactory completion of a residency program and successful completion of a specialty board examination [3].

2.2 An Overview of Medical Errors Committed by Medical Trainees

The US Institute of Medicine (IOM) reports that medical errors can occur at any stage of care, including diagnosis, treatment and preventive care. Diagnostic errors can occur in circumstances when there is (i) a mistake or delay in clinical diagnosis; (ii) is a failure to act on the results of monitoring or testing; (iii) there is a use if outmoded tests. On the other hand, treatment errors can occur in (i) administering a procedure or in a surgical intervention; (ii) avoidable delay in treatment; (iii) the dose or method of using a drug; (iv) inappropriate care for a disease.

Likewise, preventative errors can occur when there is inadequate monitoring, follow-up or by not providing prophylactic treatment. Further, there can be many other forms of medical error caused by communication failure; equipment malfunction; implications of fatigue and infection control. Moreover, medication errors can occur during the processes of prescribing, dispensing, administering, monitoring and system and management control [4]. With regards to medical trainees, the Archives of Internal Medicine, [5] the top contributing factors in resident errors can be seen as follows:

<table>
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<th>CONTRIBUTING FACTOR</th>
<th>ERRORS CONTRIBUTED TO</th>
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<tbody>
<tr>
<td>Judgment error</td>
<td>173 (72% of cases examined)</td>
</tr>
<tr>
<td>Memory or vigilance error</td>
<td>137 (57% of cases)</td>
</tr>
<tr>
<td>Lack of technical competence or knowledge</td>
<td>139 (59% of cases)</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>129 (54% of cases)</td>
</tr>
<tr>
<td>Hand off problems</td>
<td>46 (19% of cases)</td>
</tr>
<tr>
<td>Excessive workload</td>
<td>46 (19% of cases)</td>
</tr>
</tbody>
</table>

Note: Multiple factors could be present when an error was made.
Source: “Medical Errors Involving Trainees,” Archives of Internal Medicine, Oct. 22

In Malaysia, despite recognition of these risk factors, information about the types and causes of errors committed by medical trainees are rather limited. This knowledge gap inhibits the design of effective prevention strategies, such as targeted educational programs and system changes to reduce trainee errors and the advancement of patient safety.
2.3 Causes and Implications of Medical Errors committed by Medical Trainees
a. The Causes of Medical Error Committed by Medical Trainees

Among the factors and causes of stress perceived by housemen include poor work and social
life balance, annoying non-clinical personnel, medico-legal threats, high patient load, frequent
night duties, insufficient salary, inadequate time to be spend with friends and family, annoying
patients and relatives, work overload, lack of financial progress, death of a patient under care,
substandard living condition in the housemen quarters, unappreciative patients, sleep depre-
vation, frequent on-calls, and poor interaction with consultants. However, for the purpose of this
paper, focus will be made on four main causes namely (i) lack of supervision; (ii) excessive
workload; and (iii) fatigue and carelessness.

1) Lack of Supervision and Knowledge Gap

Among the causes of medical errors committed by medical trainees is lack of supervision from
the superior. In Malaysia, the house officers have to report to almost six or seven departments
during their two years of housemanship. Most of the medical officers and specialists are willing to
guide them patiently but the reality, treatment towards the medical trainees by their superiors may
vary. Some superiors tend to have high expectations of them in terms of knowledge and capabili-
ties. As such, the house officers are expected to handle their patients independently with minimal
supervision. As this point, medical trainees may face tremendous difficulties in trying to bridge
the gap between the theories which they had learned in medical school and the practical realities
occurring at the hospitals. As such, lack of supervision may ultimately cause patient safety to be
compromised [6].

2) Excessive Workload and Fatigue

Further, many trainees also work for long hours due to the excessive workload given to them.
Basically, long working hours and not getting enough rest will cause physical and mental health
issues such as excessive tiredness or fatigue, physical illness, weight loss, eating disorders, anxiety,
irritability or depressed mood, withdrawal or self-neglect, and disturbed behavior which shall
indirectly affect the performance of the medical trainees. In addition, there is some reported news
of the motor vehicle accidents suffered by the medical trainees involving death cases attributable
to fatigue. Most housemen also suffer excessive tiredness or fatigue since they need to adhere to
a substantial number of night duties causing the deprivation of proper rest and sufficient sleep.
Sleep deprivation and being under constant stress may ultimately affect patients’ well-being [7].

3) Carelessness

Another cause for medical errors to be committed by the medical trainees is carelessness.
Basically, lack of supervision, excessive workload and fatigue will indirectly lead to carelessness
committed by the medical trainees. Undeniably, carelessness will also happen due to several
factors such as insufficient knowledge and lack of focus on part of the medical trainees them-
selves. Medical trainees must avoid carelessness at all costs as it may contribute to the loss of life
and death to the patients. Carelessness must be avoided to prevent greater harm leading to
physical harm and the loss of lives.

b. The Implications of Medical Error Committed by Medical Trainees

Medical residents may face legal liabilities for alleged negligence during the course of their
official duties; and their supervisors are at risk for either direct or vicarious liability. However, in
Malaysia, the house officers will not be individually liable for the medical errors committed during their housemanship period as they are not considered as fully qualified and registered doctors. Subsequently, it is the supervisors and hospitals that will be charged in breach of duty of care. Hospitals liability with respect to medical negligence can be direct liability or vicarious liability. Direct liability refers to the deficiency of the hospital itself in providing safe and suitable environment for treatment as promised.

Vicarious liability means the liability of an employer for the negligent act of its employees. An employer is responsible not only for his own acts of commission and omission but also for the negligence of its employees, so long as the act occurs within the course and scope of their employment. This liability is according to the principle of ‘respondent superior’ meaning ‘let the master answer’. Employers are also liable under the common law principle represented in the Latin phrase, *qui facit per alium facit per se*, i.e. the one who acts through another, acts in his or her own interests [8]. Thus, an employer may be held liable for the negligent harm caused by employees acting within the scope of their employment, even if the employer acted appropriately. Claims alleging vicarious liability often coexist with claims attempting to hold the actual wrongdoer liable.

In Shull v Schwartz [9], when a medical resident followed the attending surgeon’s appropriate directive to perform a postoperative procedure on the ward, but negligently left a needle tip in the patient, the surgeon was not vicariously liable. The court reasoned that in such situations medical resident, nurses, and other hospital staff were not under the control of the attending physician and were acting primarily for the benefit of the hospital. However, in Siebe v University of Cincinnati [10], a medical resident supervised the placement of a central venous catheter by a trainee nurse anesthetist.

The catheter was incorrectly inserted and the court found the hospital negligent due to violation of its hospital policy that all such catheters are to be inserted under the supervision of an attending physician. Similarly, in Felice v Valleylab [11], a medical resident performed a circumcision without an attending physician present in the operating room and injured the patient. The medical school was held liable for permitting the operation in violation of its own policy that all elective procedures be performed with an attending physician present. Thus, failure to implement the administrative structures and personnel arrangements that enable adherence to work hour restrictions may leave medical institutions highly vulnerable to liability when fatigue-related harms occur. It has to be noted that the attending physicians may also be held liable for improper supervision, as supervising medical residents is an inherent part of their job. This form of liability is direct and physicians may be directly liable due to the negligent oversight of care on their part.

### 2.4 The Legal Liability of Medical Trainees: The Required Standard of Care

In view of the fact that medical trainees may cause their supervisors and hospitals to be liable for their mistakes, what is the standard of care that must be observed by the medical trainees? In law, the test for breach of duty in the tort of negligence is whether the defendant’s conduct was reasonable in all the circumstances of the case. This can be seen from Mr Justice McNair’s judgement in Bolam v Friern Hospital Management Committee [12], in which His Lordship stated that “the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art in the case of a medical man, negligence means failure to act in accordance with the standards
of reasonably competent men at that time”.

To date, there is no specific case law on the subject of houseman liability in Malaysia. However, house officers in Malaysia shall not be held liable for the medical errors during two years of housemanship period as discussed above. Thus, in order to examine the legal responsibilities of medical trainees in Malaysia with the objective of safeguarding patient safety, references will be made to several cases reported in the United States of America, Canada and England.

a. The Standard of Care in the United States of America

The trend in case law since the early 1980s has favored considering medical resident, even those in the first year of training, as bona fide, licensed physicians when it comes to the professional standard of care in medical malpractice cases. Specifically, the law expects first-year medical residents to exercise at least that level of knowledge and care expected of other practitioners at a similar stage of training or that standard of care applicable to licensed non-specialists, ie, ‘general practice’ doctors [13].

Although still acquiring the skills toward certification, medical residents remain individually responsible for their actions. But should the law demand the same standard of care as it would a fully qualified attending physician? [14]. Some have favoured a dual standard of conduct, with medical residents being held to a lower standard of care. This was articulated in Rush v. Akron General Hospital [15], which involved a patient who had fallen through a glass door. The patient suffered several lacerations to his shoulder, which an intern treated. However, when two remaining pieces of glass were later discovered in the area of injury, the patient sued the medical resident for negligence.

The court dismissed the claim, finding that the medical resident had practiced with the skill and care of his peers with similar training: “It would be unreasonable to exact from a medical resident, doing emergency work in a hospital, that high degree of skill which is impliedly possessed by a physician and surgeon in the general practice of his profession, with an extensive and constant practice in hospitals and the community”. However, not all courts have embraced the dual standard of review. In a case in New Jersey, the Superior Court held that licensed medical residents should be judged by a standard applicable to a general practitioner, as any reduction in the standard of care would set a ‘problematic precedent’ as in Clark v. University Hospital[16].

In this case, the medical resident allegedly failed to reinsert a nasogastric tube, which caused the patient to aspirate. Further, in Pratt v. Stein [17], a second-year medical resident was judged by a specialist standard after he had allegedly administered a toxic dose of neomycin to a postoperative patient, which resulted in deafness. Although the lower court had ruled that the medical resident should be held to the standard of an “ordinary physician”, the Pennsylvania appellate court disagreed, reasoning that “a medical resident should be held to the standard of a specialist when the medical resident is acting within his field of specialty. It is opined that a medical resident is already a physician who has chosen to specialize, and thus, possesses a higher degree of knowledge and skill in the chosen specialty than does the non-specialist”.

However, a subsequent decision from the same jurisdiction suggests a retreat from this unrealistic standard. In Jistarri v Nappi [18], an orthopedic resident allegedly applied a cast with insufficient padding to the broken wrist of a patient. The plaintiff claimed this led to soft tissue infection with Staphylococcus aureus, with complicating septicemia, staphylococcal endocarditis, and eventual death. The court held that the medical resident’s standard of care should be “higher than that for general practitioners but less than that for fully trained orthopedic specialists. To require a resident to meet the same standard of care as a fully trained specialist would be
unrealistic. A resident may have had only days or weeks of training in the specialized residency program; a specialist, on the other hand, will have completed the residency program and may also have had years of experience in the specialized field.

If we were to require the resident to exercise the same degree of skill and training as the specialist, we would, in effect, be requiring the resident to do the impossible”. In 2007, a Michigan court also overruled an earlier state court ruling that had held residents to a generalist standard of care rather than a specialist standard. Gonzalez v St John Hospital & Medical Center [19] involved a third-year medical resident performing colorectal surgery that led to patient injury. The patient argued that a physician can be a specialist without being board-certified in the specialty, especially because the medical resident was receiving advanced training in general surgery at the time of the negligence. The Michigan court looked at preceding case law and decided that those medical residents who “limit their training to a particular branch of medicine or surgery and who can potentially become board-certified in that specialty are specialists” for purposes of the standard of care.

Thus, we can conclude that the standard governing the medical resident in the United States of America could be that of a reasonably competent generalist physician, that of a specialty physician, or that based on some subjective determination considering the medical resident level of training. The courts have struggled with the question of what standard of care should govern the conduct of medical resident. Unless a medical resident specifically discloses training status to the patient, most courts have held that the reasonable standard against which resident conduct is measured is that of a licensed practitioner in that specialty.

b. The Standard of Care in Canada

As regards to the resident’s standard of care, there is uncertainty in this area of law [20]. An ambiguous statement made by the Supreme Court of Canada in Vancouver General Hospital v Fraser [21] regarding the medical resident’s standard of care, has created a fractured interpretation. The resident’s standard of care is best understood as a spectrum. Canadian jurisprudence has established three general points that guide medical residents in their legal obligations. These points include; (i) a generally agreed to minimum level of care that incorporates the doctor’s standard of care; (ii) a middle standard of care that recognizes a resident’s expanding skill set; and (iii) a more extreme upper level of care that approaches or reaches the specialist’s standard of care.

Three major issues exist and contribute to making this an unpredictable area of law; (i) no point along the spectrum is specifically defined; (ii) No specific indication as to when a resident will fall into one of the categories. Logical indicators, such as year of residency, provide some guidance but are still vulnerable to varying results and (iii) the cases are complex. Medical residents are commonly joined by staff specialists and the medical institution as named defendants. Medical expert evidence, something very technical in nature, is usually targeted at uncovering the specialist’s standard of care. This creates confusion as to whether this same standard is also applicable to the medical resident.

The earliest and most formidable comments made on the resident’s standard of care were those of the Supreme Court of Canada in Vancouver General Hospital v Fraser. In this case, the patient was placed under the care of two emergency department interns after suffering injuries in a motor vehicle accident. The patient, Mr. Fraser, presented with visible lacerations, neck pain, and neck stiffness upon arrival. The medical residents, although untrained in radiology, read the x-
rays and diagnosed and discharged Mr. Fraser without consulting the available and certified radiologist. As Mr. Fraser’s pain did not subside, he returned to the hospital and was diagnosed as having a fractured dislocation of his “axis, second cervical or “neck vertebrae”.

He died shortly after this diagnosis and as a result his wife sued Vancouver General Hospital for the alleged negligence of the interns. In confirming the medical residents’ negligence, Justice Rand identified two crucial aspects of the medical resident’s standard of care. First, a medical resident “must use the undertaken degree of skill, and that cannot be less than the ordinary skill of a junior doctor in appreciation of the indications and symptoms of injury before him”. Second, a medical resident must display, “an appreciation of his own limitations and of the necessity for caution in anything he does”. Rand J’s statement has come to form the lowest standard of care a patient can demand from a medical resident. This standard holds the medical resident to that of a “junior doctor” and demands the medical resident to be cautious and cognizant of their inexperience. Canadian jurisprudence has taken three different approaches when interpreting the appropriate standard to hold a medical resident to.

1) The Lower Limit: The Reasonable but Inexperienced Doctor

The first approach, as expressed in Wills v Saunders, Bearden v Lee and Adair Estate v Hamilton Health Services Corp, places the greatest focus on medical residents recognizing their professional inexperience. Within these cases the courts do not directly identify which of the “doctor” standards is most appropriately applied to the medical resident. However, given the deference that is granted to cautious medical residents, it is logical to infer support for the use of the lower “reasonable doctor” standard. Additionally, breach of the standard is usually determined on matters of protocol, an issue that does not require the skill and knowledge of a specialist. As a whole, this lower limit of care is most commonly applied to a medical resident within their first few years of residency.

In Wills v Saunders [22], Mrs. Wills, the 57-year old plaintiff, had surgery to correct her gallstones and reflux esophagitis. After surgery she developed serious infections and had to have her central feeding line removed. Ten days after the removal of the line, attempts were made to restart intravenous feeding peripherally, rather than by central line. A day after these attempts failed, Dr. Saunders, a first-year, medical resident, attempted to once again insert a central feeding line. This action was taken without supervision or written orders to proceed accordingly. Severe complications resulted, which ultimately lead to permanent vision loss for Mrs. Wills in her right eye. When establishing the appropriate standard of care expected of Dr. Saunders, the Court made reference to the junior doctor standard expressed by Rand J. This standard was interpreted in consideration of Justice Ellen Picard’s statement, “there is no authority... to support a lower standard for the inexperienced”.

As a result of these statements, Dr. Saunders’ standard of care was not lowered, despite his junior resident status and inexperience. The Court is not explicit in whether Dr. Saunders would be held to the standard of a reasonable doctor or surgeon. Rather, focus was placed on the importance of Dr. Saunders understanding his limitations and thereby acting accordingly. In determining the standard of care, the Court focused on the fact Dr. Saunders undertook the procedure on his own and without supervision.

Despite a lack of direct guidance, it is logical to presume that the reasonable doctor standard is implied in this case. First, placing such an emphasis on caution is not fully consistent with the specialist’s standard of care, one that demands action based on special skill and knowledge. Second, the Court identified that Dr. Saunders was “responsible to act as a primary care physician
to the patients”. Fulfilling a primary care role is more indicative of a doctor’s duties rather than a specialist’s. Because of this, the Court seems to suggest that the standard of care for a medical resident, particularly an inexperienced junior medical resident, is that of a reasonable and prudent doctor who appreciates their limitations and inexperience.

2) The Middle Standard: The Developing Resident

Comments made in Bedard v Martyn, Rietze v Bruser (No 2), Allen v University Hospitals Board, and Bauer v Seager et al open the possibility of a second interpretation of the medical resident’s standard of care. This second standard recognizes the medical resident’s growing skill set. In these cases, the courts identify a new standard, the reasonable specialized resident (e.g. the reasonable obstetrics resident). This interpretation differs from other cases, which specifically compare the standard of the resident to that of a reasonable doctor or a reasonable specialist. This new standard, being rooted to a particular area of medicine, requires a resident to have more skill than the average doctor, but less than an average specialist in that area.

In Bedard v Martyn, Rietze v Bruser (No 2) [23], twin boys were delivered and cared for by two health care professionals, Dr. Amin, the staff neonatologist, and Dr. Mauer, an anaesthesiology resident completing a four-week rotation in neonatology. Approximately 24 hours after the birth of the twins one of the infants, Logan, began to show signs of stress and irritability. Dr. Mauer ordered an ultrasound to investigate a potential haemorrhage, but indicated that the tests be done ‘today’ rather than ‘urgently’. Four hours after ordering these tests, Dr. Mauer conducted a lumbar puncture on Logan to test for meningitis, a procedure not recommended by neonatologists in the face of increased intracranial pressure. Ultrasound and CT scans were completed approximately six hours after the initial diagnosis, and they confirmed a brain haemorrhage.

The haemorrhage caused a large blood clot in Logan’s brain, damaging brain cells and the brain stem itself. The issue before the Court was not the cause of the haemorrhage, but rather the doctor’s lack of immediate testing upon the discovery of stress indicators. Dr. Maurer was found negligent for failing to order Logan’s ultrasound urgently, a procedural matter that lends itself to the standard of the average physician. It was made clear that Dr. Maurer was not expected to have the full knowledge of a neonatologist as, unlike the staff specialist, she was not faulted for conducting a lumbar puncture. However, in describing the standard of care applicable to Dr. Maurer, the Court referred to her as a “resident of neonatology on October 20, 2001 (the date of injury)”.

Given that Dr. Maurer was actually an anaesthesiology resident, it is possible that the standard of care expressed demanded some level of knowledge in the field of neonatology. On the facts this theory cannot be proven, as negligence was determined strictly on a general, procedural matter. This standard holds the medical resident to a level of skill greater than that of a doctor but less than that of a specialist. Given the language used in Bedard, this standard may also require the medical resident to have skill of the expressed level regardless of their actual focus of specialization.

3) The Upper Standard: The Reasonable Specialist

The third possible standard for a resident is that of the reasonable specialist or near specialist. In Sharp v Hurlbert [24], the plaintiff had spinal cord surgery to relieve pain in his neck. As part of this surgery, two of the discs in his spine had to be fused together. This procedure required bone graft to be attached to the plaintiff’s vertebrae with a titanium plate. Dr. Bitting, a fifth year
residents involved in the surgery, was responsible for threading the graft so it would fit a screw. While Dr. Bitting was completing the threading procedure “the graft dislodged into (Mr. Sharp’s) spinal canal”.

As a result, Mr. Sharp “suffered a spinal cord injury” which impaired his “right arm and shoulder, decreased fine finger movement and (resulted in) mild weakness in motor control of his left hand”. The court cites the junior doctor standard, expressed in Fraser and interprets it as meaning that “Dr. Bitting should be held to the standard of care of a prudent surgeon”. Despite this elevated standard of care, Dr. Bitting was not found to be in breach, as he “neither saw nor felt anything which would indicate to him that the graft would slip”.

The defendants argued that the appreciation of limitations test had application and consequently Dr. Bitting should have refused to complete the threading. This was not accepted by the Court. If a court holds a resident to the standard of a specialist, they are recognizing the experience and skill set of an individual and expecting they will act according to their knowledge. This includes performing complex surgical tasks and having the knowledge to differentiate between appropriate and inappropriate diagnostics and procedures.

However, in Sharp the Court does support some forms of limitation awareness, specifically noting that this was not a situation where “a resident was unsupervised and undertook a task beyond what was expected”. This initially appears problematic given the application of the ‘surgeon’ standard of care. This issue is resolved by a close analysis of the words chosen by the Court. Dr. Bitting was held to the standard of a prudent surgeon, not that of a prudent neurosurgeon. This standard can be viewed as one that hovers near but does not actually equate with the reasonable specialist’s standard. This standard still deems supervision and delegation of tasks by senior staff as appropriate, but recognizes the near specialist skill set of the resident. As a result the medical resident does not have to question his or her involvement in more complex procedures, but has to perform said procedures with the skill of an average surgeon.

To be successful, this standard would have to rely heavily on appropriate delegation of tasks by senior staff. The problem with this standard is that it fundamentally clashes with the Fraser principle of limitation awareness. As a result, the resident has the responsibility to function at a specialist’s skill level, without the level of independence and deference such a standard usually provides.

Despite the confusion around the medical resident’s standard of care, the case law is consistent on one issue: a resident’s inexperience will not result in a reduction of the standard of care. Whether this approach is appropriate is brought into question by Aldana v March [25]. In this case, three interns were sued for negligence following the death of a patient in their care. The patient suffered post-operative chest pains following bariatric surgery. As the patient was moved from the surgery ward to the cardiac care unit, the interns provided care in the form of diagnosis, testing, and medication. The care was provided in accordance with supervising instruction. Unfortunately, the entire medical care team misdiagnosed the patient’s symptoms. The patient had developed peritonitis as a result of his surgery, a condition that ultimately caused his death. In declining to find any of the three interns negligent, the Court determined the appropriate standard to be that of a “reasonably competent intern”. This was distinguished from the standard of a “practicing physician or specialist”. A lesser standard was found to be appropriate given the accepted description of the intern’s role:

An intern is a junior doctor doing a year of post-university training at an accredited hospital. In British Columbia, and in other provinces in Canada, it was mandatory at the time to do an
Internship as a prerequisite to becoming licensed to practise medicine independently. An intern works under the supervision of an attending staff physician who is usually a specialist. The intern is qualified and expected to perform histories and physical examinations on patients. Procedures, ordering of investigations, and initiating treatment are within the duties of the intern as long as it is under the supervision of and in consultation with an attending staff person. An intern may initiate emergency treatments and is qualified to do so as long as the attending physician for the patient is notified within a reasonable period of time.

The Court also brought attention to the fact that the interns were not certified to practice medicine independently and were training to become practicing physicians. In analyzing the standard of care issue, it was determined that given the time-sensitive nature of Mr. Aldana-Murray’s condition, the interns had taken reasonable steps in diagnosis and had been prudent in their medical care and communication efforts. Taking these steps ensured they, at a minimum, satisfied the intern’s standard of care. Additionally, the Court identified that to make the interns second-guess the instruction of the specialists would have placed an “unreasonably high duty upon their shoulders”.

Two points of interest are raised by this case. The first is the similarities shared between the modern-day resident and the historic intern. Like the intern, the medical resident is restricted from practicing medicine independently and were training to become practicing physicians. Given the likeness between the resident and the intern, it seems logical that the “reasonable intern” standard be applicable to residents. The point above may be moot given the second point of interest, the application of the “reasonable intern” standard. The interns satisfied the standard of care because they acted prudently, made reasonable diagnoses, and followed senior specialists’ orders. This behaviour would have equally satisfied a standard requiring the interns to act like a reasonable, cautious doctor. Given that finding an appropriate diagnosis was something expected of a reasonable specialist, it appears that what the Court was actually opposed to was holding the interns to the standard of a reasonable specialist.

The medical resident’s standard of care is an unclear area of the law. This is a consequence of vague governing legislation and Supreme Court of Canada guidance. As a result, the resident has been held to the standard of: a reasonable doctor, a reasonable near or actual specialist, a reasonable resident (somewhere between a doctor and a specialist), and a reasonable intern (less than that of a reasonable doctor). Despite the varying terminology used, the underlying goal of the courts is similar. At a minimum, they wish to hold residents accountable for a certain level of medical knowledge and want to ensure residents are actively aware of their professional inexperience. In addition to this, the courts want the flexibility to increase the care requirement, when it is appropriate.

To help ease the confusion, one succinct statement on the resident’s standard of care needs to be adopted. This standard would, at a minimum, require the average resident’s skill and knowledge, and demand acknowledgement of professional inexperience. Additional care expectations could be imposed on the resident as they progress through their training. Legally, the concept suggested does not significantly differ from a standard that requires a resident to act as a reasonable and cautious physician.

4) The Standard of Care in England

The junior doctor must meet the standard of care expected of his rank or status [26]. This is nothing new in the law of tort whereas the same standard of care as illustrated in the case of
Nettleship v Weston [27] was expected. In this case, the court held the same standard of care was expected of a learner driver as of an experience driver. This leading authority was applied in the case of Wilsher v Essex Area Health Authority [28]. Martin Wilsher was born prematurely suffering from various illnesses including oxygen deficiency. He was placed in a special care baby unit at the hospital. While he was in the unit a catheter was twice inserted into a vein rather than an artery and on both occasions he was given excess oxygen. The doctors administering the oxygen were a junior and an inexperienced doctor respectively.

The position of the catheter was not in itself negligent as it was a mistake a reasonably competent doctor could make. The catheter could be checked by means of an X-ray, which was in fact done in this case; however, the senior registrar failed to spot the mistake. The baby was subsequently found to be suffering from retrolental fibroplasia, which causes blindness. In the Court of Appeal, it was argued that the standard of care expected of the junior doctor was not the same as that of his experienced counterpart. It was said that a junior doctor had to learn on the job, otherwise it would be impossible for medicine to develop and function; it was therefore unavoidable that mistakes would be made. Sir Nicholas Browne-Wilkinson VC agreed with this argument (stating at page 833):

…a doctor…should only be held liable for acts and omissions which a careful doctor with his qualifications and experience would not have done or omitted.

But the majority of the Court of Appeal dismissed this argument. Glidewell LJ applied the Bolam test commenting (at page 831) that if there was not a uniform standard of care then:

…inexperience would frequently be urged as a defence to an action for professional negligence.

Thus, it has been concluded that:-

a) The judgment of Glidewell LJ sums up the current legal position. What is reasonable conduct on behalf of the defendant will not change with the post he held nor with his level of inexperience. It may be that the hospital was at fault in placing the junior doctor in such a situation; however, the wrong inflicted on the junior doctor should not be remedied at the expense of the patient;

b) Once a doctor performs a task, the patient can assume he has the competence to perform the task with care and skill. If the doctor either unwittingly or knowingly attempts a task beyond his experience then that will constitute a breach of the standard of care;

c) The junior doctor will not be liable if he seeks the advice of a senior or more experience colleague (as was the case in Wilsher). The liability will then fall upon the shoulders of the more experienced doctor for lack of supervision. A common illustration of inexperience is that often the doctor does not realize that the task at hand is beyond his capabilities and therefore does not seek help. In the Canadian case of Fraser v Vancouver General Hospital [1952] 2 SCR 36, 3 DLR 785 [Fraser cited to SCR], the Court held that an intern had to exercise the ‘ordinary skill of a junior doctor’ and must have an appreciation of his own limitations. Quite what this means is uncertain: it is all very well saying that a doctor must have appreciated his own capabilities but in most situations the junior doctor is already acting under the firm belief that this is in fact what he is already doing; and

d) The more experienced doctor could be held liable for failing to reasonably supervise the junior doctor, or the hospital could be made directly liable for placing the junior doctor in a position with which he was not qualified to cope.
5) The Standard of Care in Malaysia

Although the house officers in Malaysia shall not be held liable in the court of law, it is to be expected for them to exercise at least that level of knowledge and care expected of other practitioners at a similar stage of training. If they committed medical errors which are unacceptable due to carelessness although under full supervision of the superior, it is to be proposed that they have to face the court proceeding as well. Also, the house officers shall be held liable due to their negligence/failure/refusal in following the instructions of their superior.

This is to protect the patient safety and at the same time to give a good reminder for the house officers to always be extra careful since medical profession is a very serious profession involving life and death of patients. In addition, it is not a good practice to always put the blame on the superiors who have done their best in supervising the tasks of the house officers. In other words, a house officer’s inexperience shall not be an excuse in a reduction of the standard of care. The standard of care in Canada by holding the residents accountable for a certain level of medical knowledge is actually a good step to be followed to make the medical trainees aware of their heavy responsibilities.

2.5 Safeguarding Patient Safety: Recommendations for the Prevention of Medical Errors

In safeguarding patient safety, medical errors should be prevented since based on the analysis of the standard of care of the medical trainees in few countries, we can summarize that the courts do not hesitate to put the high standard in imposing the punishment. Furthermore, patient safety should be among the main goal of the medical providers as economy and reputation of any country may be affected. We can see that most of the developed countries in the world provides good hospitals and medical services which can attract the people to get their services. Thus, in order to safeguard patient safety, medical errors should be prevented. The following are recommendations for the prevention of medical errors by medical trainees:

a. Active and Efficient Supervision

First, more active supervision may prevent some mistakes or mitigate their adverse effects. Senior physicians should be more available for critical decisions about patient care, especially in complex cases that require more mature clinical judgment.

b. Proper and Systematic Delegation of Duties

In legal actions, the Court generally considers whether the delegation, supervision and support provided by the supervising physician were reasonable in the circumstances. Supervising physicians should therefore consider the following:

1) Is the task appropriate to delegate to an individual with the trainee’s level of training?
2) Does this specific trainee have the required knowledge, skill and experience to perform the task?
3) What degree of supervision is required?
4) Has the patient been informed of the educational status of the trainee?

When consulting with residents over the telephone, supervising physicians may additionally want to consider the following:

1) Do I have sufficient understanding of the patient’s clinical presentation to offer an opinion on the diagnosis and management?
2) Have I sufficiently questioned the resident to develop an appropriate management plan for the patient?
3) Would the patient’s condition or the needs of the resident require me to personally attend the patient?
4) Have I taken steps to determine whether the resident requires additional support to meet the current workload demands?

c. Effective Communication and Promoting Open Disclosure
Open and supportive communication by the supervisor and readiness to help the trainee will allow the trainee to voice any concerns about a task. The trainee should feel free to clarify instructions, voice concerns and ask the supervisor for help and should never be reluctant to admit to their supervising physician that they are not proficient in performing a procedure. Failure to do so, not only robs the medical trainees of a learning opportunity, but it puts the patient at an unnecessary risk.

III. Conclusions
Open and supportive communication by the supervisor and readiness to help the trainee will allow the trainee to voice any concerns about a task. The trainee should feel free to clarify instructions, voice concerns and ask the supervisor for help and should never be reluctant to admit to their supervising physician that they are not proficient in performing a procedure. Failure to do so, not only robs the medical trainees of a learning opportunity, but it puts the patient at an unnecessary risk.

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