Two sides of the same coin: educational and professional pathway for surgical residents

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AIM: *To provide a review of medical malpractice cases ruled by the Italian Supreme Court with the aims at identifying lawsuits targeting involved with surgical residents.*
MATERIAL AND METHODS: *Legal cases ruled by the Italian Supreme Court, from September 2020 to October 2020, pertaining to medical claims involving surgical residents were examined, using the main online databases.*
RESULTS: *Of a total of eleven (n=11; 100%) cases identified, four (n= 4; 36,4%) cases addressed the standard of care pertaining to the surgical residents' medical activity. The legal reasoning of the Italian Supreme Court does not focus on the manual skill in the resident's medical performance, but rather on the choice to accept to treat the patient, regardless of the participation of the tutor.*
CONCLUSIONS: *The performance of the surgical residents is made more difficult due to their peculiar nature, characterized by the complex interactions between the directives given by the tutor and the need to guarantee patients' needs.*

KEY WORDS: Surgical Residents, Tutor, Educational Pathway, Medical Malpractice, Standard of Care

Introduction

Surgery falls within the most common medical specialities for medical malpractice claims against doctors. Medical liability involves surgical residents (SRs), as it is the case for fully doctors licensed and hospitals, when incorrect procedure related with a surgery is provided and harm to a patient is caused [1]. Based on the violation of the standard of care, SRs' errors may relate to a failure of preoperative, intraoperative and postoperative care. The peculiar nature of the SR – doctor in training on the one side, and professional in the eye of patient on the other – raises problems in determining the limits and boundaries of their duties and responsibilities [2]. In this respect, Italian laws do not specify criteria for evaluating a neglect action and assign fault, leaving the determination of the standard of care violation entirely to the discretion of the courts. In addition, neither there are in Italy rules that prevent SRs from being alleged directly or indirectly in medical malpractice lawsuits, requiring each time a case-by-case evaluation.
In literature, few studies reported cases about doctors attending surgical residency and the determination of the standard of care is often remained undetermined [3]. While a strict correlation between the technical and educational part is emerged in the SRs' pathway, some US studies identified that, in several cases, surgical errors occur during the intraoperative and postoperative setting. Even a good coordination and integration of overall phases were observed as important, besides the need of an appropriate supervision by attending physicians [4]. As for the intraoperative procedures, the common errors relate to the surgery of the biliary tract, intestines, hernias, vascular system, oesophagus, and stomach [5-7].
The increase of the number of lawsuits alleging medical negligence and the massive use of residents in the National Health System, above of all during in this contingent COVID-19 health emergency, lead to think about the role of the SRs in the national healthcare system and how to protect and guide them in the medical malpractice proceedings [8].

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This paper focuses on the juridical and ethical concerns pertaining to the SRs' activity and provides a review of medical malpractice cases settled by the Italian Supreme Court, with the aims at identifying lawsuits targeting involved with SRs and new possible improvements for educational standards.

Legal Background

The regulation concerning resident physicians is governed by special rules enacted by European Directives. Unlike fully licensed physicians – who must have completed residency to practice in their specific medical field (as provided by article 15, Law n. 502/1992) or must demonstrate a comparable expertise – the resident physician is governed by specific rules that set up the modality of the training programme. The resident is a fully licensed medical practitioner who attends from 2 up to 6 years a theoretical and practical medical training in order to obtain a specialization in a specific area of medicine. Surgical residency includes 5 or 6 years of courses. Each post-doc program has its own rules which state the increasing autonomy of the resident in the specialist work.

Law no. 368 of 1999 provides that the medical training programme should require the personal participation of the resident physician in all activities and responsibilities of the discipline. The medical training programme also implies the gradual assumption of clinic-welfare duties and activities under the supervision and instruction of a tutor (T) that is a fully licensed physician (duty-bound autonomy). In no case can the resident physician replaces the T and/or any other fully licensed physician. However, with respect to professional duties and obligations, the resident is involved in doing every clinical and surgical activity. The law forbids residents from carrying out any administrative acts (e.g., requests for health examinations, certifications of medical examinations for legal purposes, discharge of patients, etc.).

Residents are not employed by the National Health System, whereas fully licensed physicians are. They are employed by the universities providing medical residency and regions after the signature of a specialist training contract (*contratto di formazione specialistica*). During the medical training, the resident receives a salary and pay a professional insurance.

Although the resident are employed as doctors in training, in the eyes of the law, they have the duty of patient care and are entitled to assist the patient with full responsibility, as well as a licensed general practitioner [8]. The law no. 24/2017, that is currently known as the Gelli-Bianco law, has equated fully licensed physicians and residents by imposing on both the obligation to follow the guidelines released by the Istituto Superiore di Sanità or, in their absence, the good clinical-assistance practices [9-11].

Surgical Resident's Liability

As fully licensed doctors, SRs have the duty to treat and care for patients correctly during all the phases (stages) of a surgical procedure. When a breach of this duty is made, surgeons in training can be held civilly responsible according to private law principles that govern execution of contract (Civil Code), and they can be held criminally responsible according to public law principles that govern torts (Criminal Code). A juridical relationship is established when a resident enters contact with a patient and provides medical care. This juridical relationship is based on an implied contract and gives rise to varying duties of care and responsibilities for any damage caused to the patient (e.g., damage compensation, prison, etc.).

Generally, patients or their relatives consider civil claims to be the best means to seek damage compensation, because they have a burden of proof more favourable for patients. In a civil claim, the plaintiff (patient), in order to see her/his damage recognized, only needs to prove the contract and the worsening of his/her former condition, while the defendant (physician) must prove that absolutely no damage can be traced back to her/his activity. In a criminal lawsuit, however, there is a stricter burden of proof, and a resident can be held criminally responsible only if three elements are established beyond a reasonable doubt: that the conduct below the standard of care, that damage was caused to the patient, and the casual relationship between the conduct and the damage. Both in civil and criminal medical malpractice cases, an expert forensic scientist's testimony is generally required in order to establish the prevailing standard of care.

Residents' Medical Malpractice may leads attending physicians and graduate medical education institutions even to share a collective responsibility. Attending physician can be hold vicariously liable for the negligence of resident physicians working with them, or directly liable for inadequate supervision. As a result, resident physicians often seek a full supervision and attending physicians provide the same.

Methods

Legal cases ruled by the Italian Supreme Court, from September 2020 to October 2020, pertaining to medical claims involving SRs were examined using the main online databases, "*Foro Italiano*", "*Pluris Data*" and "*De Jure*". The official website of the Italian Supreme Court was used, as well. These databases are commonly managed to study and analyse legal materials for professionall and/or educational purposes. The following keywords were used to collect judgments: "Physician in training," "*Residents*", "Resident Liability," "Fault for Assumption," "Specialist," "Postgraduate physician," "Medical Education," "*Vicariously Liability*".

Only the cases involving specifically SRs were collected and mentioned for the purpose of the present study.

Results

Of a total of eleven (n=11; 100%) cases identified, four (n=4; 36,4%) cases addressed the standard of care pertaining to SRs' medical activity. Two (n=2; 18,2%) cases cited residents as being directly involved a surgical technical error during intraoperative setting and two cases (n=2; 18,2%), referring to the postoperative setting, named the trainee as one of the defendants. The remaining cases (n= 7 – 63,6%) refer to the field of Oncology (n= 2, 18,2%), Anaesthesiology (n= 1 – 9,1%), Gynaecology (n= 2; 18,2%) and Cardiology (n= 1; 9,1%) and relate to surgical errors occurred in the preoperative and intraoperative setting.

The legal reasoning of the Italian Supreme Court does not focus on the manual skill in the SRs' medical performance, but rather on the choice to accept to treat the patient. This choice is connected to the SRs' ability to carrying out a certain medical activity; otherwise, he/she has the duty to refuse to do it. The acceptance to execute medical tasks is the key factor to determine residents' liability. Attending physicians and graduate medical education institutions (and/or hospitals) may even share a collective responsibility with residents.

Selected cases pertaining to surgical residents

The first judgement we found about medical malpractice liability falls within the field of the surgery and dates back to 1999. All the precedents we researched, including those one not referring to surgery, present similarities since they have hold resident responsible both when the medical activity was executed autonomously and when it is the result of directives given by the T (Table I).

In the case n. 13389/1999, the Court held a SR responsible for having executed a septoplasty surgery that was begun by the T and that required a surgical technique for expert specialists. The T was already held responsible in a separate and abbreviate criminal proceeding for not having correctly supervised the resident. Based on the data investigation of the criminal proceeding, it is emerged that after having prepared the operating site, the attending physician introduced a rasp into the depth of the nasal fossa and removed first the osseous spur and successively the overlying convexity, though assigning the trainee for this last part of the surgery. However, since an incorrect operation, a severe arterial nasal bleeding induced the attending physician to personally resume the surgery in an attempt to prevent the haemorrhage. Due to severe complications, the patient was transferred to the department of neurology where she died.

Despite the T directly assigned the SR to personally conclude the surgery, according to the Court, the SR cannot be exempted from liability solely because he/she has followed instructions. Medical training requires the active participation of residents to all activities, including those one relating to surgery, and these activities must be executed under the supervision of the T. Nonetheless, although SRs act with a limited autonomy, the execution of practical activity always entails the direct assumption of the responsibility towards patients. As a result, they have also the duty to observance of the leges artis, whose purpose is to prevent the disallowed risk (cf. Cass., Section IV, 3.11.1994, n. 11007).

In a subsequent case no. 9739/2004 concerning the failure of the preoperative and postoperative setting, the Court delivered important considerations about the role of the involved resident, though without delivering any judgement against him. The surgeon master was denied for two reasons. First, he planned a high specialistic surgical procedure in the last afternoon shift of the working day, where usually medical and paramedical services are less available, and second, he did not let specific instructions for the postoperative time to physicians in service. Immediately after the surgery, the patient showed complications and successively died due to Hypovolemic shock caused by a massive bleeding from gastro-enteric

Table I – *Screened and selected Italian Supreme Court's Cases*

Year/Case N.Br.	Medical specialization	Type of error	Injury to patient	Phase
13389/1999	Plastic surgery	Damage blood vessel	Death of PatientHaemorrhage	I
232901/2004	Anaesthesiology	Incorrect Epidural Injection	Spastic Tetraplegic	–
9739/2004	Plastic Surgery	Incorrect Escharotomy Surgery Plan and Supervision	Death of Patient	I+PO
28617/2005	Surgery	Incorrect Drug Administration	Death of Patient	PO
21594/2007	Surgery	Incorrect Epigastric Artery Suturing	Atrophy of right Gonad	I
32424/2008	Paediatrics	Incorrect Drug Administration	Death of Patient	–
6215/2010/9	Cardiology	Misdiagnosis of Myocardial Infarction and Incorrect Discharge	Death of Patient	–
6981/2012	Oncology	Misdiagnosis of Tumour Pathology	Permanent Damages	–
26311/2019	Gynaecology	Incorrect treatment of amniocentesis complications	Permanent Damages	–
20270/2019	Oncology	Incorrect drug administration	Death of Patient	–
10175/2020	Cardiology	Incorrect drug administration	Death of Patient	–

ulcer. The legal reasoning ruled by the Court is noteworthy since it points out the shortcomings of the resident not only in relation to his responsibility to check on the (ir-) regularities of the clinical course and the (non-) compliance with medical prescriptions, but also to his duty to personally take action through adequate initiatives (Italian Supreme Court, Penal Section IV, 1 December 2004). In the present case, not even the resident made the slightest effort in monitoring the patient's conditions, merely adhering to the imprecise and incomplete instructions of the T.

One year later, the Italian Supreme Court reviewed the case no. 28617/2005 where a patient undergoing a plastic colpoperineoplasty, cystouretropexy and colpoperineorrhaphy/colpoperineoplasty died after an intrapelvic hematoma from internal haemorrhage. The patient death was attributed to a number of concauses. In particular, to an incomplete and imperfect haemostasis along with a failure in the haemostatic equipment and postoperative setting. The two residents, involved with this case, were held responsible for having prescribed to the patient only an analgesic, omitting to adopt the due measures of haemorrhage management and to monitor his/her health conditions. Moreover, as for the standard of care issue, the Court reasoned that because one of the SR took part of the surgery, realizing what it was occurring during the surgery, he/she would be able to identify the postoperative complications and, therefore, more careful about the development of the patient's conditions.

In case n. 21594/2007, the Court's legal reasoning stated the responsibility of two SRs and the physician in charge of supervision for having caused a permanent and irreversible complete atrophy of the right gonad during an inguinal hernia surgery. In particular, the T left the operating theatre, charging residents who failed to correctly perform the surgical procedure, first cutting the epigastric artery and then omitting to suture the site. As a result of their conduct, a haemorrhage occurred, and the patient suffered the loss of the capacity to procreate. Whereas the Court's decision motivations on the residents were inspired to the fact that they did not meet completely the required intraoperative setting, committing a severe error, the T was denied that he left the operating theatre, not taking part to the surgery and consequently not guiding and supervising the SRs' action. Based on these arguments, the Court leads to the conclusion that the T completely failed to provide the necessary care in the intraoperative setting. Even in this case, the Court stated that the performance of surgical activities by the SRs entails the direct assumption of responsibility for any damage caused to the patient.

Discussion

SRs are responsible for delivering safe and appropriate care involving a surgery.[12] Our study shows that SRs are not integrated into the hospitals solely to receive professional training and that they do not have a passive role in the national health system. Although the refinement of technical skills is an important aspect of surgical training, the ascertainment of the fault focuses on the moment in which SRs decided to take part materially in the surgical procedure and aims at verifying the existence of some responsibilities, regardless of the participation of the T. This does not detract from the importance of an appropriate supervision by the T, given that he/she has the duty to observe and guide the SR's work. In the selected cases, the Court held the responsibility of the attending physician both when the demanding surgery was complex (case no. 13389/1999) and when it was not (case no. 21594/2007). In the latter case, for example, the T had slipped out his leading role, by leaving the operating room and entrusting the patient to two doctors who were not even adequately prepared to act independently. So much so that they committed a trivial mistake - such as not suturing or badly suturing the artery - that provoked the haemorrhage. In addition to that, according to the Court, the didactic purpose of the training activity of the trainees requires a constant and steady guidance of a T, who can fully provide the specific and needed directives. Otherwise, the guide role would only stay theoretical, and it could be learnt from manuals and scientific guidebooks and not from his teachings. In this respect, Italian medical liability framework stresses the T's duty of supervising and limits the autonomy of the resident, binding the latter to the directives given by attending physician. Whereas this unequivocal normative data establishing the need of a constant T's vigilance and guidance factually limits the SRs' autonomy, according to the Italian Supreme Court, SRs have the duty to refuse to execute the T's directive when they don't feel confident with the assignment. This peculiar situation is probably due to the ambivalent structure of the SR pathway, which can describe in two parts: 1) a purely educational part – the resident continues his/her course of study in the hospital, putting acquired theoretical knowledge into practice; and 2) a purely professional part – the trainee has a degree in medicine and is a general practitioner and, in the eyes of a patient, he/she assumes the role of a fully licensed doctor who works in the hospital. This kind of structure encompasses two different relationships: an educational relationship between resident and T and a professional relationship between resident and patient. Although these relationships are connected, both involving the protection of the patient, they have at their base different objectives and purposes. In the training relationship, the predominant aspect is the duty of the T to provide guidance and supervision to the resident's medical activity. Historically, the educational relationship was based on the idea – originated from the Hippocrates's oath – that medicine was taught through a strong teacher-student bond, comparable to a father-

son one.[13] This is due to the obvious circumstance that the teacher is, by nature, the one who must direct the student, illuminating the way to his future medical profession, just as a father does with his own son to introduce him into social life. In the professional relationship, instead, the main objective is the protection of the patient that is the third party in the educational relationship. This duty affects the relationship between T and resident, overshadowing the educational part, and focusing the attention on the scope of medicine, which is, the physical and moral well-being of the patient.

The selected cases do not focus on a specific resident standard of care, nor do they establish a precise low-manual-skill-mark as required for residents. The absence of manual skills in the medical performance of a resident has not been considered as a key issue to settle medical claims. Manual skills depend on experience. This experience increases proportionally with age and/or time spent in practice. As a result, the fault of SR is not based on performance – except when mistakes have been gross – but rather on the choice to treat the patient. In this respect, it is particularly illuminating the case no. 13389/1999 where the fault of the surgeon resident was based on the ground that the complexity of the surgery would have induced the SR to decline the T's directives. The type of the surgical procedure, in fact, did not allow any visual perception of the operating field and it required that the surgeon should identify any malformations exclusively on the basis of the stress exerted by the surgical rasp on the operator's hand at the time of its contact with any anatomical obstacle detected during exploration.

Moreover, in case no. 28617/2005, the SR was present at the surgery and saw that surgical operations were presenting several difficulties and complications that have even extended the ordinary period of the activity due to a bleeding. These circumstances should have led SR to pay particular attention to the patient's symptoms, said the Court.

Although the law governing SRs' activity provides for the gradual assumption of the duties and responsibilities and highlights the key role of the T, it is clear that the courts usually settle medical claims with aim to protect patients' health through the duty of care theory. Patients reasonably have the right to count on SRs for the protection and preservation of their health.

In all collected cases, the trend is to avoid considering the resident exclusively as a student with the aim of learning the medical profession. Indeed, if we considered the resident only as a student, the protection of the patient would be solely guaranteed by the T's guidance and supervision.

Because malpractice cases involving residents represent a serious concern both for residents and hospitals, the training of residents should be conducted in a manner that minimizes medical errors [14,15]. Workplace-based assessment methods (e.g., case-based discussion) can be very useful in teaching medical trainees [16]. Evidence-based medicine, communication, evaluation, and simulation have all received attention in medical education in recent years [17,18]. The use of feedback in medical learning and in workplace-based methods can contribute to help SRs to evaluate their competence during and at the end of training and can improve the quality of resident performance [19]. In order to contain medical claims, a critical re-evaluation of resident training programmes is required in a manner that makes SRs both more aware of medical malpractice concerns and more capable to carefully evaluate the complexity of required medical activities in light of their own medical skills.

The exposure of the SR to medical liability suits continues to be the subject of attention by the Italian Supreme Court that very even recently dealt with a new case (of incorrect drug administration of Heparin) where substantially they confirmed their trend and reminded that the concrete and personal performance of activities by the resident still involves his direct assumption of the position of guarantee towards the patient, sharing it with that which belongs to the person who gives the directives, according to the respective areas of pertinence.

Study Limits

This study has been based on few cases. Legal databases used in this study does not contain a representative sample of cases from across Italy. However, the general legal reasonings ruled by the Italian Supreme Court, in the selected cases, appear to be sufficiently described and identified in order to be applied to case out of surgery, as well. Moreover, the selected cases identify the main criticalities involving medical residents' activity and are useful for the improvement of educational framework with the aim to reduce the number of lawsuits claims.

Conclusion

Since the patients wish to achieve effective health care, they consider resident as specialist. Even the Supreme Court seems to be of the same opinion: if the error falls within the competence of the SR, it results in "unskillfulness"; if the error does not fall within the competence of the SR, there is still fault because he/she should not have accepted to treat the patient.

This idea cannot be shared because learning new skills is necessary, and it always involves an additional margin of risk. Making mistakes is part of the resident's professional growth; but it is not always possible for their Ts to find a remedy for such errors. This severe jurisprudential orientation towards the residents and their own Ts makes it necessary to take due care in managing clinical risk in healthcare facilities.

The performance of the SRs is made more difficult due

to their peculiar nature characterized by the complex interactions between education and profession, responsibility and limited autonomy, and, lastly, between directives given by the T and the need to guarantee patient needs. The path of specialist training represents for the physician a very important moment when theory meets practice in clinical care. We believe that it is very important to implement a more practical involvement of SRs, in responsibility and decisional autonomy dynamics, as part of medical training. This implementation, through educational and more inter-relational approach methods, can help to contain the diffusion of medical malpractice claims and to improve the quality of service delivered to patients. Above all, the protection of patients' health must be a constant priority in medical training that do not must be considered as the scene of legal battles between SRs, Ts and medical educational institutions.

Riassunto

Obiettivo: Il presente articolo fornisce una rassegna di casi di responsabilità medica decretati dalla Corte Suprema di Cassazione con l'obiettivo di identificare le azioni legali rivolte agli specializzandi in chirurgia.
Materiale e Metodi: Sono state esaminate le cause giudiziarie decise dalla Corte Suprema di Cassazione dal settembre 2020 all'ottobre 2020 in merito a richieste di risarcimento del danno, consultando le principali banche dati online.
Risultati: Su un totale di undici casi identificati, quattro casi (n = 4; 36,4%) si riferivano allo standard di cura relativo all'attività medica di specializzandi in chirurgia. Il ragionamento giuridico della Corte di Cassazione non si concentra tanto sulla manualità nella prestazione medica dello specializzando quanto piuttosto sulla scelta di accettare di curare il paziente, indipendentemente dalla partecipazione del tutor.
Conclusioni: La prestazione degli specializzandi è di fatto più difficile per la loro peculiare natura, caratterizzata dalle complesse interazioni tra le direttive impartite dal tutor e la necessità di garantire le esigenze dei pazienti.

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Commento e Commentary

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La problematica discussa dagli Autori non è l'unica a riguardare la particolare condizione degli specializzandi in chirurgia nei confronti dei risvolti medico-legali in cui possono trovarsi ad essere coinvolti.
Innanzitutto è evidente una incongruenza tra la condizione di laureati in medicina e chirurgia, secondo l'ordinamento universitario in Italia, che dopo superamento dell'Esame di Stato e l'iscrizione all'Ordine dei Medici, sono abilitati alla professione medica e chirurgica, e la condizione di specializzandi che li sottopone ad un regime tutoriale, limitativo di libere iniziative professionali in ambito chirurgico. Infatti essi hanno conseguito la laurea non semplicemente in Medicina ma "in Medicina e Chirurgia", e non vi sono limiti di legge all'esercizio libero della professione privata, vincolati solo dalla deontologia, ma naturalmente sotto la loro personale responsabilità. Nell'ambito della Scuola di specializzazione subentrano però quelle leggi e norme sanitarie che gli specializzandi sono tenuti ad osservare. La realtà è meno problematica perché con la diffusione delle specializzazioni e le conoscenze anche dei profani della loro esistenza difficilmente un paziente si rivolgerà ad un laureato non specialista per essere sottoposto ad un intervento chirurgico di qualche importanza. Sul piano formale però la problematica si ripropone, come evidenziato dagli Autori, nell'ambito di un corso di specializzazione in chirurgia, perché allo specializzando può e deve essere richiesto di eseguire interventi chirurgici anche di media gravità su soggetti il cui consenso informato è di fatto viziato. La responsabilità di eventuali errori a seguito di imprudenze e negligenze dovrebbe a rigore ricadere sul tutor o addirittura sul Direttore della Scuola. Certamente non si arriverà a pretendere che il paziente venga informato che l'intervento cui va a sottoporsi, sia pure per l'asportazione di una cisti cutanea, o ad una appendicectomia - per non parlare di un'ernioplastica - è la prima di quel tipo che l'operatore a lui destinato è per lui la prima esperienza come primo operatore, sia pure sotto la sorveglianza di un tutore. Senza risolvere il problema ci si affida al semplice buon senso, lasciando la soluzione degli eventuali problemi di malasanità a controversie in ambito giuridico che possono essere di difficile soluzione. Sembrerebbe necessario stabilire un limite all'imputabilità dello specializzando e di riformulare il format del consenso informato.

* * *

The issue discussed by the Authors is not the only one that concerns the particular condition of residents in surgery with regard to the medico-legal implications in which they may find themselves involved. First of all, an inconsistency is evident between the condition of graduates in medicine and surgery, according to the university system in Italy, who after passing the State Exam and enrollment in the Order of Doctors, are qualified for the medical and surgical profession, and the condition of trainees that subjects them to a tutorial regime, limiting free professional initiatives in the surgical field. In fact, they are graduated not simply in Medicine but "in Medicine and Surgery", and there are no legal limits to the free exercise of the private profession, bound only by ethics, but of course under their personal responsibility. However, within the postgraduate school there are those laws and health regulations that postgraduates are required to observe.
The reality is less problematic because with the spread of specializations and the knowledge of their existence even by the profane it is unlikely that a patient will ask a non-specialist graduate to undergo surgery of any importance. On the formal level, however, the problem arises again, as highlighted by the authors, in the context of a specialization course in surgery, because the trainee can and must be required to perform surgical interventions even of medium severity on subjects whose informed consent is in fact spoiled. The responsibility for any errors as a result of imprudence and negligence should strictly fall on the tutor or even the Director of the School. Certainly the patient will not be expected to be informed that the surgery he is going to undergo, even for the removal of a skin cyst, or an appendectomy - not to mention a hernioplasty - is the first of that type. that the operator intended for him is his first experience as a first operator, albeit under the supervision of a guardian. Without solving the problem, we rely on simple common sense, leaving the solution of any medical malpractice problems to legal disputes that can be difficult to solve. It would seem necessary to establish a limit to the trainee's imputability and to reformulate the format of the informed consent.

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