

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 8 - A-05

Subject: Resident Physicians' Involvement in Patient Care

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
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1 In recent years, the Council on Ethical and Judicial Affairs (CEJA) has undertaken a careful
2 examination of the ethical and professional issues that arise from balancing patient care with
3 medical education and training throughout a career in medicine. This began with CEJA Report 2 –
4 I-00, “Medical Student Involvement in Patient Care.” Issues related to maintenance of certification
5 were also examined in CEJA Report 10 – A-03, “Maintenance of Certification – Ethical
6 Dimensions.” This report focuses on the unique aspects of residency training and the role of
7 resident physicians** in patient care.

8 9 RESIDENCY PROGRAMS IN THE UNITED STATES

10
11 During the late 19th century the overall volume of hospital admissions increased substantially, as
12 did the proportion of admissions requiring surgical procedures.¹ This increase in the quantity of
13 surgeries required more housestaff and nursing hours, leading hospitals to seek resident housestaff
14 to provide 24-hour attendance services. The training of housestaff to meet institutional demands
15 ultimately gave rise to formal graduate medical education (GME) programs, with the term
16 “resident” being coined at Johns Hopkins Hospital to define the period of sustained specialty
17 training following an internship.² Soon thereafter, specialty residencies began to establish
18 themselves as specialized departments associated with large hospitals. Subsequently, the term
19 internship has become obsolete and is now referenced as the first year of postgraduate medical
20 education, or the first year of residency training.

21
22 Since their inception, residency programs have become increasingly structured. The National
23 Resident Matching Program (NRMP) was established to match the program preferences of
24 applicants with the applicant preferences of residency programs. By 1975, the Liaison Committee
25 for Graduate Medical Education programs began to accredit GME programs. Finally, the 1981

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** A variety of terms are used to describe physicians who are enrolled in graduate medical education programs, such as house officers, interns, residents, and fellows. In this report, we refer to all such physicians as “residents and fellows.” We use the terms “undergraduate medical education” to refer to the education of medical students, “graduate medical education” to refer to the education of physicians enrolled in residency and post-residency fellowship programs, and “continuing post-graduate medical education” to refer to the continuing post-graduate professional development of practicing physicians.

1 establishment of the Accreditation Council for Graduate Medical Education (ACGME) led to the
2 promulgation of national standards for graduate medical education. The ACGME now requires
3 accredited GME programs to ensure that residents and fellows achieve competency in the areas of
4 patient care, medical knowledge, practice-based learning and improvement, interpersonal and
5 communications skills, professionalism, and systems-based practice. The ACGME and its
6 Residency Review Committees are the primary oversight mechanisms that evaluate and improve
7 the training programs within a given specialty.

9 DISTINGUISHING CHARACTERISTICS OF RESIDENTS AND FELLOWS

11 Residents and fellows occupy a unique position along the medical career continuum: they are more
12 experienced, knowledgeable, skilled, and responsible than medical students, but generally less so
13 than practicing physicians. In addition, they have less control over their practice environment than
14 do practicing physicians. Residents and fellows are called upon to balance a multitude of roles as
15 learners, as educators, and as practitioners within a health care team

17 As learners, residents and fellows gain the skills and knowledge necessary to practice in a
18 specialized field of medicine through study and practical experience under the supervision of
19 attending physicians. While learning, residents and fellows are simultaneously expected to
20 function as teachers to medical students and to less-experienced residents and fellows. Residents
21 and fellows are assigned graduated responsibility in patient care, relative to their level of training
22 and expertise based on supervisors' assessment of their growing competence.

24 Residents and fellows may also be assigned administrative responsibilities, such as arranging on-
25 call schedules and monitoring the education of fellow residents and fellows and medical students.

27 Residents and fellows are simultaneously post-graduate students, institutional employees, and in
28 some instances, fully licensed physicians. Only recently has the National Labor Relations Board
29 (NLRB) granted private-sector residents and fellows standard rights under labor law.³

31 Residents and fellows do not have the same degree of control over their working environment as
32 practicing physicians. Their hours of duty and other working conditions are prescribed by others
33 and they are somewhat isolated from the financial aspects of providing patient care.⁴ Nevertheless
34 they do have exposure to the complexities of medical billing, coding, and, more rarely,
35 reimbursement.

37 Given those responsibilities and limitations, residents and fellows face a multitude of stressors that
38 can result in fatigue or psychological distress or lead to errors.^{5,6} Physicians involved in all aspects
39 of graduate medical education must recognize these stressors and remain committed to providing
40 proper training without compromising patient care.

42 ETHICAL CONSIDERATIONS

44 While the training of residents and fellows is essential in preparing new physicians to practice
45 medicine, medical education must enhance and not undermine patient care. Above all else,
46 residents and fellows must remain committed to patient wellbeing. This duty is prescribed under
47 Principle VIII of the AMA's *Code of Medical Ethics*, which regards responsibility to the patient as
48 paramount, and in Opinion E-10.015, which calls upon physicians "to place patients' welfare above

1 their own self-interest and above obligations to other groups, and to advocate for their patients’
2 welfare.”

3
4 *Preservation of Trust and Informed Consent*

5
6 For residents and fellows, the establishment of patient trust begins with openness and transparency
7 in the disclosure of their training status.⁷ Patients may not understand the different roles of the
8 members of the health care team and may erroneously believe that residents and fellows are
9 attending physicians fully responsible for their care. It is therefore imperative that residents and
10 fellows identify themselves clearly as members of a team that is supervised by an attending
11 physician. Indeed, studies have shown that most patients want to know about the participation and
12 specific roles of residents and fellows.⁸ Patients must also be made aware that residents and
13 fellows who participate in their care have varying levels of experience and expertise, and must
14 generally agree to residents’ and fellows’ presence or participation at each step in their medical
15 care.

16
17 In some cases, patients may request not to be treated by residents and fellows. While patients have
18 the right to participate actively in medical decision-making and even to refuse recommended
19 medical treatment, this does not necessarily entitle patients to demand that their medical care be
20 delivered in a particular fashion.⁹ In instances wherein the non-involvement of residents and
21 fellows would compromise patient care, attending physicians should strive to resolve such conflicts
22 by explaining the importance of the residents’ and fellows’ roles in patient care and identify
23 circumstances when their non-involvement might impede the provision of care. Should patients
24 still refuse the involvement of residents and fellows, the attending physicians may refer patients to
25 other physicians as appropriate.^{10,11} These informed consent issues are also discussed in CEJA
26 Report 2 – I-00 on “Medical Student Involvement in Patient Care.”

27
28 *Protecting Patient Safety*

29
30 Principle I of the AMA’s *Code of Medical Ethics* dictates that: “[a] physician shall be dedicated to
31 providing competent medical care.” Additionally, Opinion E-8.121, “Ethical Responsibility to
32 Study and Prevent Error and Harm in the Provision of Health Care,” directs physicians to “ensure
33 patient safety... and play a central role in identifying, reducing, and preventing health care errors.”
34 As such, residents, fellows, and attending physicians must work collaboratively to promote the
35 well-being of patients under their care.

36
37 Close collaboration is necessary when residents and fellows are not prepared to perform medical
38 procedures independently.¹² Attending physicians must therefore assist residents and fellows to
39 progressively gain experience. Residents’ and fellows’ training should be structured to provide
40 supervision and opportunities for consultation with more senior residents and fellows and with
41 attending faculty. Unfortunately, some surveys of residency programs have revealed instances of
42 insufficient interactions between residents and fellows and their supervisors.¹³ These systemic
43 problems raise the potential for medical errors and must be addressed as part of continuous quality
44 improvement efforts.^{14, 15}

45
46 Improper scheduling can constitute another systemic source of medical error if it results in
47 excessive fatigue among residents and fellows. It has been demonstrated that residents and fellows
48 working 80 hours per week or more commit significantly more serious medical errors compared to
49 residents and fellows who work fewer hours. The ACGME guidelines now require that the work

1 hours of residents and fellows be limited to an average of 80 hours per week.¹⁶ However, this
2 requirement is not absolute as the limitation of working hours must never compromise the delivery
3 of necessary medical services or the continuity of care.¹⁷ In addition to restricting residents' and
4 fellows' regular work hours, the ACGME recommends that residency program directors monitor
5 those individuals who choose to work additional hours outside of the residency program
6 ("moonlighting") to ensure that fatigue does not detract from their ability to care for patients.¹⁸
7 Many residency programs regulate moonlighting, either prohibiting it or requiring that the program
8 director grant approval based on the residents' or fellows' schedules. It would be incongruous to
9 support a limit on work hours to insure adequate rest hours and study time for residents and fellows
10 and to have these hours used instead for moonlighting. Ultimately, residents and fellows must self-
11 regulate their use of personal off-duty hours and avoid activities such as moonlighting if these
12 practices compromise their ability to provide safe patient care.

13

14 *Identifying and Reporting Medical Errors*

15

16 As members of the health care team, residents and fellows should be aware of their ethical
17 obligations to report problematic practices or other safety concerns. In addition to reporting
18 systemic or practice errors, residents and fellows also should be encouraged to examine their
19 individual practices so as to identify personal sources of error.¹⁹ If residents and fellows recognize
20 that they have individually committed a medical error, they are ethically obligated to disclose these
21 errors to the attending physician and cooperate in reporting them to the patient. The ethical
22 management of residents' and fellows' medical errors generally should follow the guidance outline
23 in Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm." Some have
24 recommended that attending physicians accompany residents and fellows as they disclose medical
25 errors to patients.

26

27 Because of its ethical importance, the honest discussion of medical errors and disclosure of errors
28 to patients are essential components of medical education. Evidence suggests that residents and
29 fellows who accept personal responsibility for medical errors and subsequently discuss their
30 mistakes with the hospital staff are more likely to learn from their mistakes and improve their
31 practice habits accordingly.²⁰ Residents and fellows can also learn to respond constructively to
32 medical errors by observing the actions of their colleagues and instructors as part of their residency
33 program's informal curriculum.¹⁹

34

35 To facilitate learning through personal responsibility, residency programs must move away from
36 the prevailing "culture of blame."²¹ Training programs must instead create an environment in
37 which residents and fellows can more readily discuss their medical errors. In addition, counseling
38 services should be available to residents and fellows who have been involved in such errors.

39

40 PROFESSIONAL AND INSTITUTIONAL CONSIDERATIONS

41

42 Although residency programs bear foremost responsibility to patients,²² they also have duties to the
43 residents and fellows and the hospital staff, and to society as a whole. Therefore, residency
44 programs must ensure the protection of patients' safety while maintaining the integrity of the
45 educational process²³ and safeguarding the well-being of residents and fellows.

1 *Managing Psychosocial Pressures Faced by Residents and fellows*

2
3 During the training process, some residents and fellows experience periods of “burnout” that can
4 impact negatively upon the patient-physician relationship.²⁴ Emotional support services must be
5 available to residents and fellows as the intense psychosocial pressures that occur during graduate
6 medical education may erode residents’ and fellows’ ability to care for their patients effectively.
7 Measures to promote the well-being of residents and fellows are discussed in CEJA Report 5 – I-
8 03, “Physician Health and Wellness.”

9
10 *Ethics, Values, and the Hidden Curriculum*

11
12 Residency programs must train residents and fellows in medical professionalism and provide them
13 with an understanding of the principles of medical ethics.²⁵ The concepts of professionalism may
14 be taught formally as well as through a “hidden curriculum” of examples and modeling by faculty,
15 colleagues, and peers. Residency programs must be aware of the influence of this hidden
16 curriculum in shaping residents’ and fellows’ ethics and values,²⁶ as well as their interpersonal and
17 communication skills.²⁷ Efforts must be made to align the educational content of both the formal
18 and informal curricula.

19
20 *Addressing Conflicts within Residency Programs*

21
22 Finally, residency programs have an obligation to address conflicts over any educational or patient
23 care issues that may emerge during training. According to the ACGME, all accredited residency
24 programs are required to have a grievance process for residents, fellows, and physician staff
25 members while providing residents and fellows with due process protections.²⁸ While resolving
26 issues that emerge during the training process, all parties must continue to place paramount
27 emphasis on patients’ welfare. A resident’s or fellow’s conflicts with colleagues can be addressed
28 with the assistance and support of the residency’s program director. The goals of conflict
29 resolution should be to enable residents and fellows to successfully complete their graduate
30 medical education, rather than to punish. The resolution of conflicts between residents and fellows
31 and their supervisors or colleagues is further discussed within Opinion E-9.055 “Disputes between
32 Medical Supervisors and Trainees.”

33
34 In addressing a training program’s potential non-compliance with ACGME standards, residents are
35 recommended to contact the program director first. Otherwise complainants should bring the
36 matter to the attention of higher levels of authority, including the department chair or the director
37 of graduate medical education, the institutional graduate medical education committee, or, if it
38 exists, the institutional resident organization. In rare circumstances, the certifying body of the
39 program may be contacted.

40
41 **CONCLUSION**

42
43 The fundamental challenge for residents and fellows is to pursue their education in the context of
44 safe and effective patient care. This is achieved through structured learning, appropriate
45 supervision, and good coordination with the entire health care team.

1 RECOMMENDATIONS

2
3 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
4 remainder of the report be filed:

5
6 Residents and fellows have dual roles as trainees and caregivers. First and foremost, they
7 are physicians and therefore should always regard the interests of patients as paramount.
8 To facilitate both patient care and educational goals, physicians involved in the training of
9 residents and fellows should ensure that the health care delivery environment is respectful
10 of the learning process as well as the patient's welfare and dignity.

11
12 (1) In accordance with graduate medical education standards such as those promulgated by
13 the Accreditation Council for Graduate Medical Education (ACGME), training must be
14 structured to provide residents and fellows with appropriate faculty supervision and
15 availability of faculty consultants, and with graduated responsibility relative to level of
16 training and expertise.

17
18 (2) Residents' and fellows' interactions with patients must be based on honesty.
19 Accordingly, residents and fellows should clearly identify themselves as members of a
20 team that is supervised by the attending physician.

21
22 (3) If a patient refuses care from a resident, the attending physician should be notified. If
23 after discussion, a patient does not want to participate in training, the physician may
24 exclude residents or fellows from that patient's care or, if appropriate, transfer the
25 patient's care to another physician or non-teaching service, or to another health care
26 facility.

27
28 (4) Residents and fellows should participate fully in established mechanisms for error
29 reporting and analysis in their training programs and hospital systems. They should
30 cooperate with attending physicians in the communication of errors to patients. (See
31 Opinion E-8.121)

32
33 (5) Residents and fellows are obligated, as are all physicians, to monitor their own health
34 and level of alertness so that these factors do not compromise their ability to care for
35 patients safely. (See Opinion E-9.035, "Physician Health and Wellness") Residents
36 and fellows should recognize that providing patient care beyond time permitted by their
37 programs (for example, "moonlighting") might be potentially harmful to themselves and
38 patients. Other activities that interfere with adequate rest during off-hours might be
39 similarly harmful.

40
41 (6) Residency programs must offer means to resolve educational or patient care conflicts
42 that can arise in the course of training. All parties involved in such conflicts must
43 continue to regard patient welfare as the first priority. Conflict resolution should not be
44 punitive, but should aim at assisting residents and fellows to complete their training
45 successfully. When necessary, higher administrative authorities or the relevant
46 Residency Review Committee (RRC) should be involved, as articulated in ACGME
47 guidelines. (New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500.00 to implement.

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