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FROM THE EDITOR
Job Description: Resident

Faith Lagay, PhD

Internship and residency have been portrayed in novels and movies and on television for many decades, in terms that range from the heroic and melodramatic to the downright comic. The reasons for the appeal of the residents' stories are fairly obvious. Generally young and handsome or beautiful people, society's best and brightest, brimming with book knowledge, then set at the bottom of the clinical hierarchy as indentured servants and expected to cure and care for patients whose own life and death stories would make decent drama in itself. A dead-on formula for success.

Many of these fictionalized accounts have sensationalized the residents' private lives—what they get into when they're not on the job. What hasn't been recognized and examined until recently—until residents began talking about going on strike to gain more reasonable working conditions—is the fact that residents are filling 4 different and demanding roles while they are on the job: student, teacher of other students, clinician, and employee. This month's *Virtual Mentor* focuses on these 4 aspects of the resident's worklife and the conflicts inherent in endeavoring to function competently in all roles at once.

The potential conflicts are realized in one of this month's clinical cases (*Performing Procedures on the Newly Deceased*) and in the PowerPoint® presentation (*Balancing Patient Care and Student Education*). This issue's health law case points out that, in the eyes of the law, a resident may be liable for negligence or malpractice if he is acting in one role (clinician) but not if he is acting in another (student). Two essays in the Policy Forum section look at the National Residency Matching Program and changes proposed to the matching system by the NRMP itself and by an external critic of the system. In the Medical Humanities section, resident Joe Bovi, MD reflects on the (not uncommon yet) always unique experience of a patient's death. And, in a column for Medicine and Society, *Virtual Mentor's* editor, Audiey Kao, MD, PhD, suggests an alternative to the moonlighting activities that residents pursue for additional income and experience.

The learning objectives for the March issue are simply stated, but not so easy to master.

1. Identify the chief responsibilities of each role the resident is expected to fulfill.

2. Understand how the role responsibilities can come into conflict.
3. Learn to analyze conflicts between role responsibilities.
4. Identify resources that can help resolve conflicts between role expectations.

There's always much more to say on any topic than a journal can expect to cover in one issue, so let us hear from you about the stress and challenges (or the victories and rewards) of internship and residency.

Faith Lagay, PhD is managing editor of *Virtual Mentor*.

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CASE AND COMMENTARY
Performing Procedures on the Newly Deceased, Commentary 1
Commentary by Leonard Morse, MD

Case
Scott Lynch is a third-year emergency medicine resident in a large urban teaching hospital. Dr. Lynch has 2 fourth-year medical students under his supervision. Lydia Santos and Carl Mason have a few days remaining in their month-long clerkship, and the ER has supplied rich opportunities to observe and participate in treating patients with acute illness and injury as well as those who use the ER for primary care.

Dr. Lynch, a conscientious clinician and teacher, is pleased with Lydia and Carl's performance during their rotation. He has been increasingly including them in hands-on treatment whenever he judged it prudent. Each has gained a good knowledge base and is acquiring skills in suturing lacerations, wound debridement, and assisting in advanced CPR codes.

On the students' last day in the ER rotation, Mrs. Milos is brought in by ambulance from a local skilled nursing facility. Mrs. Milos, a 76-year-old woman with a history of two previous MIs, complained of shortness of breath, so the nursing home staff called the ambulance. On the way to the hospital, Mrs. Milos suffered cardiac arrest. The ambulance crew continued chest compressions and administered shock and pharmacologic treatment. Mrs. Milos was intubated when the EMTs wheeled her into the ER.

At about the same time, Mrs. Milos's son arrives by car and comes into the emergency room asking to see his mother. He is kept away from the resuscitation attempts and wais for news about his mother outside the treatment area.

Despite all attempts to resuscitate Mrs. Milos, Dr. Lynch calls off the code approximately 20 minutes after her arrival in the ER. Within moments of calling off the code, he says to Lydia, "On the chance that there's some pericardial blood, I want you to do a pericardiocentesis. It's something you need to know how to do." Lydia prepares to follow Dr. Lynch's instructions.

Commentary 1
Dr. Lynch appears to have fulfilled his teaching obligations to Lydia Santos and Carl Mason very responsibly, and, undoubtedly, they have had an excellent learning experience as senior medical students during their one-month ED rotation.

However, performing pericardiocentesis (or any other invasive learning procedure) without consent, after halting resuscitative efforts and the pronouncement of death is unethical. The question of performing procedures on the newly deceased was referred to the Council on Ethical and Judicial Affairs (CEJA) about 3 years ago by the House of Delegates of the AMA in response to a resolution introduced by the AMA Medical Student Section. In June 2001, CEJA Opinion 8.181, "Performing Procedures on the Newly Deceased," was adopted as AMA ethical policy by the House of Delegates. It calls for obtaining consent from the patient upon hospitalization or seeking permission by an advance directive or from the patient's guardian before performing a procedure after death. The Opinion states, "When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient."

Appreciating that "preserving, expanding (research), and teaching the body of knowledge" distinguishes medicine as a profession, patients should be educated to understand that hands-on learning experiences are essential, with the most junior learning under the guidance of those more senior. Informed consent should be obtained at the time of hospitalization from the patient or surrogate, so that, in the event of death, a medical student, resident, or fellow might expand his or her skill by performing a procedure under supervision. Opinion 8.181 clearly states that "the teaching of life-saving skills should be the culmination of a structured training sequence rather than relying on random opportunities," and that such "training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties." The Opinion also recommends that any procedures undertaken on the newly deceased be recorded in the medical record.

Developing skills as a physician draws fundamental human emotions into the pursuit of learning. Most physicians remember performing their first venapuncture. Acquiring skills and new knowledge in medicine is a life-long experience. Opinion 8.181 should prompt hospitals to seek from all patients, upon admission, permission for authority to approve or reject the performing, after death and under supervision, of procedures to improve the skills of trainees in order that they may better serve their future patients. Permission to acquire skills in this manner is recognized as a very special privilege.

Leonard Morse, MD a retired internist, is currently the Chief Medical Officer of the Greater New Bedford Community Health Center, New Bedford, MA, and professor of Clinical and Family Medicine, and Community Health at the University of Massachusetts Medical School. He became chair of the AMA's Council on Ethical and Judicial Affairs in June 2002.

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CASE AND COMMENTARY
Performing Procedures on the Newly Deceased, Commentary 2
Commentary by Gregory Larkin, MD

Case
Scott Lynch is a third-year emergency medicine resident in a large urban teaching hospital. Dr. Lynch has 2 fourth-year medical students under his supervision. Lydia Santos and Carl Mason have a few days remaining in their month-long clerkship, and the ER has supplied rich opportunities to observe and participate in treating patients with acute illness and injury as well as those who use the ER for primary care.

Dr. Lynch, a conscientious clinician and teacher, is pleased with Lydia and Carl's performance during their rotation. He has been increasingly including them in hands-on treatment whenever he judged it prudent. Each has gained a good knowledge base and is acquiring skills in suturing lacerations, wound debridement, and assisting in advanced CPR codes.

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At about the same time, Mrs. Milos's son arrives by car and comes into the emergency room asking to see his mother. He is kept away from the resuscitation attempts and wais for news about his mother outside the treatment area.

Despite all attempts to resuscitate Mrs. Milos, Dr. Lynch calls off the code approximately 20 minutes after her arrival in the ER. Within moments of calling off the code, he says to Lydia, "On the chance that there's some pericardial blood, I want you to do a pericardiocentesis. It's something you need to know how to do." Lydia prepares to follow Dr. Lynch's instructions.

Commentary 2
However well intended, Dr. Scott Lynch's attempts to educate the medical students under his tutelage runs afoul of current norms of ethical medical behavior. Performing procedures on the newly dead can materially undermine societal trust in

the healing arts and violate the surviving interests of newly deceased patients and their families. It is important for caregivers to respect the dignity of patients—both living and newly deceased. Teaching procedural skills, however laudable, must not interfere with family grief, visitation, and in some cases, the need to collect forensic evidence. The preponderance of data in the western medical literature suggest that consent from family members prior to practicing procedures on newly dead patients is mandatory.[1-5] This is further supported by two studies demonstrating the feasibility of obtaining consent for postmortem procedures from family members.[6, 7]

However, while dogmatically requiring consent is all well and good, there are practical and ethical challenges with this approach as well. One well designed study by Olsen et al showed only a minority of patients would allow doctors to practice cricothyrotomy on newly deceased patients in the Emergency Department.[8] In addition to being pragmatically challenging, attempting consent from distraught family members may exacerbate the grieving process and undermine trust in the profession as much if not more than doing procedures without consent[9, 10] An intermediate view between the extremes of mandating consent and foregoing consent altogether is that of teaching procedures so long as family members are not available; if they are available, consent should be attempted. However pragmatic, the inconsistency of this approach is problematic as well.

Both the professions and the general public are split on this issue. While consent is advocated, most studies suggest that practicing procedures on the newly dead is perceived to be an acceptable practice among the general public.[11, 12] In addition to widespread public support, a study of Emergency Medical Training Programs revealed that nearly half (47 percent) use the recently deceased for teaching purposes.[13] Another recent study shows that more than 1 of every 4 teachers in emergency medicine admitted to using recently deceased patients to teach procedural skills without consent.[14] Teaching procedures such as central line placement, chest tube insertion, cricothyrotomy, venus cutdown, and thoroacotomy and pericardiocentesis are all better practiced on newly deceased bodies than living patients whose well-being is materially threatened if these procedures are not done competently. The ethical principles of non-maleficence (avoiding harm to a living patient) and beneficence (providing benefits to future patients) are both satisfied when teaching procedures on the newly dead are done with dignity and care. While the recently bereft family may be concerned about the practice, most medical procedures pale in comparison to what is actually done to a body when it is sent to a funeral home. And, unlike being sent to a funeral home or having resuscitation continued for the sole purpose of education, there is never any financial cost to the patient or the family when the procedures are done on the newly deceased.

In the current case scenario, Dr. Lynch would not have been faulted for continuing the flogging of Mrs. Milos (the patient) if he felt there was a potential benefit for performing a pericardiocentesis toward the end of the resuscitation attempt. Practically speaking, he could have easily extended the resuscitation attempt and used that window to teach procedures to the medical students without fear of

retribution; however, whether such artificial extension of resuscitation attempts is ethical must also be questioned. Certainly, medically appropriate procedures should be attempted on all patients who may benefit, including dying patients, but they must be documented in the medical records and appropriately billed—hence, the conundrum of having resuscitation attempts artificially prolonged and generating inflated costs versus the ethics of performing procedures on newly deceased patients in order to insure beneficent and competent care to future patients.

Indeed, technologic advances may someday make this discussion moot, but until realistic alternatives to training on real patients are widely available, the use of mannequins, virtual reality, and patient simulators, must take a back seat to practicing on cadavers and consenting patients. Perhaps more concerning than the alleged dilemma of teaching procedures using the newly dead is the altogether acceptable practice of teaching procedures on living patients using newly minted doctors and students, often without explicit disclosures of training status or express patient consent. One recent study demonstrated that senior resident physicians were patently unwilling to have other resident physicians as their doctors, belying a more serious inconsistency, if not flagrant hypocrisy, in medical education today.[15]

In conclusion, before worrying about the rights of the deceased, we should preoccupy ourselves with the rights of the living and make every effort to disclose the status of every non-physician, student, and resident trainee involved in the care of unsuspecting patients. Given the ubiquity of moonlighting residents, unsupervised mid-level providers, and anonymous interns and students running amok in hospitals, practicing procedures on the newly dead is a minor and non-egregious concern.

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Gregory Larkin, MD is a professor of Surgery, Director of Academic Development at UT Southwestern and Director of the Violence Intervention Prevention Center. He is also a member of the Society for Academic Emergency Medicine's Ethics Committee and a member of the American College of Emergency Physicians Ethics Committee. He is one of the authors of the ACEP *Code of Ethics*.

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CASE AND COMMENTARY
An Impaired Resident, Commentary 1
Commentary by Erin Egan, MD, JD

Case
Steven and John are second-year residents in internal medicine at a major urban hospital. They have been friends since medical school and became closer while sharing long shifts during their intern year.

Over the past few weeks, John has not been himself. Steve thinks John has looked more sleep-deprived than the usual resident does, and that he might even appear tearful at times. John hasn't been joining the other residents for lunch and, when he does, Steve notices that he doesn't eat very much. Concerned, Steve realizes that John has been somewhat withdrawn for several months now. Previously, John, Steve, and Steve's wife Maria often went out to dinner or got together in the evenings, but John has declined the past few invitations. Steve has been passing off John's new behavior as the "winter blues" combined with the normal ups and downs of residency training. The R2s have been working as many hours as they did as interns, so Steve didn't make a big deal out of the fact that John didn't have time to hang out.

Last week, Steve saw the normally friendly and even-keeled John growl at a medical student and then yell at a nurse on the unit. Afterwards, he heard the nurses complain that John seemed distracted, hard to locate sometimes when they needed him, and had yelled at them about some missing lab results when it was he who had forgotten to order them in the first place. John had also been asking them for the correct dosages of commonly prescribed medications. In fact, John's behavior seemed so unpredictable and difficult of late that one nurse on the unit was asking for a transfer.

When Steve asked John whether everything was okay, John replied, "Yeah, fine." When Steve pressed a little about John's mood, John became defensive. "What, I'm supposed to be cheerful, too? Just because I'm not here 15 minutes before everyone else, and I ask some questions before charging ahead with treatment, suddenly the attending is all, 'You'd better shape up, Dr. Masterson.' Whatever."

Steve began thinking John must be depressed, or at least that John should talk to someone about his dissatisfaction with how things were going. Since he had been ignoring his friends, Steve wondered how willing John would be to accept help. Steve even found himself worrying about John's patients.

On the other hand, Steve thought that he might be making too much of what was just a bad mood. And he worried about the potential harm he could do to John's career by mentioning the situation to the residency director. Steve had heard that state medical boards require psychiatrists to turnover records of doctors whom they saw as patients. He also thought about the negative image many in the hospital had of mental illness (or any weakness in general) among residents. He didn't want to paint John as deficient just because he had a bad week.

Finally, Steve brought up the topic with Chris, another resident, and a mutual friend of his and John's. Chris said, "Oh, man, I wouldn't touch that with a ten-foot pole."

"If he was drinking or doing drugs, would you do something?" Steve asked.

"Yeah, but there's a difference."

"What's the difference?" asked Steve. "He's actin' weird. He's making mistakes. You want to wait til someone gets hurt? What if John gets hurt?

"Yeah, but if you label him as a psych case, he'll never get a job. Hell, he may not get a license."

"And if he screws up and causes harm to somebody?"

Chris did not respond. Great. Steve was more confused than before.

Commentary 1

Residency is a time of physical, emotional, financial, and intellectual stress. Each resident reacts differently, but all experience times when their reactions to the stress affect their behavior. The emotional and cognitive behavior disturbances that occur in residency have been well-documented. Residents report mood swings, appetite disturbances, depression, and increasing cynicism.[1] They frequently report feeling burned out and admit that this emotional state affects the patient care they provide.[2] Sleep deprivation is increasingly recognized as a cause of impairment and error.[3] All of this indicates that residents (and almost everyone else) are regularly expected to perform their clinical duties with some degree of impairment at least some of the time. It is hard to say when an individual resident has crossed the line from the normal reaction to residency training to being dangerously impaired.

Physicians have a duty to report impaired or incompetent physicians. This duty is reflected in professional codes of ethics and is reinforced in medical ethics training.[4, 5] However, beyond impairment due to substance abuse, there is little guidance as to what constitutes impairment or incompetence. Deciding when another resident is dangerously impaired is a difficult call, largely left to the judgment and conscience of each physician. Residents already have anxiety about their clinical decision-making skills and responsibility, and making this type of judgment about a colleague can be overwhelming. On the other hand, it is essential

that residents be willing to take proper ethical action when the behavior of a colleague becomes alarming. Because residents work together and depend upon one another, they will be the first to notice problems in other residents' clinical performance. Residents are therefore the first warning mechanism when patient safety is threatened by a resident's impairment.

Patient safety is the crucial issue. Issues of professionalism are extremely important, and if a resident is behaving inappropriately toward other providers or ancillary staff some action must be taken. But when patient safety is a tissue the problem takes on a special urgency.

The first step in determining what to do in this month's clinical case requires that Steve decide whether he believes John's behavior is a threat to patient care. If so, then Steve has no choice but to go to the program director immediately. The fact that Steve is aware of specific instances of errors and omissions probably means that there are many instances that he is not aware of. As painful as it is, and regardless of the possible effect of John's career, if patients are even possibly at risk, there is no excuse for any delay.

If patient safety is not immediately threatened, Steve has time to look at a few other options. Getting feedback from others is helpful. It may help Steve feel more comfortable that he is doing the right thing, and it may open up options that Steve had not previously considered. There may be resident support services at the hospital, or a counselor that John can talk to. Chief residents are also a resource for this type of conflict.

One concern that Steve has is that John's career may be affected. There are 2 perspectives on this that may help. First of all, John's career may be enhanced if he needs help and gets it now. Certainly, John will have better career options if he is not seen as difficult to work with and unprofessional. In addition it is unlikely that John's career would be affected by alerting the program director to the problem. Most programs understand that residents are under a huge amount of stress, and that other aspects of a resident's life may make that stress temporarily unbearable. Program directors have avenues to deal with these kinds of problems that have no long-term effect on a resident's career. If Steve waits until others report John's behavior, early interventions may no longer be available. Steve may best protect John's career by alerting the people who are in a position to help John.

Residency training is a difficult time. Every resident will experience some degree of impairment due to stress or sleep deprivation. Other residents are an important support system when stress becomes overwhelming. Sometimes problems are severe enough that additional action must be taken. When those situations arise, residents must act to protect patients' welfare. Ultimately the decision to intervene is matter of conscience and personal integrity. These problems are present at all levels of medical practice and they do not become any easier to address. The ethical

duty to report impaired colleagues is part of the price of being a professional, and the duty is to patients, not colleagues or friends.

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Erin Egan, MD, JD is a senior associate at the Neiswanger Institute for Bioethics and Health Policy at the Stritch School of Medicine at Loyola University, Chicago and a resident in the Department of Internal Medicine, Loyola University Medical Center.

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CASE AND COMMENTARY
An Impaired Resident, Commentary 2
Commentary by DeWitt C. Baldwin, Jr, MD

Case
Steven and John are second-year residents in internal medicine at a major urban hospital. They have been friends since medical school and became closer while sharing long shifts during their intern year.

Over the past few weeks, John has not been himself. Steve thinks John has looked more sleep-deprived than the usual resident does, and that he might even appear tearful at times. John hasn't been joining the other residents for lunch and, when he does, Steve notices that he doesn't eat very much. Concerned, Steve realizes that John has been somewhat withdrawn for several months now. Previously, John, Steve, and Steve's wife Maria often went out to dinner or got together in the evenings, but John has declined the past few invitations. Steve has been passing off John's new behavior as the "winter blues" combined with the normal ups and downs of residency training. The R2s have been working as many hours as they did as interns,so Steve didn't make a big deal out of the fact that John didn't have time to hang out.

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When Steve asked John whether everything was okay, John replied, "Yeah, fine. "When Steve pressed a little about John's mood, John became defensive. "What, I'm supposed to be cheerful, too? Just because I'm not here 15 minutes before everyone else, and I ask some questions before charging ahead with treatment, suddenly the attending is all, 'You'd better shape up, Dr. Masterson.' Whatever."

Steve began thinking John must be depressed, or at least that John should talk to someone about his dissatisfaction with how things were going. Since he had been ignoring his friends, Steve wondered how willing John would be to accept help. Steve even found himself worrying about John's patients.

On the other hand, Steve thought that he might be making too much of what was just a bad mood. And he worried about the potential harm he could do to John's career by mentioning the situation to the residency director. Steve had heard that state medical boards require psychiatrists to turnover records of doctors whom they saw as patients. He also thought about the negative image many in the hospital had of mental illness (or any weakness in general) among residents. He didn't want to paint John as deficient just because he had a bad week.

Finally, Steve brought up the topic with Chris, another resident, and a mutual friend of his and John's. Chris said, "Oh, man, I wouldn't touch that with a ten-foot pole."

"If he was drinking or doing drugs, would you do something?" Steve asked.

"Yeah, but there's a difference."

"What's the difference?" asked Steve. "He's actin' weird. He's making mistakes. You want to wait til someone gets hurt? What if John gets hurt?

"Yeah, but if you label him as a psych case, he'll never get a job. Hell, he may not get a license."

"And if he screws up and causes harm to somebody?"

Chris did not respond. Great. Steve was more confused than before.

Commentary 2
There are 4 basic questions here.

1. What is going on with John?
2. What is causing it?
3. How aberrant is it?
4. What can/should Steve (or others) do about it?

Is John behaving in an impaired manner? Of course he is! His friends and fellow residents, Steve and Chris, as well as the nurses and medical students have all noted and even commented on it. And it will probably not be long before his attendings become aware of it, if they are not already. Is it unusual? From what we are told, it seems to be unusual for him. He simply is not behaving the way he usually does both at work and away from work.

Is such impaired behavior unusual among sleep-deprived and overworked residents? Not at all! Over half of the PGY1 and PGY2 residents in a recent national survey reported that they had worked at least once during the past year while in an "impaired condition," ascribing it largely to sleep loss and overwork.1

Should we be concerned about his behavior? Absolutely! If he continues to do the things he is doing, the care of his patients is going to suffer and the chances of a medical mistake appear likely. Steve's concern for his friend and colleague is well founded. And even Chris knows that John is heading for trouble, but is fearful of the traditional "marine corps" mentality of medicine that admits of no "weakness or failure."

But is this all that's going on? No! He is also clinically depressed. In addition to showing some of the types of impaired behavior that many residents may show under conditions of sleep deprivation and stress, he also exhibits some classical symptoms of depression: social withdrawal, loss of appetite, mood disturbances, mental distraction, sleep loss, cognitive impairment, and emotional outbursts that are not typical of him.

Is this unusual? Again, not at all! Many studies have described the serious physical, psychological, and emotional consequences of prolonged sleep deprivation, fatigue, and stress during residency.[1] In one report, more than 30 percent of residents were found to be clinically depressed during their first post-graduate year.[2] In the past, many such residents simply "toughed it out" or self-medicated.

What should/can Steve (or others) do? Since the situation appears to be deteriorating and clinical depression is eminently treatable, it would seem to be a friendly and collegial act to assist John to get some relief from the symptoms that must surely be disturbing to him as well. Indeed, not reporting behavior of a colleague that could potentially result in harm to a patient is unethical, since it violates the fundamental fiduciary responsibility of physicians to their patients. Allowing John to continue to "screw up" clinically also is unfair to him as well as to his colleagues and patients.

While Chris may feel concerned about the possible negative professional consequences of getting help for John, most residency directors today have been sensitized to the effects of prolonged sleep deprivation and fatigue during residency, and confidential systems for referral and treatment are nearly always available without prejudice. Talking to a sympathetic and trusted faculty member, or to the program director, or even to the director of medical education in the hospital, is probably the best way to start the process if John cannot accept the fact of his impaired and potentially harmful behavior and seek help himself.

As far as stigmatizing John with a psychiatric diagnosis, his depression, while clinically real, seems fairly recent and largely situationally determined. As such, it can probably be treated as well by an experienced internist or generalist as by a psychiatrist. Since medication for depression may take a few weeks to become fully effective, a brief medical leave may be considered. However, recognition and acceptance of the problem, together with good medical treatment and collegial support, should make such a disruption unnecessary. As for Chris's concerns about how this could affect John's future licensure, since depression is frequently treated

by physicians other than psychiatrists and is such a common problem among residents, I believe there is little substance to his worries about John's having a psychiatric record that would be of concern to a State Medical Board.

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DeWitt C. Baldwin, Jr, MD trained in pediatrics, psychiatry, and family medicine and has held professional rank at 9 medical schools, 2 of which he helped to start. He currently serves as scholar-in-residence at the Accreditation Council for Graduate Medical Education (ACGME), where he continues to research and write about the working and learning environment of medical students and residents.

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IN THE LITERATURE

Debate Over the 80-Hour Work Week

Jeremy Spevick

In residency, the final stage in a physician's formal medical training, long hours and altered sleep schedules are the norm, as residents take on the full responsibilities of a medical professional. With workweeks regularly exceeding 80 hours, resident fatigue is a common problem. Work hour regulations are set and enforced by the Accreditation Council for Graduate Medical Education (ACGME), which, as its name indicates, accredits all US medical residency programs. Current regulations stipulate that residents must average (over a month) 1 day per week free of patient care and cannot be on-call more frequently than every third night.

The issue of overworked residents came to national prominence in 1999, when the National Labor Relations Board overturned a 23-year precedent by ruling that residents at private institutions could unionize and enter into collective bargaining. Although many thought this would lead to widespread unionization and large-scale changes in resident work hours, this has not been the case.[1] Organized medicine's resistance to being considered a trade group rather than a profession exerted a restrictive influence on those who wished to unionize.

In April of 2001, several groups, including the Public Citizen Health Research Group, the Committee of Interns and Residents, and the AMA, petitioned the Occupational Safety and Health Administration (OSHA) to establish and enforce a federal work hour standard for residents. They petitioned to limit the residents' workweek to 80 hours, restrict consecutive hours of on-call duty to 24, and allow for minimal periods of 10 hours rest between shifts. As of March 2003, the OSHA has not formally responded to this petition.[2]

In June 2002, the ACGME announced that new guidelines for resident work hours would become effective for all residency programs on July 1, 2003. The new guidelines specify an 80-hour work week, averaged over a four-week period. Failure to comply with regulations could result in the non-compliant program's loss of accreditation. Implementing the new changes will be challenging and expensive.[3] Residents' salaries are lower than those of staff physicians, and reducing residents' work hours will create a need for more expensive medical help.

A debate has emerged as to whether the ACGME's new policy will be beneficial to the medical profession. Will it provide patients with better care from doctors who are more rested, or will it cut short valuable time that residents need to mature into

fully qualified physicians? This and related questions are discussed in a *New England Journal of Medicine* article by David M. Gaba and Steven K. Howard.[4] First, the authors review the challenges to current work hours that I have just mentioned. Then they turn to the arguments for and against limiting work hours and discuss the changes in hospital environment that will be needed to implement the policy changes.

Those in favor of restructuring the environment of graduate medical education argue that the medical profession, like the aviation and transportation industries, should limit its work hours to reduce employees' fatigue. Gaba and Howard cite many studies that link fatigue to higher levels of depression, anxiety, confusion, and anger.[5] With more rest, the inference is, residents would have better interactions with patients and be better equipped to learn.

It is not entirely clear to Gaba and Howard that sleep loss leads to poor clinical performance, which, in turn, may cause harm to patients. Most of the studies that draw that conclusion have methodological flaws such as inconsistent definitions of fatigued and rested subjects, invalidated measures of clinical performance, and failure to account for circadian effects. Despite this uncertainty, Gaba and Howard feel that it is necessary to limit excessive work hours. In fact, they believe that the upcoming ACGME policy may not go far enough. For one thing, it will allow individual programs to apply for a 10 percent increase in the hour limit (to 88 hours per week) if the program can provide a sound educational rationale for doing so. And, they say, the guidelines are not as strict as those of other Western countries.

On the other side of the limited hours debate are physicians who think that the current working environment is essential for the learning and maturation of residents. Residents must learn that being a medical professional means having obligations to patients that go beyond personal schedules and conveniences. Only by spending long periods of time with patients can residents observe disease progress and how it affects patients and their families.[6] Those hesitant about work-hour changes are also concerned that shorter work weeks will result in more frequent changes in who is caring for each patient. Less continuity in care could possibly lead to more miscommunication between practitioners and delays in treatment for patients.

The only precedent to limiting residents' workweeks occurred in 1989 when New York state enacted legislation limiting work to 80 hours per week in response to the death of Libby Zion, in which physician fatigue was suspected as a contributing factor. The New York legislation has been expensive and difficult to enforce and has illustrated the difficulty in instituting widespread changes in the residency system. In June 2002, the New York State Health Department announced that 54 of 82 teaching hospitals inspected were cited for violations of the law.[7]

The ACGME may confront a conflict of interest in enforcing the regulations. Shortly after the announcement of the new regulations, a *New York Times* editorial[8]

noted that the Council's board is dominated by the trade associations of hospitals, doctors, and medical schools, all of which benefit from the inexpensive labor performed by residents. The Council may find it difficult to enforce regulations that go against the interests of its constituency organizations.

As the New York experience demonstrates, the cost of implementing the new regulations will pose problems. The New York state government allocated funds to teaching hospitals to cover some of the costs of reforming the system. The ACGME has no funds to give to hospitals to ease the cost of the transition, and most doctors fear that accepting state funds for residency programs would give the state a reason to think it could regulate resident work hours. Self-regulation is one of the most highly guarded rights of the medical profession (of most professions for that matter).

As this debate continues, the irony is that both proponents and critics of the changes share similar views on quality of care and the goals of residency training, although they differ in their means for achieving these goals.[9] In the end, the goals of improving residency training will not be achieved merely by limiting work time to 80 hours a week. This task will require a broader restructuring of training programs to achieve balance between the duties devoted to educating residents and those devoted to caring for patients.

Questions for Discussion

1. Will the new ACGME policy improve patient care by allowing residents to be more alert and rested, or will it hinder patient care by limiting the time needed for resident development?
2. If you are a resident, do you think that the number of hours you work negatively affects your functioning as a doctor?
3. Gaba and Howard argue that changing the behavior of clinicians goes beyond the limiting of work hours. What other changes are needed in the culture of medicine in which exhaustion is viewed more as a sign of dedication than as an unacceptable risk?
4. Should the government be involved in enforcing regulations on resident work hours?

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Jeremy Spevick is a research assistant in the AMA Ethics Standards Group.

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HEALTH LAW

Are Surgery Residents Liable for Medical Error

Lisa Panique

Henry Allen was scheduled for a routine vein ligation procedure with Dr. Smith, a surgeon to whom he had been referred. The surgery was performed in March 1990 at a private hospital. A first-year surgery resident assisted Dr. Smith with the operation. It was the residents first exposure to this procedure, but he had assisted in other surgeries. He made the opening incisions during this surgery and "closed" after Dr. Smith had performed the actual vein ligation.

Following surgery, Mr. Allen complained of extreme pain in his right groin. No immediate attention was paid to his complaint. The pain continued, and Mr. Allen sought the advice of several medical specialists. More than a year later, Mr. Allen employed another surgeon to attend to the problem. This surgeon performed a second operation, during which he found and removed a large fibrous mass in Mr. Allen's right groin. The surgeon also removed a portion of Mr. Allen's lymphatic system. As a result of this surgery, Mr. Allen developed lymphodema of his right leg from which, according to medical testimony, he will suffer permanent disability.

Mr. Allen sued Dr. Smith, the resident physician, and the hospital for medical malpractice. Experts for Mr. Allen testified that during the March 1990 operation, a tributary of the saphenous vein had been tied and ligated by suture material entrapping a tributary of the ilioinguinal nerve. As a result of this nerve entrapment, Mr. Allen suffered substantial pain. Mr. Allen argued that the botched procedure caused the fibrous mass and was the proximate cause of his permanent disabilities resulting from the lymphodema.

Legal Analysis

The above facts are adapted from *Alswanger v Smego*.[1] The plaintiffs claim against the hospital rested on the theory of "respondeat superior" (employers are liable for harms caused by the negligence of their employees, acting within the scope of employment).[2] Using this theory the hospital would be liable for the residents negligent acts, since the resident was technically an employee of the hospital at the time. The defendant hospital, however, argued that the first-year resident was a "borrowed servant," an argument that would establish an exception to the respondeat superior theory of negligence. The hospital contended, "a surgeon may replace a hospital as a master of a hospital employee by exercising supervision and control over the employee, thereby assuming liability for negligence of the borrowed servant."[3] Thus, since the first-year resident was under the surgeons—not

the hospitals—control during the procedure, the hospital could not be found liable. The court agreed with the hospital, reasoning that Dr. Smego had control over the means and methods of the plaintiffs operation, and the Stamford Hospital did not. During the operative procedure, the resident was the borrowed servant of Dr. Smego.[4] Thus, the resident and hospital could not be liable for medical negligence.

In contrast to this Connecticut court decision, Virginia courts have allowed recovery against resident physicians. In *Lilly v Brink*, for example, the court found that, even though a resident physician was employed by a public entity—a state university hospital—he was not protected by a state immunity statute that prohibits suits against state employees who are acting within the scope of their duties.[5] The court questioned the appropriateness of granting immunity based solely on the nature of employment rather than on the specific function performed by the resident.[6] The court distinguished between the resident as a student and the resident as a physician. In this case the resident had diagnosed indigestion and released the patient, who died later that day from a cardiac event. The court determined that the physical exam and assessment were not training exercises for a second-year resident. Rather, the resident used his own discretion in diagnosing, treating, and releasing the patient. The court viewed this performance as equal to that of any fully licensed physician, so the resident should also be treated as one.

Questions for Discussion

1. The law differentiates between the roles of residents, holding them responsible when they are evaluating and using judgment as physicians and not responsible when they are acting as students or "borrowed servants." Do you think most residents are aware of this legal distinction? Should they be made aware?
2. Would knowing how the law views residents status make any difference in their response to supervisors requests or in their everyday clinical conduct?
3. Do you think the legal distinction is just, or should a resident always (never) be liable for mistakes made during training?

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Lisa Panique is a contributor to *Virtual Mentor*.

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STATE OF THE ART AND SCIENCE

Diagnosing Alcohol Abuse and Treating Withdrawal Syndrome

Audiey Kao, MD, PhD

According to the American Board of Internal Medicine, a problem resident is defined as a "trainee who demonstrates a significant enough problem [to require] intervention by someone of authority, usually the program director or chief resident."[1] Among the factors that contribute to creating problem residents is substance abuse, including alcohol abuse.[2, 3] Studies have revealed that, with the exception of alcohol abuse, resident physician substance use is lower than that in comparable age-related cohorts in the general population,[4] and where there is substance use, much of it started prior to medical school.[5]

Diagnosing Alcohol Abuse

Standard screening questions for excessive alcohol use constitute a simple and reliable method of identifying potential alcohol abuse.[6] The CAGE questionnaire is a brief test that consists of 4 yes-or-no questions:

1. Have you ever felt you should **cut** down on your drinking?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**eye-opener**)?

Answering "yes" to 1 or more questions on the CAGE questionnaire indicates a need for further assessment, including a detailed family history for alcohol abuse. Alcohol abuse may be evident in physical exam findings that include hepatomegaly, rhinophyma (hypertrophy of the nose with follicular dilatation), hand tremors, and skin petechiae, or laboratory findings of elevated GGT, MCV, and serum uric acid. However, physical exam and lab studies are less reliable in identifying alcohol abuse because they have low sensitivity except in cases of severe, longstanding alcohol abuse.

Treating Alcohol Withdrawal Syndrome

Alcohol withdrawal syndrome (AWS) results from the cessation of or reduction in heavy or prolonged alcohol use, and is characterized by 2 or more of the following symptoms developing over a period of several hours to a few days[7]:

- Autonomic hyperactivity (diaphoresis, tachycardia, systolic hypertension);
- Hand tremor;

- Insomnia;
- Transient hallucinations;
- Nausea or vomiting;
- Psychomotor agitation;
- Anxiety;
- Grand mal seizures.

According to a recent study, many US teaching hospitals have ethanol on their formulary and continue to prescribe it as a treatment for alcohol withdrawal syndrome.[7] Of the 122 eligible hospitals surveyed, physicians in 62 hospitals were reported to have used ethanol to prevent or treat AWS. Standard pharmacological therapy should be benzodiazepine, with beta-blockers and clonidine as adjuvant therapy.[8-10] No clinical trials have shown that ethanol administration is appropriate therapy for AWS.

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Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.

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POLICY FORUM

Justice in Residency Placement

Timothy Murphy, PhD

Residency training is an essential component of medical education and is required in most jurisdictions for licensure as an independent medical practitioner. In the United States, a matching system assigns approximately 23,000 applicants to residency training programs in the areas of pediatrics, obstetrics and gynecology, internal medicine, and the rest. The system has been in place since 1952 and is overseen by the National Residency Match Program, a non-profit organization. Rank order lists are at the heart of the Match. An applicant picks a number of residency programs and ranks them according to preference. The residency program prepares a similar list, ranking the candidates it most wants in its program. A computer program compares the rankings and makes assignments according to a certain algorithm. These assignments are then announced to all parties on specific days. This system is effective in a number of ways. First of all, it standardizes the timetable for decisions; applicants are in no position to tie up offers while waiting to hear from another institution, and institutions are not held captive in making assignments while waiting to hear from particular parties.

A bioethicist at Mercer University, D. Micah Hester, has recently argued that the match system is incompatible with the core values of medicine.[1] Hester's chief criticism is that the current match program embodies a competitiveness that corrupts core values in medicine. According to Hester the competition involved in the Match encourages values that are antithetical to the medical profession. He says that "so long as competitive practices run rampant in institutionalized activities such as residency matching, medicine simply will never fully meet the concerns of the people who need its help and a society that needs its comfort."[2] In short, medicine is hyper-competitive, the Match is part of this syndrome, and we all suffer as a result.

Hester proposes an alternative to the Match as it currently exists: random assignment. Under his proposal, all candidates would stand an equal chance of being selected for each residency opening in a designated discipline. For example, each candidate interested in a pediatrics residency would be assigned at random to one of the available slots in pediatrics residencies around the country. There would be no rank order lists and no communication between candidates and institutions. This approach would—as Hester does not fail to note—eliminate personal choice altogether. In addition to curbing the competition involved in jockeying for candidates and positions, Hester says this approach would free up new resources and energies: "Eliminating the competitive match system would provide residency

programs and candidates with the resources to work on other more pressing issues. More time, energy, and money could go to support such concerns and activities as better salaries and hours for residents, outreach programs, deeper professionalism, and ethics and humanities education—concerns and activities that go to the heart of moral medical care."[3]

This is a drastic proposal and, I think, unwarranted both in terms of damaging effects on residency programs and the undermining of personal choice.

Medical residencies are not equal in terms of what they prepare their residents to do and how well they achieve their goals. There is a social division of labor in terms of what residencies are training their physicians to do, and they are not interchangeable replicas of one another. Some residencies are much more likely than others to encourage their trainees to engage in clinical research, to assume academic posts, and to go on to leadership roles in the profession. Others are much more likely to channel their trainees into certain kinds of practice, for example, working in institutions that provide large amounts of charitable care. It *does* matter which students are tracked into residencies because these programs train particular people whose knowledge and skills are fundamental to the design of the health care system, produce trainees who are expert in the management of certain kinds of patients, and develop the skills of particular people who will fill specific roles in the delivery of health care. It is reasonable to believe that random assignment of residents would undercut this division of labor and compromise the ability of residencies to achieve their important social goals.

When it comes to the fate of residents themselves, there are important reasons to avoid complete randomness in residency assignment. For example, many residents are married and have children. Some residents have primary responsibility as caregivers for aging or sickly parents. It would be a fundamental hardship to say that these residents should have no say whatsoever in where they train. A decision to pursue a particular residency is not only about where one continues medical education; it also reflects choices about one's familial and financial interests. For some residents it would be a hardship in the extreme to move their families from Florida to Alaska or to relocate them to rural programs far from their families. In another instance, it would be an undue economic hardship to ask some residents to shoulder the unwanted costs of residency in Manhattan when they actually prefer less costly living in a smaller city in the South. These kinds of complications could be multiplied without much difficulty. That some residencies last 6 and 7 years makes it all the more important to recognize that random assignment in residency could create and magnify all kinds of problems for trainees.

Hester does acknowledge that some residents would be resentful about assignments given to them by chance, but he thinks that this resentment would be offset by the value of being exposed to trainees from all across the country. He says that residency programs with their supply of trainees chosen at random "would benefit from having fully supplied medical staffs and residents from an array of educational

backgrounds, and the diverse residents could learn from each other while providing care for otherwise underserved patients." On the flip side of the equation, if it is in fact the case that some residency programs are better than others, these so-called "top" programs would have the opportunity to work with a variety of residents from different schools and backgrounds, residents who might not otherwise have had the opportunity to learn from the "best." In response, it must be said that it is not clear how random assignment would necessarily improve care for underserved patients. A lottery might help distribute talent more broadly across residencies, but by itself this would not mean that underserved patients would necessarily receive better care. If "the best" medical graduates do not like their placement, lingering resentment could work to sabotage the quality of patient care they deliver as residents.

Hester goes on to compare his proposal for random assignment to the kind of drafting that occurs in professional sports. Many professional athletes are assigned to teams without their having a say in the matter—and their families and living preferences are not taken into consideration. Hester wonders why this same attitude—it is enough for small town heroes to play in the National Football League no matter where they end up—should not also prevail in medicine. In other words, the rewards of being in medicine should override any specific concerns about where one wants to live and train. It is not clear, however, that random assignment would promote selfless values in physicians any more than it does in professional football recruits. Random assignment would undoubtedly disrupt important interests for more than a few residents—a disruption which could easily undermine selfless attitudes. Moreover, it is certainly not clear that random assignment would make trainees better diagnosticians, better therapists, or even help them exhibit more humane behaviors toward patients. Simmering resentment could corrode humane values and foster poor clinical habits just as badly—if not more so—than the competitive aspects of the Match. Even professional football players—the best of them anyway—try to control where they play, especially those concerned with the rewards of league victories, championship rings, and commercial endorsements.

Over and above the effect random assignment would have on residents, a lottery system could also be expected to undercut motive and effort among medical students. Certain medical school graduates are better than others with regard to their capacities in diagnostics, in therapeutic judgments, and interpersonal skills. It is to be wondered what incentive there would be for medical students to strive toward superior achievement if residency assignment turned a blind eye toward *all* accomplishment and occurred only by chance. It might well be true that some students would go the extra mile in medical school, those who do so for personal satisfaction or some other intrinsic reward. However, it is hard to believe that performance would not suffer if extra efforts *could not, could never* help in securing a preferred residency. And, to continue the theme of performance for a moment, it is hard to see that one would be doing the poorest performing students any favor by placing them in the most demanding residencies in the nation. By extension, it would be doing little favor to burden highly functional residencies with applicants who have done little more than stumble and limp their way to a diploma. After all,

it is not only talent that would be randomly distribute, a lottery would distribute the opposite of talent—whatever one wants to call that—as well.

Hester does acknowledge that random assignment would mean the loss of personal choice, but he believes this loss is acceptable because of the way in which residency competition would be undercut. It is simply untrue, of course, that once some resources are freed up that these would flow automatically to more noble causes. For example, physicians involved in overseeing residency recruitment—interviews, answering questions, preparing promotional materials, ranking candidates—might just as easily turn their attention to clinical revenue as to improving humanistic education of residents.

Lastly, there is also an important difficulty in Hester's claim that the Match operates in a way that is inconsistent with the core values of medicine. The preservation of choice is one core value in medicine, one that undergirds patient-physician encounters. The American Medical Association Principles of Medical Ethics asserts that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."[4] In other words, choice is a core value of medicine because it is important to both patient and physician alike to enter into mutually satisfactory relationships. To put it another way, except for emergency or court-ordered treatment, health care relationships should not be *random* or *involuntary*. It is hard to understand why this principle—so important to health care relationships—should not also extend to educational relationships.

In one study of residency applicants, only 4 percent of the respondents believed that the Match should be completely overhauled.[5] Whatever the problems of the Match system are, it is not clear that residency assignments made at random will solve them without also causing broad, systemic problems on a large scale. It is one thing to dream of medicine that is shorn of the worst effects of competition and that is fully committed to ethics, professionalism, and humanities. There is no reason, though, to think that a lottery system would help achieve these goals in any meaningful way. There is no obvious reason to think that revolution rather than reform should be the appropriate response to problems in the Match.

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Timothy Murphy, PhD is professor of philosophy in the biomedical sciences in the Department of Medical Education at the University of Illinois College of Medicine in Chicago. He is a 2002-2003 visiting scholar in the AMA's Institute for Ethics.

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POLICY FORUM

National Residency Matching Program Proposed Rule Change

Douglas C. Miller, PhD

The National Resident Matching Program (NRMP) has proposed a rule change for the 2003-2004 Match year. The proposed change would require all students applying for residency, including the currently exempt international medical graduates (IMGs) and US graduates who have been out of medical school for 1 year or more (doing research, in a different specialty, etc), To join the Match. Furthermore, this change would require any residency program participating in the Match to fill *all* of its positions through the Match. Presently a program can fill some positions with candidates from outside the Match and other positions with the match participants, most of whom are graduating US senior medical students.

The NRMP administration suggests that the proposed rule change would make the Match more fair. Currently the out-of-match applicant is at a potential disadvantage. There are anecdotes of out-of-match candidates being pressured to accept positions with programs that they regard as "second-line" but "safe." Out-of-match applicants have no real recourse if a residency program views it as ethical (or knows it isn't ethical but goes ahead), to make an out-of-match offer with short decision deadlines coupled with a vow that rejection of the offer means the applicant has no chance to come to that program via the Match. Thus the ability of the applicant to get into the best program willing to take him or her depends in part on the ethical sense of the program director or chairman. A great many program directors have recognized this and behaved in an exemplary fashion. We, at NYU, are hardly alone in making offers, limited only by the Match deadlines themselves, unless another equally qualified out-of-match candidate appears and there is only one available position. The new rule change would help eliminate this vulnerability on the part out-of-match candidates seeking residency positions.

While the NRMP doesn't need the assent of the residency programs to proceed with the proposed rule change, the change raises concerns worth discussing for specialties like pathology. As a specialty, pathology has never attracted large numbers of applicants for residency programs. Although the past year was an exception, the number of US students applying to pathology residency programs through the Match has dwindled to a level such that there are fewer applicants than open positions. As a consequence, a large number of entry-level residency positions in pathology programs across the country have been filled by with out-of-match applicants. Pathology programs, that historically had relied upon the Match to fill all of their positions, found that the dearth of US seniors in the Match looking for

pathology positions led them to have 1 or more positions unfilled when the Match results were announced. This is never a pleasant experience for a residency program or its director. Some of the most prestigious programs in the country, including those at the Massachusetts General Hospital, the Brigham and Women's Hospital, Columbia Presbyterian Medical Center, Barnes-Jewish Hospital at Washington University in St Louis, and my own program at NYU School of Medicine, have been in this situation at least once in the last 6 years.

To avoid having an unfilled position after the Match, pathology program directors began filling some positions with applicants eligible to be outside the Match prior to the NRMP closing date for ranking applicants. Quite a number of excellent IMG candidates and US graduates not required to be in the Match were eager to receive offers for "pre-match" positions. For eligible applicants, this eliminated the uncertainty of the Match, allowing them to make plans to live and work in a specific city well in advance of the Match and to resolve the visa problems some IMGs have (especially the time required for the government to process applications for H1-B visas). For a program, reducing the number of positions open to the Match, while not cutting the overall number of positions to be filled, lowered the risk of having an unfilled position at the announcement of the Match results. Furthermore, programs could select among a variety of different types of IMG applicants, choosing to hire those willing to sign contracts and those who fit certain criteria such as extensive research experience with publications or prior pathology training in their home country.

There have been and still are "gray" areas in these out-of-match interactions. Most IMGs and others not required to be in the Match register for it anyway. The interview process often involves a semi-ritualized "dance" around the subject of out-of-match offers. Candidates interviewing at a program they find desirable want to know if they might get an offer (at which point they would resign from the Match). The residency program often wants assurance that an extended offer would be promptly accepted and the candidate would indeed withdraw from the Match. The residency program directors in pathology have discussed this situation at their recent annual meetings. Some directors held that any discussion of out-of-match positions with a candidate registered in the Match is a violation and unethical. Others, who do not think these interactions are unethical, find no problem in exploring with candidates their rights to resign under Match rules should they wish to do so, provided that those explorations lack any coercive content. As program director for the NYU pathology program, I will forthrightly state that most IMG applicants know their rights and ask me about out-of-match positions. I make the Match rules clear, and, if we are interested in making an offer (after I have the opinions of all of those who participated in the candidate's interviews), I will extend one, with the condition that, if it is accepted verbally or by e-mail, I receive confirmation of the candidate's resignation from the Match with that acceptance.

Unfortunately, some programs, through their chairs or directors, have gone beyond the ethically questionable (but probably legal) coercive behavior to behavior that

clearly constitutes "breach of contract" and Match violations. Most commonly, the breach involves an out-of-match agreement between a program and a candidate who is a current senior medical student at a US school. The NRMP allows such contracts only if the student petitions to be released from the Match obligations by reason of a particular hardship, such as a spouse who cannot move or a chronically ill relative the applicant must help care for, and then only if this request is supported by the student's current medical school dean. Yet, numerous accusations have surfaced over the years concerning an applicant, recently interviewed and expressing a strong interest in a program, with no talk of any hardship, suddenly and mysteriously being allowed out of the Match just prior to the closure of Match lists. The applicant then appears on the list of newly hired residents of another program. Personally, I have talked to some pathologists who were recruited to resign from the Match on a fabricated hardship and were told by a program: "accept this offer or you will not be on our Match list." Of course, the candidate who succumbs to such pressure is not available to be matched by any other program.

To date, the NRMP has not enforced its existing rules or applied sanctions against residency programs that commit such gross violations of the Match contract. With the difficulty of proving any single case, the reluctance of program directors who learn of these violations to file official complaints, and the absence of a sufficient enforcement mechanism that would act as a deterrent, there appears to be the sense that a program that violates the cardinal rule of the NRMP will not suffer any penalty. On top of this, such a program receives the reward of filling 1 or more positions with applicants it wants without the uncertainty of the Match process. In view of the failure of the NRMP to enforce the most basic of its rules, many pathology program directors have expressed the view that the proposed new rule will empower programs willing to violate the rules to "cherry-pick" Match applicant participants. We have communicated to the NRMP administration our desire to see them enforce the existing rules effectively, and to deter Match violators, before making it mandatory to include IMGs and match-exempt US graduates. So far, there has not been an adequate response, although we are told they are still considering the issue.

The NRMP has stated that enforcement of its rules will be on a hospital- or institution-wide basis. This could mean that if a single program in an institution with many programs registered in the Match were to violate the rules, all of the institution's programs would somehow be sanctioned. If this sanction were a sufficient threat (not just a monetary fine, but perhaps being barred from the Match for the next year) then presumably peer pressure from the directors of all of an institution's programs on a director prone to violate the rules would be a sufficient deterrent. This needs to be apparent to all programs, their directors, and the department chairs before one can place faith in the NRMP's ability to deter residency programs' unethical behavior.

Douglas C. Miller, PhD is a professor of neuropathology and neurosurgery and director of the Pathology Residency Training Programs at New York University School of Medicine.

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MEDICINE AND SOCIETY

Moonlighting for Charity

Audiey Kao, MD, PhD

Want to Earn Up to $100,000 in Extra Cash per Year? Work as a Moonlighting Physician during Your Residency Training To Find Out How, Call 888-MOONLIT

If this fictional ad seems ludicrous, think again. A recent study revealed that 3 emergency medicine residents in their R3 year earned more than $100,000 a piece in one year as a moonlighting physician.[1] Moonlighting, the unsupervised practice of medicine by residents before the completion of residency, has been going on for decades. In the late 70s, more than 40 percent of all residents in a national survey reported that they had moonlighted.[2] While that percentage has decreased slightly, a significant number of residents, especially in certain specialties such as emergency medicine and family practice, engage in the practice of moonlighting.[1,3,4] In keeping with full disclosure, I never moonlighted during residency, but many of my friends and colleagues did.

It's Not Just About the Money

There are many reasons why residents moonlight, and earning money is certainly one of the motivations. Approximately two-thirds of residents report that paying off student loans or other debt is very important when considering whether to moonlight.[1] Many also consider moonlighting as a positive educational experience that helps them with career decisions,[5] and allows them to provide relief to physicians in underserved areas.[6]

There has been a long debate about whether moonlighting is a right or privilege and whether it improves or degrades the educational and work experience of resident physicians.[7-9] With recent attention on quality of care and patient safety, questions have been raised about the appropriateness of resident physicians providing unsupervised care. Many prominent medical organizations have come out with policies forbidding moonlighting;[10-12] others have voiced support for it.

In 1998, the Federation of State Medical Boards (FSMB) released guidelines stating that "all applicants for licensure should have satisfactorily completed a minimum of 3 years of postgraduate training in an ACGME- or AOA-approved postgraduate training program including completion of PGY-3 level training before full and unrestricted licensure. This guideline would have precluded the possibility of moonlighting as it is currently practiced because hospitals and other health organizations only hire licensed physicians. To date, only Nevada has adopted the

requirements set out by the FSMB. In response, the American Medical Association, Association of American Medical Colleges, and the American Osteopathic Association have recommended a "dependent licensure" with which a resident can moonlight under another physician's license with direct on-site supervision by a board-certified physician in the resident's specialty.

The 80-hour Workweek and 1 Day Off in 7

Beginning July 1, the Accreditation Council for Graduate Medical Education expects accredited residency programs to limit the number of hours that residents can work per week to 80 hours.[13] The new rule will also require 10-hour rest periods between daily duty periods and after in-house on-call periods. Currently, medical residents average approximately 120 hours per week. These new requirements may complicate the moonlighting issue. According to ACGME, moonlighting in the institution where one is a resident must count in the allowable 80 hours of work. Residency programs may find it difficult to monitor the time their residents spend moonlighting elsewhere.

As a resident who was trained at a time when duty hours were not a hot topic, I have doubts about the value of mandating a specific quantity of time as appropriate for residency working conditions. Rather, I believe that it is the quality of the experience and not the quantity of time that is critical to training the next generation of physicians. If it is true that money is not the primary motivation for moonlighting, I would submit that resident physicians would benefit from spending a little of their time moonlighting for charity. Free clinics are always looking for physician volunteers and, given the increasing number of uninsured, the demand is surely going to rise. Other public health safety net organizations are in similar straits and would benefit from an infusion of physician volunteerism.

It is time for the medical organizations that are responsible for ensuring the professionalism and professional self-regulation enterprise of medicine to speak up and mandate that all physicians moonlight for charity.

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PERSONAL NARRATIVE

Going Beyond "We Did Everything We Could"

Joseph Bovi, MD

Most medical schools address caring for a dying patient early on, since it is a distressing subject for most young physicians. As a first-year radiation oncology resident I have cared for many patients at the end of their lives. Thus far the clinical care of these patients has usually been straight forward, but knowing how to handle their death is an entirely different issue. Most young physicians are unsure of how to approach the death of patient with the patient's family and how to handle their own emotions. We do not always receive the best advice from other physicians we look to as mentors.

Last month on the hematology/oncology service, I had a particularly young patient who had been in the hospital for 2 months prior to my assuming his care. He had a very rare, highly aggressive tumor that was not responding well to the chemo/radiation therapy. Pain control was a persistent issue for this young man, and his family was told early on that his prognosis was poor. The palliative care team was called to follow the progress of the patient. The patient and his family activated DNR orders.

When I began to care for this patient, I was initially overwhelmed. I spent many nights reading through his 3-volume medical chart in order to get a handle on all his previous treatments. My patient was discussed in great detail during morning rounds each day. He was completing his second round of chemotherapy and his acute side effects were severe. I had many conversations with the patient and his family about their treatment goals. I made it my goal to see some improvement in this young man while I was caring for him. Soon after the completion of this second round of chemotherapy we did begin to see some improvement. I began to hope.

His condition improved to the point where his tracheotomy tube could be capped allowing him to communicate better . He was able to get out of bed and undergo physical therapy. I was quite pleased with his progress and began to think that he could return home with his family. This upturn lasted only a matter of days, however, and his condition deteriorated. After seeing the possibility of improvement in this dying patient, I was frustrated. I was attached to him and viewed improving his condition as a personal goal. It was emotionally difficult to watch this patient die, and, at the same time, explain to his family that he was dying.

Many physicians respond to a situation like this by immediately assuring themselves they did everything they could for their patient. These physicians begin conversations with colleagues or family by saying, "We did everything we could but…." I have never understood this type of justification. It seems to me that physicians who approach their patient's death in this manner are simply trying to distance themselves from the death. In saying, "We did everything we could," physicians are talking about themselves, about what "they" did, that they are blameless. They are not attending to what has happened to the patient and his or her family.

Patients expect and seek comfort in the fact that their physician will take responsibility for their care. Whether you are seeing patients for routine exams or caring for them in their dying days, you should be their advocate. I think the best piece of advice I have received thus far in my residency is to always take responsibility for your patient. It may seem like a simple piece of advice, but, when you are treating dying patients, taking responsibility can be difficult. It becomes so easy to pass by a dying patient's room and concentrate all of your efforts on those patients who need acute care. It becomes easy to seek solace in the fact that you "did everything you could do" for the patient. I am reminded daily by my medical team that doing everything you can do is part of your job, and it continues even when "all you can do" is to give care to a patient who is dying.

Joseph Bovi, MD is a first-year resident in radiation oncology at the Medical College of Wisconsin in Milwaukee.

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VIEWPOINT

Random Acts of Kindness: Sustaining the Morale and Morals of Professionalism

Audiey Kao, MD, PhD

Each generation of physicians passes down countless stories about the experiences of working, learning, and living within medicine's crucible. This crucible, otherwise known as internship, is often described in military terms with interns as privates in boot camp, their physical, mental, and emotional skills pushed to the limits. Food rations and bunks are basic if not occasionally substandard; and many of the skirmishes and battles fought by interns are chronicled like wartime reports from the front lines. As in the military, a certain bond is established among physicians who live through the ordeal together.

While many of these boot camp analogies are on target, the goals of military and medical training are very different; one system training individuals to do enormous harm, if necessary, and the other teaching students to treat the sick with competency and compassion. The boot-camp atmosphere of the internship year, however, often creates circumstances in which the ends of medical education—producing competent and caring physicians—become a casualty. Leaders in medical education and attending physicians (including myself) have a duty as teachers and mentors to bolster the morale of young physicians in their internship years with random acts of kindness.

Though internship is now many years behind me, I still reflect on my experiences as an intern and wonder how things would have been different (or how *I* would have been different) if there had been greater attention to sustaining the morale of interns, residents, and those around them. Many physician-educators have said that being on-call for 36 hours straight and seeing the disease through its initial acute phase is a requirement of internship; it toughens you. Without it, these educators claim, one's ability to cope with the anxiety, frustration, and seeming chaos is undermined. There may be some truth to that practical reasoning, but many of the internship experiences are unnecessarily exhausting and demoralizing. I would argue that the training and education of the next generation of physicians would be improved if attending physicians were to give greater consideration to their role in setting the tone and encouraging the spirit and morale of their "troops."

I am not suggesting that individual attending physicians can address all of the problems, especially the structural challenges, that confront academic medical centers in our changing health care marketplace.[1-3] But I firmly believe that

attending physicians must be keenly aware that their values and actions serve as powerful signals to others on the medical team. Our conduct and our actions to bolster (or undermine) the morale of our students set important examples. I'm talking about simple actions such as providing food for the team post-call, something I make a point to do consistently, or drawing blood or inserting an IV if my team were to need an extra hand. At this point, I'm sure some of my colleagues are muttering to themselves, "Get a reality check."

Whether one considers such actions as placing an IV or offering food to be random acts of kindness is not the issue. The relevant issue is that, as teachers and mentors for the next generation of physicians, we must find our own practical ways to sustain the morale of our students. The why, what, and how is up to each attending physician, as random opportunities for acts of kindness present themselves. Sustaining morale among interns and residents strengthens the moral basis of professionalism and our ability to educate and train future physicians in the practice of ethical and compassionate medicine.

I would like to conclude by briefly touching on the "golden rule." As children, most of us learned about right and wrong, good and bad, and what constitutes proper conduct by reciting the golden rule: do unto others as you would have others do unto you. For many faiths and religions around the world, this ethic of reciprocity serves as the basis for moral and ethical conduct. In reflecting on the value of morale, all of us who are teachers of medicine should ask ourselves: If I were an intern again, how would I want to be treated by my attending? The teacher inspired by the ethic of reciprocity is not motivated by personal benefit. Those who will benefit will be the generation of students who have as *their* attending physicians the students we are now guiding and teaching. Ultimately, and more importantly, the beneficiaries of our attention to the tenor of the learning environment will be the current and future patients of our students. I firmly believe the simple wisdom of this ethic of reciprocity is a key to educating for professionalism.

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Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.