

# Virtual Mentor

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## CLINICAL CASE

### The Ethical Dilemma of Duty-Hour Reporting

Commentary by Mary E. Klingensmith, MD, and Katrina S. Firlik, MD

Mary, less than halfway through her intern year in surgery, was already feeling burned-out. She thought back to her orientation just a few months ago, when she and her fellow interns received many assurances from the program directors that the department would strictly adhere to the 80-hour work-week limitations. Those pledges, however, were followed by a speech from Dr. Thompson, the chair of the department and a world-renowned surgeon, who emphasized the importance of devotion to patient care and the field of surgery. One phrase in particular stood out during his speech to the incoming interns: “Great surgeons are those who see the extra patient, scrub in on the extra case, and stay the extra hour.”

Darren, a particularly aggressive member of the intern class, had taken to working well beyond his 80 hours each week while underreporting his hours. His violation of the rules was obvious to his peers, but instead of receiving a reprimand from the program he was met with praise; Dr. Thompson singled him out as the hardest worker in his class and allowed him to scrub in on especially complex cases. The remaining interns found themselves forced to work nearly 100 hours on some weeks in order to avoid appearing less dedicated than Darren. Mary had resorted to underreporting her hours along with her fellow interns, and, while she felt bad about this, she knew that reporting the violation could cause her program to lose accreditation, which was a highly unfavorable outcome.

### Commentary 1

by Mary E. Klingensmith, MD

In July 2003, the ACGME instituted duty-hour reform, limiting resident hours to fewer than 80 per week. This reform, which was radical and disruptive for a great number of residency training programs, came after several years of increasing concern that fatigued residents placed their patients and themselves at risk and that sleep-deprived learners were less able to master the cognitive aspects of training than those who were better rested. The vast majority of us in graduate medical education agreed heartily with the concepts if not the actual details; most of us who trained in the era of unrestricted work hours had personal stories to share about the errors we made, the patients we harmed (or nearly missed harming), and the personal tolls that unlimited working hours took on our lives and emotional well-being.

Much has been written about the impact of duty-hour reform, ranging from influence on resident well-being (improved) to impact on patient safety (mixed at best).

Regardless, it's clear that restricted working hours for medical trainees is here to stay. This notion received additional support from the Institute of Medicine (IOM) in December 2008, in its report, "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety," which argued in favor of continued and modified work-hour limitations and increased supervision for trainees. One might quibble over the details (16 hours of continuous work versus 30 hours with an imposed 5-hour nap?), but it's clear we will never revert to unlimited working hours again.

The dilemma is that the vast majority of us who supervise and teach in residency training programs trained in "the old system" where our hours were limited only by the amount of work to be done, the only thing wrong with every other night call was that you missed half the cases, and using grand rounds and other didactic lectures as nap time was, while not ideal, widely practiced. We like to think that we are well-trained and competent physicians and that the system that created us was "good enough for us" and surely is good enough for the current generation. This flawed logic is pervasive in human nature. But it's not a helpful tenet in the current consideration of resident training. We need to hold onto the "good" about the old system (handoffs were few, opportunities to learn from patients through the entirety of their illness were many, continuity of care was taken for granted) and dispense with the "bad" (we were really tired and a potential liability to our patients).

As a residency program director in general surgery who has been in this role for 8 years (and thus lived through the transition to the 80-hour work week), I can say that the scenario created for reflection is very realistic. I oversee a residency training program at a large urban academic medical center with busy trauma, transplant, vascular, and general surgery services. I am blessed to have incredibly hard-working residents who are bright and aspire to successful careers in academic surgery. They have gotten where they are by a combination of very hard work and intelligence, and they recognize as they become more senior that connections and mentors are important aids to future success. They don't want to risk offending a potential mentor by scrubbing out of a case because they are approaching the end of a scheduled shift or being unavailable on their weekends off for discussion of cases for the upcoming week. But as program director, I tell them they must scrub out and turn their pagers off (or at least screen out work pages) on scheduled weekends off. They are caught in the middle and face ethical dilemmas as a result. Do they offend me, the program director who wants them to comply with the schedules I design (and thus aid in retaining ACGME accreditation) or Dr. Attending, who is a nationally recognized leader in the specialty they hope to join?

The system for reporting duty hours itself entangles residents in conflict of interest. If they honestly report exceeding duty hours, they risk the accreditation of their training program. And what resident wants to be in a program that loses accreditation?

What's the solution? I see two. First and foremost, those who trained before the 80-hour work week need to "get over it" and acknowledge that duty-hour reform is a

good thing. We need to stay engaged in the debate and help to fine-tune the details, but we should not argue against the more humane working hours of our trainees. We need to find some middle ground on issues of continuity of care and shift length, scheduled days off, and learning opportunities. I have faith that those details can and will be worked out both on a local level and nationally. Attending physicians and surgeons must be mindful of the access we demand of residents, plan work flow around resident availability, and not get bent out of shape when trainees cannot comply with what we want because of scheduled shifts that follow duty-hour rules. Further, we should not imply (or worse, overtly display) that he or she who stays late is stronger, better, more worthy, or more deserving of a “prize case.”

I was gratified during a recent visit to another large academic department of surgery to learn that it, too, is taking duty hours seriously and actively counseling residents who are working excessive hours but not reporting them to find more balance in their lives, leave the hospital according to the schedule, and devote time to the other aspects of their lives. Increasingly, balance is being acknowledged as difficult to achieve but imperative for a lifetime of professional fulfillment.

Secondly, we should remove the moral dilemma of accurate hour reporting from residents’ shoulders. I approach this by designing work schedules and manpower availability in full compliance with duty-hour regulations, and I closely monitor the system to see where we need to make adjustments. I beg my residents to be truthful in reporting their hours, focusing my concerns on the system I have created and not on them as individuals who might have violated duty-hour rules. I ask the resident who reports a 31-hour shift, “What in the system failed you?” Not, “Why did you fail my system?”

So what approaches should residents take to address these concerns if their attending physicians and program director place them in the middle? First, the intern class, including the “aggressive” peer in this scenario, should work constructively toward consensus on how the class, as a group, can help each other so everyone looks good, all the work gets done, and each has access to the good cases. Secondly, junior residents should enlist the aid of more senior residents in reporting concerns. A group of residents should approach the program director together to express concern and propose solutions to the problems of compliance. Could housestaff be better deployed across services? Should call schedules be rearranged?

Residents themselves usually have terrific answers to these problems and should be empowered to help improve their programs. If this approach to the program director is not met with success, residents should next consider taking their concerns either to other faculty in the department (division chief, chair) or another well-connected physician who will be sympathetic to the cause. Again, entering such a meeting with proposed solutions goes a long way toward gaining a successful outcome. If that seems to fail, the resident group can approach the designated institutional official (DIO) of their medical center. This person oversees all graduate medical education for residencies at the institution and can be extremely helpful in applying pressure to

departmental leadership to be certain ACGME standards are observed. The DIO wants to avoid having a training program under his or her supervision in violation because this places the entire institution in a bad light and can compromise the accreditation status of all affiliated programs at that institution.

In general, I would discourage residents from going directly to the ACGME with complaints until the preceding four attempts have been made and failed. Further, if a sizable group of residents undertakes these meetings with a unified voice, with realistic and meaningful suggestions for improvement, and in a constructive and positive manner (rather than an accusatory and emotional one), success is virtually guaranteed.

In summary, resident duty-hour reform is a good thing, will be permanent, and must be accepted and acknowledged by everyone involved in graduate medical education. To place our trainees in a situation where they are rewarded for violating these regulations is immoral, unethical, and a detriment to our profession.

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## **Commentary 2**

by Katrina S. Firlik, MD

As a neurosurgery resident, I became accustomed to the mantra: “Eat when you can; sleep when you can; and don’t mess with the brainstem.” The more casually one could toss off the brainstem bit, the more compelling, as if one were lumping it together with grabbing a KitKat from a vending machine or taking a catnap in the back row of M&M conference. We took the “sleep when you can” quite literally and almost as seriously as “avoiding the brainstem.” Patients would have been horrified to find out where and when we caught our desperately needed snatches of sleep during our 100-plus-hour work weeks.

One of our attending physicians was notorious for having us scrub in on the lengthiest and most tedious of craniotomies, but allowing us no role other than observer for large stretches of time while he toiled under the microscope. Many of us learned how to position our sterile selves just so on an OR stool, arms crossed, head tipped back against the wall, angled so that the scrub nurse could not see that we were asleep for minutes at a time rather than observing the micro movements of the instrument tips on the television monitor. We would marvel at one another’s ability to sleep during these cases as we peeked in on each other from the hallway, stifling our laughter.

The neurosurgery program I trained in was the largest in the country at the time. At one point, our chairman started a new policy: the on-call resident would call him at 9 p.m. with a brief update. He wanted to keep closer tabs on our behemoth service. I remember a several-month period when we had a particularly large number of

patients, during which I would have to break free from routine evening rounds in order to call the chairman. Our entire team was still rounding at 9 p.m., generating new to-do items that would land us home at 11 p.m. (“Sorry to wake you up, Mrs. Jones. It’s 10 p.m. and time for your lumbar puncture.”) Some of us had been in the hospital since 5:30 a.m. (not to mention the resident who had been on call the previous night).

In retrospect, a quick nap in the operating room—during a case—is horrifying, and team rounds at 9 p.m. is simply ridiculous. Given my experiences as a resident prior to the work-week restrictions, I am strongly in favor of residents’ getting a healthy amount of sleep, even if forced through regulation and looked upon with contempt by certain members of the old guard. I have to admit, though, that “Eat when you can; sleep during your regulated hours off; and don’t mess with the brainstem” delivers less of a punch than the original version.

But how can an 80-hour work week be enforced in surgery training? As Mary the intern has discovered, the traditional culture of surgery, with its extreme dedication, bravado, and competition, will not be stuffed easily into the tight mold and the new culture of regulation.

With the passing of the old guard, for better or for worse, enforcement will come more naturally. When the Dr. Thompsons of the attending world are no longer in charge, the Darrens of the intern world will be less motivated to violate the rules. But what can be done during this awkward period of culture clash, with the slow changing of the guard?

I sympathize with Mary, and I do have a suggestion for her. Use the military-like hierarchy of residency to your advantage. Interns don’t have much clout. Appeal to the most well-respected and sympathetic senior or chief resident, and have him or her convey the strong concern regarding violations to the program director, as well as to Dr. Thompson himself. This indirect route, which may seem passive or even cowardly at first, accomplishes two important goals. It prevents Mary and her like-minded interns from having to worry about “appearing weak” in front of their attendings (sadly, a potential career threat) or having to play the direct whistleblower role so early in their long training. It also allows her and her colleagues to preserve at least cordial relations with Darren, which is important while looking ahead to several years in the trenches together.

Interestingly, I have also found that appealing to a well-respected nurse or other allied professional can have a powerful influence on certain senior surgeons. Some surgeons have spent 1 or 2 decades working with the same ICU or OR nurses and maintain close professional bonds with them. These nurses are more likely to witness the questionable behavior or judgment of an intern who has been working those extra hours, sleep deprived. If such a nurse can act as an ally in Mary’s desire to monitor work-hour violations, chances for enforcement may be greater. Dr. Thompson or the program director is likely to take that nurse’s concerns seriously.

Tangentially, I recall that the most tangled of ethical violations during my own training—a resident colleague’s use of intravenous drugs while on call and caring for patients—was uncovered and reported by a perceptive emergency department nurse, based on a series of unusual clues. In retrospect, many of us had noted subtle signs ourselves, but failed to piece together the clues or to act on our suspicions.

Failing these indirect but potentially more powerful approaches—appealing to a more senior resident or allied health professional—Mary may need to report the violations herself, despite the social or professional risks.

Whatever the approach, I firmly believe that the work-week violations cannot simply be swept under the rug. Fear of losing accreditation does not justify inaction, and nipping the problem in the bud is the only way to go. As a simple exercise, Mary should try the classic *New York Times* test. Suppose a grave and preventable medical error were made by Darren or another sleep-deprived intern and hit the front page of the *New York Times* in an explosive expose. The resourceful *Times* reporter then uncovered longstanding and unreported violations of work-week limitations. If Mary had failed to report these violations, how would she feel about her inaction (and, of course, the medical error itself)? Your personal and professional actions—or inactions—should always be able to withstand this effective, albeit contrived, test.

And here is one final, even simpler test: pretend that you are a patient. You find yourself sitting, cold and vulnerable in your flimsy gown, in the pre-operative holding area. The resident who will be scrubbing in on your case walks in and introduces herself. With nervous laughter, forcing a smile, you say, “Hope you got enough sleep last night!” She nods, tentatively. You’re not convinced.

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