9.2.2 Resident & Fellow Physicians' Involvement in Patient Care

Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals.

Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should:

(a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending physician if a patient refuses care from a resident or fellow.

(b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients.

(c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting" or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients.

Physicians involved in training residents and fellows should:

(d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient's welfare and dignity.

(e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient's care. If appropriate, the physician may transfer the patient's care to another physician or nonteaching service or another health care facility.

(f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise.

(g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

AMA Principles of Medical Ethics: I, II, V, VIII

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 8-A-05 Resident physicians' involvement in patient care

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AMA Principles of Medical Ethics: I, II, V, VIII

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 8 - A-05

Subject: Resident Physicians' Involvement in Patient Care

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Art L. Klawitter, MD, Chair)

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

RESIDENCY PROGRAMS IN THE UNITED STATES

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

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

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* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

** 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.

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

DISTINGUISHING CHARACTERISTICS OF RESIDENTS AND FELLOWS

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

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

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

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

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

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

ETHICAL CONSIDERATIONS

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

Preservation of Trust and Informed Consent

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

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

Protecting Patient Safety

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

Close collaboration is necessary when residents and fellows are not prepared to perform medical procedures independently.[12] Attending physicians must therefore assist residents and fellows to progressively gain experience. Residents' and fellows' training should be structured to provide supervision and opportunities for consultation with more senior residents and fellows and with attending faculty.[6] Unfortunately, some surveys of residency programs have revealed instances of insufficient interactions between residents and fellows and their supervisors.[13] These systemic problems raise the potential for medical errors and must be addressed as part of continuous quality improvement efforts.[14, 15]

Improper scheduling can constitute another systemic source of medical error if it results in excessive fatigue among residents and fellows. It has been demonstrated that residents and fellows working 80 hours per week or more commit significantly more serious medical errors compared to residents and fellows who work fewer hours.[6] The ACGME guidelines now require that the work hours of residents and fellows be limited to an average of 80 hours per week.[16] However, this requirement is not absolute as the limitation of working hours must never compromise the delivery of necessary medical services or the continuity of care.[17] In addition to restricting residents' and fellows' regular work hours, the ACGME recommends that residency program directors monitor those individuals who choose to work additional hours outside of the residency program ("moonlighting") to ensure that fatigue does not detract from their ability to care for patients.[18] Many residency programs regulate moonlighting, either prohibiting it or requiring that the program director grant approval based on the residents' or fellows' schedules. It would be incongruous to support a limit on work hours to insure adequate rest hours and study time for residents and fellows and to have these hours used instead for moonlighting. Ultimately, residents and fellows must self-regulate their use of personal off-duty hours and avoid activities such as moonlighting if these practices compromise their ability to provide safe patient care.

Identifying and Reporting Medical Errors

As members of the health care team, residents and fellows should be aware of their ethical obligations to report problematic practices or other safety concerns. In addition to reporting systemic or practice errors, residents and fellows also should be encouraged to examine their individual practices so as to identify personal sources of error.[19] If residents and fellows recognize that they have individually committed a medical error, they are ethically obligated to disclose these errors to the attending physician and cooperate in reporting them to the patient. The ethical management of residents' and fellows' medical errors generally should follow the guidance outline in Opinion E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm." Some have recommended that attending physicians accompany residents and fellows as they disclose medical errors to patients.[6]

Because of its ethical importance, the honest discussion of medical errors and disclosure of errors to patients are essential components of medical education. Evidence suggests that residents and fellows who accept personal responsibility for medical errors and subsequently discuss their mistakes with the hospital staff are more likely to learn from their mistakes and improve their

practice habits accordingly.[20] Residents and fellows can also learn to respond constructively to medical errors by observing the actions of their colleagues and instructors as part of their residency program's informal curriculum.[19]

To facilitate learning through personal responsibility, residency programs must move away from the prevailing "culture of blame."[21] Training programs must instead create an environment in which residents and fellows can more readily discuss their medical errors.[6] In addition, counseling services should be available to residents and fellows who have been involved in such errors.[6]

PROFESSIONAL AND INSTITUTIONAL CONSIDERATIONS

Although residency programs bear foremost responsibility to patients,[22] they also have duties to the residents and fellows and the hospital staff, and to society as a whole. Therefore, residency programs must ensure the protection of patients' safety while maintaining the integrity of the educational process[23] and safeguarding the well-being of residents and fellows.

Managing Psychosocial Pressures Faced by Residents and fellows

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

Ethics, Values, and the Hidden Curriculum

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

Addressing Conflicts within Residency Programs

Finally, residency programs have an obligation to address conflicts over any educational or patient care issues that may emerge during training. According to the ACGME, all accredited residency programs are required to have a grievance process for residents, fellows, and physician staff members while providing residents and fellows with due process protections.[28] While resolving issues that emerge during the training process, all parties must continue to place paramount emphasis on patients' welfare. A resident's or fellow's conflicts with colleagues can be addressed

with the assistance and support of the residency's program director. The goals of conflict resolution should be to enable residents and fellows to successfully complete their graduate medical education, rather than to punish. The resolution of conflicts between residents and fellows and their supervisors or colleagues is further discussed within Opinion E-9.055 "Disputes between Medical Supervisors and Trainees."

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

CONCLUSION

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

RECOMMENDATIONS

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

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

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

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

(3) If a patient refuses care from a resident, the attending physician should be notified. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from that patient's care or, if appropriate, transfer the

patient's care to another physician or non-teaching service, or to another health care facility.

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

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

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

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

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