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Clinical Cases

When Resident Duty Hours and Patient Care Collide

Limits on resident work hours help physicians to function at full capacity and ensure patient safety.

Commentary by Michael Suk, MD, JD, MPH

Dr. Grace Pointe is a third-year internal medicine resident in a medium-sized rural teaching hospital. She has been the sole resident on the cardiology service for the past 3½ weeks and has earned a great deal of respect from her attending physicians for her advanced clinical judgment and dedication to patient care.

Grace has enjoyed the rotation tremendously but has been extremely tired, having worked between 85 and 90 hours each week. The residency program has violated the resident work hour requirements on several occasions in the past and has received stern warnings from the administration in regard to this matter. When Dr. Sighe, the residency director, is informed that Grace will exceed the 80-hour limit if she remains on the cardiology service today, he promptly asks her to find a fellow resident to take her place for the remainder of the week.

Grace has just called one of the internal medicine residents to take her spot, when her pager goes off. She answers the page and discovers it is a call regarding Mrs. Fuller, 73, who has been on the cardiology service almost as long as Grace has. She has heart failure, diabetes, and hypertension among several other medical conditions and has been in poor health for quite some time. Grace has taken care of Mrs. Fuller in the internal medicine clinic in the past as well as on the cardiology service in the hospital, and they have developed a close patient-physician relationship. According to Mrs. Fuller, "there isn't anyone in the hospital I trust more than you, Dr. Grace."

Mrs. Fuller's chemistry panel is abnormal, and it appears a central venous line will have to be placed before the end of the night. When Grace arrives at Mrs. Fuller's room, she finds her anxious and short of breath. Mrs. Fuller exclaims, "Oh Dr. Grace, I am so happy to see you! They told me things were not going well and I would need some sort of monitoring device for my heart, then they said that somebody else would do this procedure. I told them they must be making a mistake—you are my doctor, you'll do the procedure, right?"

Grace looks down at Mrs. Fuller lying in the bed and doesn't know what to do. She knows if she stays to give orders and perform the procedure she will certainly be in violation of the 80-hour work week. At the same time, she knows Mrs. Fuller will be very upset if another physician takes over her care so abruptly and that, despite her fatigue, she is the only resident who is familiar with Mrs. Fuller's extensive medical history. Grace decides that the resident work hour restrictions—rights that her predecessors worked so hard to win—are not as important as caring for her patient.

Commentary

The safety of physicians and patients is at the core of the work rule that places limits on resident work hours. Most people easily recognize the value of being awake and alert when caring for patients. Questions often arise, however, as to whether the benchmark of 80 hours a week is too little or too much. A debate continues about the rule's potential impact on resident education. And as with every good debate there are strong arguments on both sides of the question. With that in mind, clinical scenarios like the one presented here provide an excellent and yet challenging lesson from which we can all learn.

Clearly Dr. Pointe is torn between providing care to a patient she has known for a long time and adherence to a "rule," which in this instance may seem unimportant in the larger scheme of things. In some ways, it is comparable to stopping for a red light when there is no one around. At the moment the rule may seem unnecessary, and the chance of getting away with it may seem good.

It is important to keep in mind that implementation of rational limits on resident work hours is an attempt at reform of a system to prevent abuse while maximizing the educational value for the resident. Each clinical scenario, while individual in nature, must be evaluated from that global view. For me, the analysis starts with an evaluation of 3 broad categories: (1) educational and hospital environment; (2) clinical situation; and (3) individual and personal challenges. Each category raises important questions that may be useful in evaluating this difficult case of Dr. Grace Pointe.

Educational and hospital environment

- Is there adequate coverage for the service by residents and attendings?
- Is there enough support staff to help Dr. Pointe do her job?
- What safeguards does the hospital have in place to create a safe and reasonable working environment?
- How are the rules enforced?

Dr. Pointe is acting as the sole resident of a cardiology service at her hospital. Situations such as these can create undue pressures on any resident who is both eager to learn and under evaluation. What I find particularly problematic in the scenario is that Dr. Sighe, the residency program director, upon hearing that Dr. Pointe is in near violation of the work-hour rules, then requires *her* to find a replacement. On its surface this might not strike us as strange—finding a resident to cover for a resident is the norm in most residency training programs. As the sole resident on service, though, she is in an untenable situation. Absent a contingency plan for these scenarios that includes a coverage contribution from residents *and* attendings alike, it is a recipe for disaster. Furthermore, Dr. Sighe fails in his enforcement of the work-hour limitations by focusing on the rule and not the resident. Conveniently, this sets the rule to be the problem and ignores its larger purpose.

In my view the residency program director bears the ultimate responsibility not only to identify residents who are overworked and overtired for the purpose of protecting patient lives, but also to ensure a healthy and productive educational environment for physicians-in-training.

In my view, as well, it is a good sign that the hospital administration has taken notice of near violations of the work-hour limitations. This suggests that the hospital and administration is attuned to the work environment.

Clinical situation

- What are the specifics of the clinical situation that make decisions particularly challenging?
- What was the patient's condition?
- What is the nature of the patient-physician relationship?
- What intervention is required and what is its level of difficulty?

The clinical scenario here is challenging. A patient with multiple chronic diseases on the border of an acute scenario is one we have all been faced with at one point in time. Compounding the difficulty of decision-making is the strong patient-physician relationship that exists between Dr. Pointe and Mrs. Fuller. The intervention required is of moderate difficulty, given Dr. Pointe's level of resident education.

Individual and personal challenges faced

- Subjectively, how tired is the resident?
- What are the internal pressures to stay?

Dr. Pointe clearly enjoys her rotation but is "extremely tired." She is confronted by a patient who would be "very upset

if another physician takes over her care" and requests that she "do the procedure." Balancing these interests is difficult. But in my view the fact that she is admittedly exhausted tips the scales in the direction of respecting the work-hour rules. An internal reference is often helpful here. If you were the patient, would you want an "extremely tired" medical resident to perform a procedure on you? Probably not. A statement of support, such as "my covering doctor is excellent and I would not hesitate to have him perform the procedure on me," might go a long way to defuse the situation. And if the relationship is as strong as it appears in this situation, a truthful acknowledgment of one's tiredness will surely be understood.

Within this very simple—and by no means comprehensive—framework for analysis, I believe Dr. Pointe did not act in the patient's best interests by consciously violating the work-hour limitations. More troubling to me, however, is the passive role the residency program director played in this situation. These ingredients often lead to difficult scenarios such as this, and make it easy to blame the rule. It is important to keep in mind that the rule is not the problem here, it is a failure to recognize and to adequately address the systemic challenges that make the rule necessary.

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