

Are Duty Hour Regulations Promoting a Culture of Dishonesty Among Resident Physicians?

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Since the implementation of common duty hour standards by the Accreditation Council for Graduate Medical Education (ACGME) in 2003, and the release of added standards in 2011, there have been efforts to assess these requirements on patient safety and resident learning. A number of resident and program director surveys have sought to gauge the effects of the standards on trainee competency, fatigue, quality of life, and patient safety.¹⁻¹⁷ While the results of these surveys differ slightly among specialties, several pervasive themes have emerged. First, the 16-hour limitation for first-year residents enacted in July 2011 is not popular, with most respondents indicating that this regulation may be detrimental to resident training.^{1,8,11,13,14,16} Second, many respondents have indicated that they think the regulations have not significantly improved patient safety.^{2,3,5,6,17} Third, residents in many medical specialties and most in surgical specialties disapprove of the regulations.^{1,14,15,17}

The most recent systematic review and meta-analysis evaluating the effects of the ACGME regulations on morbidity and mortality in surgical patients demonstrated no observable effect on patient safety.¹⁸ This review corroborates previous studies¹⁹⁻²⁴ that showed patient outcomes or the quality of care in the United States has not improved since the implementation of the duty hour restrictions.

A review of studies evaluating duty hour violations indicates that many resident physicians in the United States violate the regulations on at least an occasional basis.^{4,7,14,25,26} In a review of programs that were recurring offenders, Philibert and colleagues²⁷ identified 2 universal reasons for violations: first, “rotations to institutions valued for their clinical volume and intensity, but with a heavy service component,” and second, “excess hours because residents identify deeply with the culture of their program, with longer hours attributed to their engagement in and commitment to their program and patients.” A physician’s responsibility toward his or her patients and the

conflict this creates with compliance with the regulations may be particularly challenging for learners. Residents frequently cite the need for continued care of a patient as the reason for intentional violations.²⁸ They are faced with a moral dilemma²⁹ when they feel rushed to leave the hospital at the potential expense of their patients.

Trainees essentially have 3 basic avenues for maintaining compliance and avoiding violations when faced with excessive duties. First, they may become more efficient and complete more work in a shorter period of time. While some enhanced resident efficiency has probably occurred, residents cannot be expected to simply “work harder.” Often they are dealing with factors that do not have set timetables and are beyond their control, including critically ill patients or the needs of patients and families. Second, residents can shift responsibilities and sign out incomplete duties to other residents. While this is frequently used to off-load residents at the end of their duty period, residents may wish to avoid this because it puts work onto the shoulders of others, and residents may be labeled as lazy or incompetent by their colleagues. Residents often are expected by their senior colleagues to get their own work done before going home. Residents also have an established relationship with patients and feel a responsibility toward completing patient tasks because of this bond. The third option is for residents to complete their duties by working longer than allowed, and underreport their hours to avoid being penalized for duty hour noncompliance. This strategy allows them to complete their duties, care for their patients, maintain a close physician-patient relationship, and avoid being labeled as lazy.

The means by which the ACGME and its Residency Review Committees assess compliance with the resident duty hour standards is through direct resident interviews during accreditation site visits, review of duty hour logs submitted by the program, and the ACGME Resident Survey. Unfortunately, these methods are easily subverted through inaccurate reporting. One study comparing an internal graduate medical education survey and the ACGME survey demonstrated wide discrepancies in resident reporting of issues.³⁰ Furthermore, in 1 survey 14% of 26 general surgery residents admitted to not answering the ACGME survey questions truthfully.³¹ Why would residents lie about violation occurrence on the

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ACGME survey? The answer is that residents are aware of the consequences of survey responses suggesting noncompliance with the duty hour standards, including the potential of repercussions to the residents. It may be easier to deny programmatic issues because it ensures that the program itself will remain viable. Furthermore, denying problems on the ACGME survey may lead to less frequent monitoring from program directors and chairs. Less oversight in this regard provides individual residents the opportunity to make decisions regarding patient care at their own discretion.

Residents also are aware that there can be personal repercussions when they report duty hour noncompliance in their program. Residents may be punished by faculty for logging hours that exceed the limit. To avoid potential penalties for truthfully reporting their hours, residents will underreport the number of hours worked. Recently, in a national survey of more than 1000 surgery residents regarding the effects of the 2011 ACGME regulations, greater than 60% of residents indicated that they falsely reported duty hours to appear in compliance, with almost 15% doing so on a daily or weekly basis.³² In a national survey of neurological surgery residents, 60% acknowledged that they underreport their hours, with 25% doing so on a regular basis.³³ Previous studies of surgical and medical residents at 1 institution and a nationwide survey of family medicine residents indicated that 50% and 20% of respondents, respectively, indicated that they underreported duty hours.^{1,34} Residents, particularly in surgical specialties, may consistently work beyond the duty hour limits, yet rarely report violations. While program directors may be unaware this behavior is occurring, in some programs, the program director is aware of this behavior but is not motivated to correct it because the reported hours for the residents appear to be in compliance. In addition, many residents and program directors disapprove of the restrictions,^{1,14,15,17} which may offer added justification for these individuals to inaccurately report their hours or to be complicit in resident underreporting.

Medical educators have a responsibility to ensure that residents being trained in the United States are competent professionals. The ACGME competencies clearly indicate that honesty and adherence to legal and medical regulations are key components of professionalism that practicing physicians must adhere to. However, the ACGME duty hour regulations have inadvertently created a learning environment where intentional violations, dishonest reporting of hours worked, and inaccurate ACGME survey responses are occurring. While such behavior is not universally practiced among US residents, there is a significant proportion of the population, particularly in surgical specialties, who may be engaging in these activities

on a regular basis.^{1,31-34} Are we fostering dishonesty and disregard for authority within our residents by placing them in a situation where lying is the easiest option?

Medical educators can expect debate over further limitations to resident work hours in the near future given the growing public concern³⁵ for physician fatigue, the example of the European Working Time Directive whereby physicians are allowed to average only 48 hours per week,³⁶ and the agenda of the Institute of Medicine calling for further hours reductions in the United States.³⁷ As we go forward, it is imperative to consider the unintended consequences of the duty restrictions regarding the competencies we are seeking to develop in our trainees. The first step in addressing the dilemma is further study of resident behaviors and the means by which we monitor compliance with the duty hour standards. Most importantly, medical educators must realize that the punitive measures created to keep residents compliant, while well intentioned, have inadvertently generated a learning environment muddied with dishonest behavior. Unfortunately, solutions to this problem will not be easy. Should duty hours be reduced further, without associated changes to how to deal with violations of the standards, we are likely to see increased resistance among residents and program directors and further amplification of dishonest behaviors regarding duty hours.

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