

10-15-2003

Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked & Sleep Deprived Medical Residents: Should OSHA Still Step In?

W. Paige Hren

Follow this and additional works at: <https://digitalcommons.pepperdine.edu/naalj>



Part of the [Administrative Law Commons](#), [Labor and Employment Law Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

W. Paige Hren, *Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked & Sleep Deprived Medical Residents: Should OSHA Still Step In?*, 23 J. Nat'l Ass'n Admin. L. Judges. (2003)
available at <https://digitalcommons.pepperdine.edu/naalj/vol23/iss2/5>

This Comment is brought to you for free and open access by the Caruso School of Law at Pepperdine Digital Commons. It has been accepted for inclusion in Journal of the National Association of Administrative Law Judiciary by an authorized editor of Pepperdine Digital Commons. For more information, please contact bailey.berry@pepperdine.edu.

Is It the End of an Era or the Beginning of an Error? The American Medical Association Finally Approves Work Hour Limits for Overworked & Sleep Deprived Medical Residents: Should OSHA Still Step In?

By W. Paige Hren*

“The most disheartening feeling as a resident physician is when you feel that your own patients have become the enemy. By enemy I mean the one thing that stands between you and a few hours of sleep.”¹

I. INTRODUCTION AND BACKGROUND

Imagine working sixty to one hundred and thirty hours per week with continuous shifts lasting thirty-six hours or more² for up to seven years straight.³ Now imagine doing this while confronting

* J.D. Candidate, May 2004, Pepperdine University School of Law; B.S. Biochemistry, 2000, University of California, Davis. Academic Fellow, Pepperdine University School of Law Center for Entrepreneurship and Technology Law; Editor-in-Chief, Journal of the National Association of Administrative Law Judges; Editor-in-Chief, Manual for Administrative Law Judges (Morell E. Mullins, © 2004). I wish to express my sincere thanks to Professor Gregory Ogden, Faculty Editor of the Journal of the National Association of Administrative Law Judges, for his invaluable advice and words of wisdom. I would also like to thank Mr. Bill Wax, for initially igniting my interest and passion for higher education and academic scholarship. I dedicate this article to my husband, Jeffrey Hren, in heartfelt gratitude for his love and support in this and all of my endeavors.

1. Internal Medicine Resident, Philadelphia, *Work Hour Stories from the Front Lines: How Patients & Residents Are Affected*, at <http://www.amsa.org/hp/reshours.pdf#200m=100,0,0> (last visited Feb. 11, 2004).

2. Dori Page Antonetti, *A Dose of Their Own Medicine: Why the Federal Government Must Ensure Healthy Working Conditions for Medical Residents and How Reform Should Be Accomplished*, 51 CATH. U. L. REV. 875, 875 (2002).

3. Jay Greene, *Residencies Successful in Curbing Work-Hour Violations*, 44 AM. MED. NEWS 28, July 30, 2001, available at <http://www.ama-assn.org/amednews/2001/07/30/prsc0780.htm>.

death, despair and disease *and* while fighting off the effects of chronic sleep deprivation. Finally, add the pressure of having to master, both in theory and in application, the subtle intricacies of human medicine and patient care. It's difficult to fathom, but prior to July 1, 2003, this was the common protocol for transforming medical school graduates into qualified doctors and specialists throughout our nation's hospitals.

So what happened on July 1, 2003 that changed the grueling working conditions endured by generations of medical residents? And did that change—albeit notable in theory—actually make a meaningful difference? Answering these questions first requires a look back at the events and circumstances surrounding resident work hour reform prior to July 1, 2003. Then, the new resident work hour guidelines, which became effective nationwide on July 1, 2003, are reviewed. Finally, by looking at the loopholes inherent in the current regulatory scheme, an inquiry is made into whether a more appropriate agency *could*, and most importantly, *should* take over the responsibility of regulating and enforcing resident work hours.

A. Pre- July 1, 2003: The Great Debate

Resident work hour reform has been the subject of hot debate for eons.⁴ Incidentally, those in greatest opposition of reform are actually (non-resident) medical doctors themselves, who assert that the tradition of working long hours is “maintained by inertia, in a bow to medicine’s historic foundations”⁵ and “serves as a test of residents’ worthiness;” a “rite of passage acting to weed out less qualified candidates.”⁶ Other members of the medical community say the long hours are essential to a resident’s medical education and are imperative for providing the proper standard of patient care required of medical doctors. Thus, because “proper training requires residents to observe a condition from beginning to end *whenever possible*,”⁷

4. See Lindsay Evans, *Regulatory and Legislative Attempts at Limiting Medical Resident Work Hours*, 23 J. LEGAL MED. 251 (2002).

5. *Id.* at 252, (quoting David A. Asch & Ruth M. Parker, *The Libby Zion Case: One Step Forward or Two Steps Backward?*, 318 NEW ENG. J. MED. 771, 774 (1988)).

6. Evans, *supra* note 4, at 252.

7. *Id.* (emphasis added).

and because residents should stay with their patients for the duration of their visit so as to avoid “dangerous gaps in patient care,” opponents of resident work hour reform say that residents have no other choice but to work long hours.⁸

Proponents of resident work hour reform, on the other hand, have successfully argued two valid points: first, the long hours and resulting sleep deprivation endured by residents are counterproductive to the learning process and actually hinder the educational goals of residency training programs;⁹ second, not only do the long hours prevent residents from providing adequate patient care, they also pose serious health and safety risks to residents and patients alike.¹⁰

Optimistic about future reform, proponents more recently shifted their focus on soliciting various regulatory agencies capable of enacting and enforcing resident work hour limitations. In fact, April 2001 marked the first time that a federal agency, the Occupational Safety and Health Administration (OSHA), had been asked to address the issue of resident work hours.¹¹ Nonetheless, the critical news came in June 2002, when, for the first time in history, the American Medical Association (AMA) adopted new policy guidelines detailing specific definitions, hours, and working conditions for medical residents.¹² A short while later, the Accreditation Council for Graduate Medical Education (ACGME), the private trade association responsible for accrediting 7,800 residency programs and teaching hospitals, created guidelines similar to those outlined by the AMA.¹³

After the AMA’s unprecedented announcement, the question as to whether or not OSHA would play a part in regulating resident work hours remained unanswered until October 2002, when OSHA announced their intent to rely on the work hour guidelines and enforcement processes recently drafted by the ACGME.¹⁴ Shortly

8. *Id.*

9. *Id.*

10. *Id.*

11. See AMA-RFS Governing Council Report F, (I-O2), Page 2 (on file with author).

12. *Id.*

13. *Id.*

14. *Id.*

thereafter, the AMA, stating that resident work conditions are best addressed “without regulation by agencies of government,” announced that it too would rely on the guidelines set by the ACGME.¹⁵ Hence, amid persuasive endorsement from both the AMA and OSHA, the ACGME began to solicit comments on its proposed standards from members of the medical community and the general public.¹⁶ In February 2003, the ACGME’s final standards were approved¹⁷ and became effective for all accredited United States residency programs on July 1, 2003.¹⁸

II. M.D. OR BUST: THE LONG AND GRINDING ROAD TO BECOMING A DOCTOR

A. *The Medical “Resident”—literally*

During the 1920s and 1930s, new physicians actually lived at hospitals as “residents,” exchanging their paychecks for room, board, and the opportunity to study medical science in a real-life setting.¹⁹ Unusually young and forbidden to marry, these residents spent the majority of their lives focused on learning the intricacies of human medicine while taking advantage of the close proximity to the hospital and their patients.²⁰

After World War II, most residents chose to forego full time residency status for marriage, families and paychecks.²¹ Pulling in about \$60 per month and living outside of the hospital’s four walls, resident’s shifts changed from twenty-four hours per day, seven days per week, to thirty-six hour shifts buffered with twelve hour rest

15.AMA *Delegates Approve Limits on Resident Working Hours*, at <http://www.ama-assn.org/ama/pub/print/article/1616-6390.html> (last visited Sept. 26, 2002).

16.*Statement of Justification/Impact for the Final Approval of Common Standards Related to Resident Duty Hours* (on file with author).

17. *Id.*

18. *Id.*

19.Frank Michota, *Do Today’s Medical Residents Really Have it Better?*, *Cleveland Clinic J. Med.* (Oct. 1997), available at <http://www.ccjm.org/1minuteconsults/oct7com.htm>.

20. *Id.*

21. *Id.*

breaks in between.²²

Today, residents must earn both a four year undergraduate degree and a four year medical degree (M.D.) before entering into a three to seven year residency training program. In 2003, the annual pay for first year residents was about \$37,300; sixth and seventh year residents pulled in about \$45,800 and \$47,200, respectively.²³

Residency programs are designed to prepare physicians for the independent practice of specialty medicine by increasing the resident's responsibilities as they progress through the program.²⁴ Thus, by their final year of residency, residents are usually "as capable of performing specialty practice as they ever will be."²⁵ Upon completion of the residency program, residents are eligible to sit for board certification, which ultimately leads to licensing in a medical specialty.²⁶

B. Vital Signs and Vital Roles: A Resident's Role in Patient Care

Residents and residency programs are the life blood of most public hospitals in America. "Medical schools need the public hospitals as sites to educate their medical students, and public hospitals need the faculty of medical schools for the education and supervision of their residents."²⁷ In fact, in most of America's public hospitals, "residents assume the brunt of the 'on call' patient care services."²⁸ These services include critical responsibilities, such as caring for and treating most emergency room patients, and delivering

22. *Id.*

23. For example, the annual resident salary schedule at the George Washington University Medical Center in Washington D.C. is as follows: First year resident: \$37,291.68; Second year resident: \$38,732.40; Third year resident: \$40,569.84; Fourth year resident: \$42,240.24; Fifth year resident: \$44,140.32; Sixth year resident: \$45,852.48; Seventh year resident: \$47,209.68; George Washington University Medical Center Website, available at <http://www.gwumc.edu/smhs/gme/salaries.html> (last visited April 21, 2004).

24. Stewart R. Reuter, *Professional Liability in Postgraduate Medical Education: Who is Liable for Resident Negligence?*, 15 J. LEGAL MED. 485, 485 (1994).

25. *Id.* at 517.

26. *Id.*

27. *Id.*

28. *Id.*

most newborn babies.²⁹ It is also quite common to find residents practicing and learning in private hospitals as well. In fact, “[i]n private hospitals with residency programs, senior residents provide most of the care at night, supervised by the patient’s physician on call by telephone.”³⁰ Therefore, “in all probability, a patient will have some interaction with a resident nearly every time he or she goes to a hospital at night.”³¹

III. THE ACGME

A. ACGME’s Accrediting Procedures

Sponsored by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies, the ACGME is a “private, non-profit council that accredits 7,800 residency programs in [26 major specialty areas]^{32]}³³ [and 82 other specialized training areas]³⁴ affecting 100,000 residents.”³⁵ Its mission is to “improve the quality of healthcare in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training.”³⁶

The ACGME’s accreditation mission is carried out by “serving

29. *Id.*

30. *Id.*

31. *Id.*

32. The 26 specialty areas include: Allergy and Immunology; Anesthesiology; Colon and Rectal Surgery; Dermatology; Emergency Medicine; Family Practice; Internal Medicine; Medical Genetics; Neurological Surgery; Neurology; Nuclear Medicine; Obstetrics and Gynecology; Ophthalmology; Orthopedic Surgery; Otolaryngology; Pathology-Anatomic and Clinical; Pediatrics; Physical Medicine; Plastic Surgery; Preventative Medicine; Psychiatry; Radiology-Diagnostic; Radiation Oncology; Surgery; Thoracic Surgery; and Urology. ACGME 2001 Annual Report, *available at* <http://www.acgme.org> (last visited Jan. 18, 2004).

33. Statistical information obtained from The 2004 ACGME Annual Educational Conference literature, *available at* <http://www.acgme.org> (last visited Jan. 29, 2004).

34. *Id.*

35. ACGME mission statement, *available at* http://www.acgme.org/media/news01_05_04.asp (last visited Jan. 3, 2004).

36. *Id.*

as the deliberative body through which standards for residency programs as well as procedures for accreditation are established.”³⁷ To assist in the accreditation process, the ACGME utilizes residency review committee (RRC) volunteers in each of the twenty-six medical specialty areas who “normally make the accreditation decisions within their areas of expertise.”³⁸ These RRC volunteers “come from the membership of national medical societies and specialty boards across the country”³⁹ and “[e]ach has a demonstrated history of involvement and commitment to excellence.”⁴⁰ Under the certification requirements of the ACGME, the RRCs must ensure “adequate supervision for all residents,” and “duty hour schedules that are consistent with proper patient care.”⁴¹

The ACGME serves as the final decision-making body in contested accreditation decisions.⁴² Although certification with the ACGME is voluntary, most medical schools seek ACGME accreditation for “recognition...and to qualify for federal Medicare funding.”⁴³ In fact, Medicare has been one of the largest financial sources for residency programs across the nation for over thirty years.⁴⁴ Finally, in order to be eligible for board certification, residents must complete ACGME-accredited residency programs.⁴⁵

B. ACGME’s Classification Standards: Are Residents Students or Employees?

“To residents, the argument is simple: they work like employees; they act like employees; they’re paid like employees”—therefore,

37. *Id.*

38. *Id.*

39. ACGME 2001 Annual Report, available at <http://www.acgme.org>.

40. *Id.*

41. *Id.*

42. The 2004 ACGME Annual Educational Conference literature, available at <http://www.acgme.org> (last visited Jan. 5, 2004).

43. Medical Group Issues Resident Work Limits, 2/19/03 L.A. Times Feb. 19, 2003, at A14, available at 2003 WL 2386397.

44. APA Presses HCFA for Medicare GME Funding, <http://www.apa.org/practice/pu/feb99/gme.html>

45. ACGME duty hour standards now in effect for all residency programs, available at http://www.acgme.org/Media/news7_1_03.asp (last visited Dec. 15, 2003).

they ought to be treated like employees.⁴⁶

The ACGME remains steadfast in their opinion that “[r]esidents are first and foremost students, rather than employees.”⁴⁷ As such, all of the ACGME’s “accreditation standards and activities [related to residency programs] reflect [that] distinction.”⁴⁸ Moreover, because “[r]esidents need to be protected as students with respect to their educational environment and the clinical settings in which they learn,” the ACGME is unlikely to ever waver on their viewpoint that residents are students rather than employees.

Historically, the ACGME’s view was also shared by the National Labor Relations Board (NLRB). In two decisions rendered in 1976 and 1977, the NLRB held that because the primary purpose of participating in a residency program was to further a resident’s medical education rather than to earn a living, residents were not considered “employees” under the National Labor Relations Act (NLRA).⁴⁹ However, on November 26, 1999, the NLRB reversed its two prior decisions, reasoning that because residents provide and are compensated for the medical services they render to patients, residents are also “employees” under the NLRA.⁵⁰ The 1999 decision had two important impacts: first, it paved the way for residents to organize labor unions and collectively bargain as employees, with all of the statutory rights and protections afforded under the NLRA; and second, because the Occupational Health and Safety Act applies only to “employment performed in a workplace,” the decision allows resident work issues to fall under OSHA’s regulatory jurisdiction, due to the employment relationship established between residents and their residency program’s hospital.⁵¹

46. *All Things Considered* (National Public Radio broadcast, Sept. 4, 1997), available at 1997 WL 12833407.

47. David C. Leach, M.D., *Statement of ACGME Relating to November 26, 1999 Decision of National Labor Relations Board Holding Resident Physicians to be “Employees” Under the National Labor Relations Act*, available at http://www.acgme.org/Review_docs/pos_stmt.asp (last visited Jan. 15, 2004).

48. *Id.*

49. Cedars-Sinai Med. Ctr., 223 N.L.R.B. Dec (CCH) 251, 253 (1976). For a thorough discussion on this decision, see Dori Page Antonetti, *supra* note 2, at 895-897.

50. 330 N.L.R.B. Dec. (CCH) 152 (1998). For a thorough discussion on this decision, see Dori Page Antonetti, *supra* note 2, at 895-897.

51. Occupational Safety and Health Act of 1970 § 4(a).

IV. THE PUBLIC APPROACH TO RESIDENT WORK HOUR REFORM THROUGH OSHA

A. *Public Citizen's Petition to OSHA: A Sound Plan Gets Silenced*

OSHA currently regulates all "establishments of licensed practitioners having the degree of M.D. and engaged in the practice of general or specialized medicine and surgery."⁵² Intuitively, this broad category, along with the 1999 NLRB decision, would seem to encompass all levels of medical doctors, regardless of whether they practice medicine as residents or not. Instead, however, OSHA maintains that their regulatory powers remain specifically limited to post-resident medical doctors.

In April 2002, the American Medical Student Association (AMSA), the Committee of Interns & Residents (CIR) and Public Citizen⁵³ sought to include medical residents under OSHA's current regulatory jurisdiction by filing Public Citizen's Petition to OSHA (Petition).⁵⁴ Based on the conclusion that "residents' excessive work hours result in occupationally-related injuries and illnesses,"⁵⁵ the Petition asked OSHA to consider enforcing the following resident work hour guidelines:

52. <http://www.osha.gov>. This broad category includes: ambulatory surgical centers; physician clinics; freestanding emergency medical centers; primary care medical clinics; and offices of anesthesiologists, dermatologists, gynecologists, neurologists, obstetricians, oculists, ophthalmologists, orthopedic physicians, pathologists, pediatricians, plastic surgeons, psychiatrists, psychoanalysts, radiologists, surgeons and radiologists. *Id.*

53. Public Citizen is a "national, nonprofit consumer advocacy organization founded in 1971 [with 150,000 members] to represent consumer interests in Congress, the executive branch, and the courts." From Public Citizen's webpage, at <http://www.citizen.org/about/> (last visited March 23, 2004).

54. Petition to the Occupational Safety and Health Administration Requesting that Limits Be Placed on Hours Worked by Medical Residents (hereinafter, "Petition to OSHA"), available at http://www.citizen.org/publications/print_release.cfm?IDW6771 (last visited Feb. 13, 2002).

55. See OSHA Response to Petition (hereinafter, "Response to Petition") available at www.citizen.org/documents/ACFC2B.pdf (last visited June 10, 2003).

- 1) Residents should not work more than 80 hours per week or more than twenty-four consecutive hours, averaged over a one week period.⁵⁶
- 2) On-call resident shifts should be limited to every third night, averaged over a one week period;⁵⁷ and
- 3) Residents should be given at least ten hours off between shifts and at least one 24-hour period of off-duty time per week, averaged over a one week period.⁵⁸

Furthermore, the Petition suggested that compliance and enforcement be maintained through:

- 1) Requiring hospitals to keep resident schedules as public records;⁵⁹
- 2) Requiring frequent unannounced inspections by OSHA;⁶⁰
- 3) Allowing public disclosure of residency programs found to be in violation of the guidelines;⁶¹
- 4) Establishing official procedures for reporting violations;⁶² and
- 5) Imposing civil penalties against violators to discourage future violations.⁶³

On October 4, 2002, OSHA rejected the Petition and the idea of being responsible for creating federal workplace standards to control

56. Petition to OSHA, *supra* note 54.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

resident work hours.⁶⁴ Opting instead to rely on ACGME's standards, OSHA stated that they believed that the ACGME was "well-suited to address work-duty restrictions of medical residents" because the fatigue caused by working excessive was more than just a potential occupational hazard—it also put patient safety at risk.⁶⁵ For that reason, OSHA argued, resident work hour issues would be better addressed by "entities with experience both in patient care and employee health."⁶⁶ Thus, because the ACGME has "extensive experience in patient health, employee health, and medical education and training," and because "OSHA's rulemaking resources [were] fully committed to working on a range of critical workplace and safety issues," the ACGME was in a better position to "address the issue in a manner that comports with the complexity of the various interests."⁶⁷

V. THE PRIVATE APPROACH TO RESIDENT WORK HOUR REFORM THROUGH THE ACGME

At its September 2002 meeting, the ACGME Board of Directors approved a set of proposed standards for resident work hours developed in the report of the *ACGME Work Group on Resident Duty Hours and the Learning Environment*.⁶⁸ Consistent with its policy, the ACGME received comments on the proposed standards through December 31, 2002, with final approval of the standards occurring at the February 2003 ACGME meeting. On July 1, 2003, the ACGME's work hour standards became effective for all accredited residency programs.

The ACGME refers to its new standards as "common duty hour standards" because they "establish a minimum for all specialties where no standards existed prior to July 2003."⁶⁹ Thus, specialties with more restrictive standards already in place (such as Emergency

64. Response to Petition, *supra* note 55.

65. *Id.*

66. *Id.*

67. *Id.*

68. *ACGME Work Group on Resident Duty Hours and the Learning Environment* (on file with author).

69. Frequently Asked Questions about the Proposed Common Duty Hour Standards, available at <http://www.acgme.org> (last visited Jan. 4, 2004).

Medicine, which limits work hours to seventy two per week), will continue to enforce those more restrictive standards.⁷⁰

The ACGME defines “duty hours” as “all clinical and academic activities related to the residency program,”⁷¹ i.e., “patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.”⁷² Duty hours do not include “reading and preparation time spent away from the duty site.”⁷³

The following is a summary of ACGME’s common duty hour standards:

A. Duty Hours

- 1) “Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.”⁷⁴
- 2) “Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.”⁷⁵
- 3) “Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.”⁷⁶

70. *Id.*

71. Section D. 2. (a): *For Insertion Into the Common Program Requirements for all Core and Subspecialty Programs by July 1, 2003*, available at http://www.acgme.org/DutyHours/dutyHoursLang_final.asp (last visited Jan. 15, 2004).

72. *Id.*

73. *Id.*

74. *Id.* at Section D. 2 (b).

75. *Id.* at Section D. 2 (c).

76. *Id.* at Section D. 2 (d).

B. On Call Activities

The ACGME states that the objective of on-call activities is “to provide residents with continuity of patient care experiences throughout a 24-hour period.”⁷⁷ “In-house call,” which is defined as “those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution,” is limited to the following:

- 1) “In-house call must occur no more frequently than every third night, averaged over a four-week period.”⁷⁸
- 2) “Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.” However, “[r]esidents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care[.]”⁷⁹
- 3) “No new patients...may be accepted after 24 hours of continuous duty.”⁸⁰
- 4) “At-home call (pager call) is defined as call taken from outside the assigned institution.”⁸¹
 - a) “The frequency of at-home calls is not subject to the every third night limitation.” “However, at-home call[s] must not be so frequent as to preclude rest and reasonable personal time[.] Furthermore, “[r]esidents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.”⁸²

77. *Id.* At Section D.3.

78. *Id.* at Section D. 3(a).

79. *Id.* at Section D. 3(b).

80. *Id.* at Section D. 3(c).

81. *Id.* at Section D. 3(d).

82. *Id.* at Section D. 3(d)(1).

- b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the eighty-hour limit.⁸³
- c) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.⁸⁴

C. Moonlighting

The ACGME notes that “[b]ecause residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.”⁸⁵ Thus, internal moonlighting (moonlighting that “occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor’s primary clinical site(s)”) “must be counted toward the 80-hour weekly limit on duty hours.”⁸⁶

D. Oversight

- 1) “Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.”⁸⁷
- 2) “Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.”⁸⁸

83. *Id.* at Section D. 3(d)(2).

84. *Id.* at Section D. 4(a).

85. *Id.* at Section D.4(c).

86. *Id.*

87. *Id.* at Section D.5(a).

88. *Id.* at Section D.5(b).

E. Exceptions

Exceptions to the common duty hour standards may be granted on a program-by-program basis⁸⁹ by an RRC for up to ten percent of the 80-hour limit if the exception is based on “sound educational rationale.”⁹⁰ Hence, “all hours in the extended workweek [must] contribute to resident education,” or there must be a “very high likelihood that [the increase in hours will] improve the residents’ educational experience.”⁹¹ Thus, a surgical residency program, for example, requesting an exception would need to demonstrate that: (1) surgical residents do not attain the required case experiences unless their hours are extended beyond the 80-hour weekly limit; and (2) “all reasonable efforts to limit activities that do not contribute to enhancing [the residents’] surgical skills have already been made.”⁹²

Furthermore, to be eligible, the institutional sponsor must have (1) a “favorable [accreditation] status from its most recent review by the ACGME Institutional Review Committee;” and (2) “[t]he program must be accredited in good standing, i.e., without a warning or a proposed or confirmed adverse action.”⁹³

As of January 2004, about one percent of the 7,900 ACGME-accredited programs had applied for the ten percent weekly increase in duty hours; of that percentage, fifty-three programs were granted the increase and seventeen programs were denied the request.⁹⁴

89. <http://www.acgme.org> (last visited April 21, 2004).

90. *Supra* note 69.

91. *Id.*

92. *Supra* note 45.

93. <http://www.acgme.org>.

94. <http://www.acgme.org> (last visited April 21, 2004).

VI. INHERENT LOOPHOLES IN ACGME'S DUTY HOURS STANDARDS
ILLUSTRATE WHY FEDERAL INTERVENTION THROUGH OSHA IS
IMPERATIVE

A true story from an anonymous surgery resident from Illinois:

Only two weeks into the new academic year and my program is already in violation of the new [ACGME] guidelines. I continue to work 35-45 hour shifts[,] as I was instructed not to go home post-call....When the residents told our chairman about this issue, we were asked to 'lie' in our reporting of work hours. Fearing retribution from the faculty, the residents will 'comply on paper' but not in actuality.⁹⁵

In December 2003, CIR and AMSA launched www.hourswatch.org, a new website created to serve as the "independent watchdog"⁹⁶ for resident work hour violations. One important feature of the website is a section allowing residents to post stories like the one above. Unfortunately however, this disturbing story does not come as the result of a single isolated incident. In fact, countless numbers of appalling stories concerning resident work hour violations have been posted on the website since the ACGME's new guidelines went into effect.

This information illustrates the fact that the ACGME guidelines contain loopholes which are allowing residency programs to continue the practice of overworking residents. However, these loopholes can be avoided altogether if OSHA were to take over the regulation of resident work hours and adopt the guidelines outlined in the Petition. Indeed, at first glance, ACGME's guidelines appear similar to those outlined in the OSHA Petition. But upon closer inspection, subtle differences materialize that yield both erroneous and unseemly results. An inquiry into these differences—specifically, flawed rule drafting which allows residents to work over one hundred hours per

95. <http://www.amsa.org/hp/reswork.cfm> (last visited Jan. 29, 2004).

96. AMSA's National President Lauren Oshman,
<http://www.amsa.org/news/pr/03/1209.cfm>.

week, and enforcement provisions that inherently raise potential conflicts of interest—are considered in the following section.

A. ACGME's Compliance & Enforcement Provisions

The ACGME monitors compliance of guidelines using the following three sources: (1) annual surveillances; (2) site visits; and (3) complaints or external information. The following section and *Figure 1* will consider ACGME's algorithm for compliance monitoring under the annual surveillance context.⁹⁷

Under ACGME's annual surveillance context, work hour data obtained from both the online program director and resident surveys⁹⁸ are monitored for compliance. If the results from both surveys suggest compliance with ACGME's guidelines, the accredited residency program is reevaluated annually and at its next site visit. If, on the other hand, noncompliance is suggested by the survey data, the RRC for that particular program is responsible for evaluating the conflicting data and deciding upon one of two actions: (1) moving the site visit date to an earlier time; or (2) requesting information and a correction plan from the Residency Program Director. If, under option (2), the RRC requests a correction plan from the Residency Program Director, that plan must be implemented within eight to twelve weeks.

If the correction plan is indeed found to be compliant, the residency program is reevaluated annually and at the next site visit. If, however, the correction plan is found to be noncompliant, the ACGME, along with the respective RRC, decide whether or not to require an immediate site visit, or alternately, in the case of egregious violations, require an "unannounced"⁹⁹ site visit. Either way, the

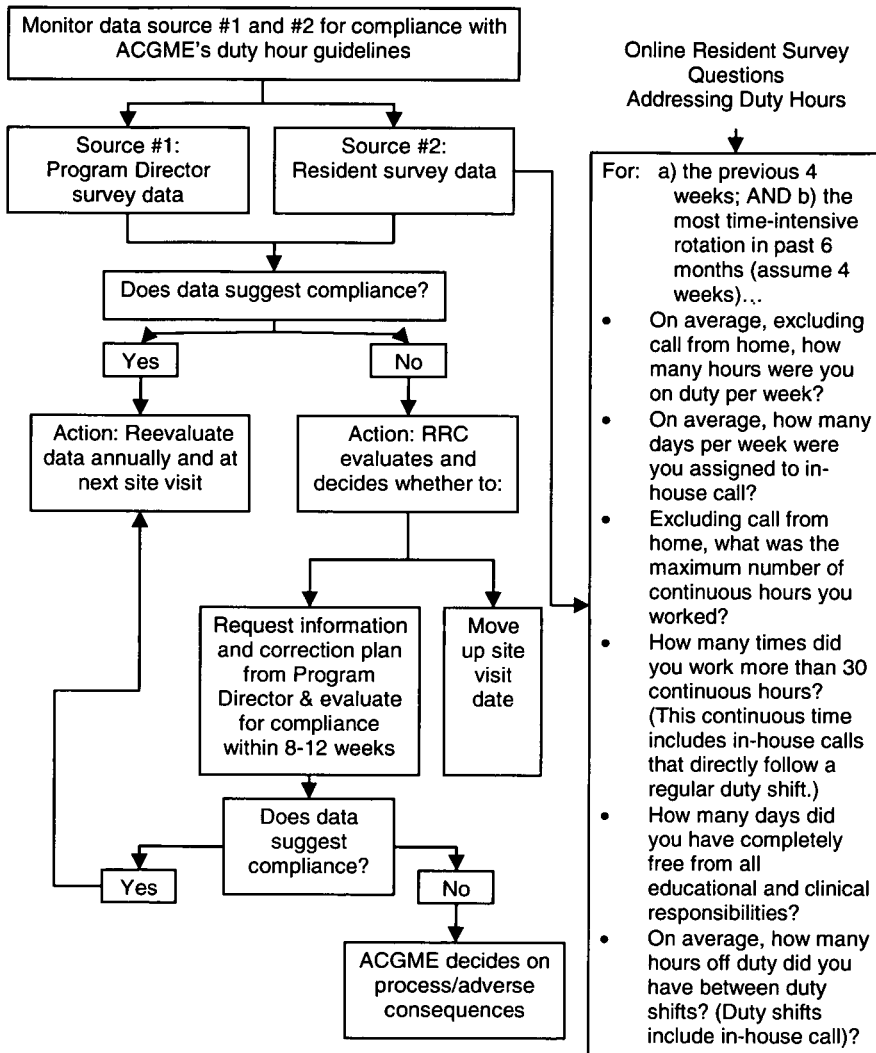
97. Figure I was derived from the information obtained from the First Report of the ACGME Duty Hour Subcommittee, June 2003, *available at* www.acgme.org/DutyHours/dutyHrs_subcomreport1103.pdf (last visited Jan. 2, 2004).

98. The resident work hour survey can be found at www.acgme.org/surveys; http://www.acgme.org/Resident_Survey/res_FAQ.asp (last visited Jan. 15, 2004). "Currently active full- and part-time residents are required to participate, and at least 70% participation is required" of all programs (both cores and subspecialties) that have at least five active residents. *Supra* note 45.

99. "Unannounced" site visits under the ACGME are actually site visits with forty-eight to several days notice. *Id.*

results of the immediate or unannounced site visit dictates which actions, including citations, probation, or withdrawal of accreditation status, are taken.¹⁰⁰

Figure II



Contrary to the ACGME compliance provisions, which leaves the discretion of determining noncompliance up to the RRC volunteers, OSHA's guidelines dictate that when a Secretary has

100. *Id.*

reasonable grounds to believe that a violation or danger exists (after an employee has requested an inspection based on the belief that a “violation of a safety or health standard exist[ed]”), the *Secretary* “shall make a special inspection...as soon as practicable, to determine if such violation or danger exists.”¹⁰¹ This is an important distinction because under the ACGME’s provisions, there is an inherent conflict of interest in allowing the RRC volunteers—who are self proclaimed members of the very same medical societies and specialty boards as many of the Residency Program Directors—to make judgment calls on whether compliance has been met or not. Clearly, the RRCs can be seen as having vested interests in *not* issuing citations to their peers and colleagues in the same specialty boards they represent. On the contrary, if regulations were handled through OSHA rather than the ACGME, the task of making adverse judgments against the Residency Program Directors in the event of noncompliance, would be handled by an outside, uninterested party.

Another flaw with ACGME’s guidelines is that they arbitrarily assign an eight to twelve week deadline for the Residency Program Directors to create and implement corrective action plans after noncompliance has been established. Under OSHA, on the other hand, if the Secretary believes an employer is in violation, the Secretary shall “fix a reasonable time for the abatement of the violation.”¹⁰² As certain violations are likely to arise that require immediate corrective action, using a reasonableness standard to set abatement time limits is imperative. Thus, in the paramount interest of patient and resident safety, the eight to twelve week restrictions set under the ACGME guidelines are likely to be too long or too short to implement proper corrective measures and should not be endorsed at any cost.

101. Emphasis added. Occupational Safety and Health Act, § 8(f)(1). The notice must be reduced to writing and should set forth with “reasonable particularity the grounds for the notice.” *Id.*

102. Occupational Health and Safety Act, § 10(a).

B. The Effects of Averaging Hour Limitations over Variable Time Periods

One of the most troubling differences between the proposed guidelines in the OSHA Petition and the current provisions under the ACGME is that the ACGME allows residency programs to average hour limitations over a four-week period rather than a one week

Regulation	ACGME	Petition to OSHA
Resident work hours limited to a maximum of 80 duty hours per week	Averaged over a FOUR week period	Averaged over a ONE week period
One day out of seven must remain free from all clinical and educational responsibilities	Averaged over a FOUR week period	Averaged over a ONE week period
Residents cannot be scheduled for 24 continuous hour in-house calls more than once every three nights	Averaged over a FOUR week period	Averaged over a ONE week period

period under the OSHA Petition. *Figure II*

illustrates an example of an acceptable resident work week schedule under the current ACGME guidelines when (1) the 80 hour per week limitations; (2) the 1-day-in-7-off limitations; and (2) the 24-hour continuous on-call duty frequency limitations (no more than once every three days) are averaged over a four week period.

Under the sample schedule, the ACGME

guidelines allow a resident to work 118 hours per week during Week One and Two,¹⁰³ (represented by the boxes labeled "On") for at least fourteen days straight without a full twenty-four hour period off (the full days off are represented by the dark outlined boxes in Week Three and Four).¹⁰⁴ Furthermore, in Week One and Two, a resident could work eight twenty-four hour shifts (represented by the shaded boxes labeled "On") separated only by the required ten hour rest

103. Because the ACGME guidelines allow averaging over a four-week period, the 80 hour per week limitation is equivalent to 320 hours per 28 days. Thus, as long as the resident's hours do not exceed 320 hours in the four week period (28 days), the ACGME guidelines have not been violated.

104. Because the ACGME guidelines allow averaging over a four-week period, the 1-day-in-7-off limitation is equivalent to 4-days-in-28-off. Thus, as long as the resident gets four days off in a twenty-eight day period, the ACGME guidelines have not been violated.

periods (represented by the boxes labeled “Off” in Week One and Two) required by the ACGME guidelines.¹⁰⁵

Figure II

A sample four week resident work schedule permitted under the current ACGME guidelines

Week One

On	Off	On	Off	On	Off	On	Off	On	Off	Total Hours worked
24	10	24	10	24	10	24	10	22	10	118

Week Two

On	Off	On	Off	On	Off	On	Off	On	Off	Total Hours worked
24	10	24	10	24	10	24	10	22	10	118

Week Three

Off	Off	On	Off	On	Off	On	Off	On	Off	On	Off	Total Hours worked
24	24	10	14	8	16	8	16	8	16	8	16	42

Week Four

Off	Off	On	Off	On	Off	On	Off	On	Off	On	Off	Total Hours worked
24	24	10	14	8	16	8	16	8	16	8	16	42

105. Because the ACGME guidelines allow averaging over a four-week period, the limitation requiring that 24-hour continuous on-call duty shifts occur no more than once every three days is equivalent to a limitation requiring that 24-hour continuous on-call duty shifts occur no more than eight times in every twenty-eight day period. Thus, as long as the resident does not work more than eight continuous 24-hour shifts in a twenty-eight day period, the ACGME guidelines have not been violated.

It is also important to mention two other significant discrepancies between the ACGME guidelines and those outlined in the OSHA Petition which were not considered in *Figure II*: Unlike the OSHA Petition guidelines, the ACGME guidelines allow residents to extend their 24-hour shift limit to thirty hours *and* increase the 80-hour week limit by ten percent under special circumstances. This means that a resident would be allowed to tack on thirty-two additional hours and several thirty-hour shifts to the already exhausting schedule in *Figure II*!

C. Public Reporting of Citations

The *First Report of the ACGME Duty Hour Subcommittee* in June 2003 stated that while “the ACGME has explored public disclosure of duty hour citations,...the importance of other aspects of the standards makes it inadvisable to single out duty hours for public disclosure.”¹⁰⁶ Additionally, the subcommittee raised concerns about the effect of public disclosure on the ability to “conduct...frank and forthright review[s] of programs.” Thus, rather than publicly disclosing information on whether particular residency programs have been cited for work hour violations, the subcommittee recommended that: (1) “the ACGME continue its practice of periodically providing summary data on compliance [internally;]” and (2) the Monitoring Committee be asked to consider [the] issue as part of its ongoing discussion of the degree to which accreditation information should be made public.”¹⁰⁷

OSHA, on the other hand, does allow for public disclosure of information relating to safety and health standard violations under the Occupational and Safety Health Act by authorizing both the Secretary of OSHA and the Secretary of the Health and Human Services to “compile, analyze, and publish, either in summary or detailed form, all reports or information obtained” under the

106. Advising the ACGME on the Implementation and Monitoring of the Duty Hour Standards, *The First Report of the ACGME Duty Hour Subcommittee*, June 2003, page 1, available at www.acgme.org/DutyHours/dutyHrs_subcomreport1103.pdf (last visited Jan. 2, 2004).

107. *Id.*

respective sections of the Act.¹⁰⁸

Allowing for public disclosure of residency programs in violation of work hour guidelines would likely curb the frequency and gravity of violations, thus resulting in an all around safer environment for residents and patients alike. Furthermore, because future residents could use the public information when deciding which residency programs to apply to, those residency programs who comply with the standards would be fittingly rewarded with more residents applying to their programs.

VII. CONCLUSION

"For decades, the ACGME has done very little as residents were abused and patients put at risk...now OSHA is asking the public to trust the very individuals who allowed this mess to continue."¹⁰⁹

The mission of the ACGME is to "improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training."¹¹⁰ This mission, however, can only be accomplished by allowing OSHA, the agency created to "[a]ssure so far as possible every working man and woman in the Nation safe and healthful working conditions," to take over the responsibility of regulating and enforcing resident work hours.¹¹¹ Rather than permitting the medical profession to continue self regulating an industry so fundamental to our nation's health and safety, the federal government, through OSHA, must step up to the plate to replace ACGME's dangerously weak enforcement provisions with more improved and realistic regulations.

108. Occupational and Safety Health Act § (g)(1).

109. Peter Lurie, Deputy Director of Public Citizen's Health Research Group, *OSHA Denies Petition to Reduce Work Hours for Doctors-in-Training. Voluntary Approach Will Not Work, Public Citizen Says*, at <http://www.citizen.org/pressroom/release.cfm?ID=1239> (last visited April 20, 2004).

110. ACGME Website, at <http://www.acgme.org>. (last visited April 21, 2004).

111. Petition to OSHA, *supra* note 54.

