Fear, Regulations, and the Fragile Exoskeleton of Medical Professionalism

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We live in a world riddled with rules. Standards of group behavior innervate virtually every aspect of our social and work lives. Some are formal (laws); others are informal and tacit. Some appear well intentioned; others, draconian. Most arise from—and reflect—power dynamics. This can be the power of groups (how "people like us" see and do things), or the power of those among us able to impose their will on others. As a form of social structure, rules can precipitate unanticipated consequences[1] and subcultures of purposeful circumvention. Some circumvention is public and transparent: "the rules say do it this way, but everybody knows it is best to do it the other way." Others are sub rosa—even subversive. At the group level, acts of opposition rarely are clandestine, sometimes rising to the level of insurrection. Medicine's current insurrection against the principles of maintenance of certification is a case in point.[2,3]

Whatever the unintended or oppositional particulars, reactions to rules often spawn still more rules as those in power attempt to mute the havoc wrought by countervailing action. Examples abound. Americans face a regulatory environment strewn with more than 4000 types of federal crimes (a 50% increase since 1980) and a *Code of Federal Regulations* that exceeds 175 000 pages. The National Collegiate Athletic Association rulebook, covering college sports, is infamous for having morphed into a mountainous tangle of qualifications and addenda. This April, Churchill Downs issued a bevy of new rules that outlaw the use of drones and selfie sticks during the Kentucky Derby. And so it goes.

In an ideal sense, professionals (unlike denizens of "normal" occupations) are expected to stand somewhat outside this tangle of ferment and fugue. Professions, by definition, are allowed to regulate themselves, and do so on behalf of the others—the patients and society—they serve. In turn, this nominative mandate, reflective of medicine's social contract with society, is supposed to be both individually internalized and collectively expressed in the form of altruistic practices. Relevant to the data collected and reported by Byrne and colleagues[4] in this issue of the *Journal of Graduate Medical Education*, professions house strong normative structures mandating that explanations of individual and collective behaviors be couched within a lexicon of expressed professionalism. Professionals describe what they do using a language of patient primacy. To fail to do so would be—unprofessional.

Byrne and colleagues[4] sought to "determine the motivation for residents' decisions to falsify duty hour reports." They conclude that there are multiple causal factors that exist within the complexity of medical practice, resulting in conflicting values within the larger construct of medical professionalism. While neither of these conclusions is novel,[5,6] both raise important issues around the tension that exists between patient safety and optimizing the training of future physicians.[7] Moreover, rather than serving solely as harbingers of disaster, tensions about what it means to be a good physician also function as a conversational glue that anchors medicine's modern day professionalism movement.[8] In short, it is the manifestation of such tensions, rather than their absence, that forms the lifeblood of what we call *medical professionalism*. In this way, issues like duty hours, rather than highlighting a fatal flaw in how medicine goes about organizing its work, actually offer physicians at all stages of their career an opportunity to reflect on how medicine may, or may not, embody the ideals of professionalism.

In the history of professionalism in medicine, few things have created more moral havoc about what it means to be a good physician than limits on duty hours. Duty hour regulations have pitted fidelity to patients against individual and institutional compliance. They also have set the duty of truth telling against the perceived negative consequences of disclosure. As a consequence, the emergence of intended and unintended manipulations of duty hour rules and reporting requirements has compromised resident loyalty to their professional and moral community. As argued by Byrne and colleagues,[4] these stressors have contributed to a climate of fear: trainee fear about being blamed for being inefficient if they violate duty hours, and trainees' and programs' fear about jeopardizing program status if all work is

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honestly reported. An attempt by organized medicine to make medicine safer through duty hours[9–11] (a largely unproven hypothesis[12]) has created a system of counting and confessing that has destabilized group cohesion and fatally disrupted the camaraderie that physician training, at its best, is supposed to foster.

On the face of it, we have a conflict between the need to educate future physicians and the safety of current patients. Below the surface, we have a conflict between, on the one hand, a "professionalism" that fosters the internal sense of duty, loyalty, and honor physicians need for a life of public service, and, on the other hand, a "professionalism" that fosters compliance in service of the public face-saving organized medicine must engage in to avoid fiscal penalties, lawsuits, and further bureaucratic encroachment. Although duty hours are not the only element in this caldron, it is a significant one.

Data

We note a few key observations about the data reported by Byrne and colleagues.[4] First, most residents (77%) did not report falsifying duty hours. This is a provocative finding that raises a number of questions, including why so many residents did *not* feel the need to do so. Second, violations decreased over time, with more advanced residents reporting significantly fewer violations than junior residents. Third, of the residents who reported falsifying their hours, certain programs/specialties were overrepresented. Fourth, most residents (69%) either did not know about the Accreditation Council for Graduate Medical Education (ACGME) stipulation to extend duty hours to care for a single patient or did not know anyone who had done so. Finally, this is perceived as a temporary stricture, as indicted by a free-text data quote: "When I graduate, there will be no duty hour requirements." These and related findings provide us with a complex depiction of residency life.

Before dipping into this complexity, it is important to note the 3 data sets collected by Byrne et al[4] are not fully connected and should not be interpreted as such. In other words, residents were not asked if they had violated duty hours, and *if so*, to report on the reasons for those violations. Instead, this study asked residents if they had violated duty hour rules. Second, *as a separate issue*, residents were asked about the general reasons they saw as contributing to these duty hour violations. Third, residents who reported having falsified duty hour data were asked "why" (and were given a predetermined list of responses from which to choose). In short, the reasons given for duty hour violations are reasons in the abstract. They did not originate with those who had violated the regulations.

The link between actions and motives is further confounded if we rotate the data 180 degrees and ask if residents who *did not* violate duty hour standards failed to do so because there *was no need* (eg, they never found themselves faced with too many patients or individual patient acuity/complexity), or because they *felt no need* (eg, there was an absence of conflicted values). This is an important question because the majority of residents (78%) did not falsify the data, and this likely included a fair number of the least experienced residents (although study data were not broken down to this level).

Thus, while data suggest that patient and workload demands decrease as residents become more senior, it also is true that the majority of first- and second-year residents appear to be at peace within the structural conditions (patient care demands, duty hour limits, and residency vulnerabilities) of their learning environments. Why this is so is not clear. Although Byrne et al[4] sought to link altruism and falsification, the analysis sidesteps the issue of whether those who did not lie did so because they did not find themselves faced with too many patients or acuity/complexity issues—or because they lacked the counterbalancing altruism with which to begin. In the end, we cannot firmly conclude, given the data presented, that residents who violated the duty hour limits did so because of too many patients, patient/family demands, or issues of patient acuity/complexity—particularly given our assumption that such structural precursors were present for all residents, but particularly novice residents.

Given that, what do the data tell us? This is a study in which the "F" word (fear) appears with grating regularity. Residents, we read, "fear punishment." They fear "jeopardizing their program's accreditation." They fear "reprisals from the program, colleagues, or faculty for being labeled as inefficient or incompetent." They fear being "scolded for putting patient care first." While the medical education literature is awash with data on resident burnout,[13] resident suicide,[14] and the absence of work-life balance,[15] we need more data on fear. Fear is a distinctly social phenomenon and is different from other responses to stressful circumstances. We fear many things, but high on our list of fears is "others." We fear what these "significant others" can do to us (bad things), what they might think about us (negative things), or that we may be letting them down (although here, what we are talking about may be closer to guilt than fear). These others (and the surrounding circumstances) can be real—or imagined. Fear also can involve the structural conditions of

power, hierarchy, punishment, and retribution. Individuals fear, but so do groups. Moreover, fear can be contagious—as a group phenomenon. Fear can spread throughout the group. Finally, as a separate dynamic, fear can breed more fear. It can replicate.

In sum, while it is important to gather data about individuals, and their actions and motives with respect to issues of fear, it is critical that we consider this phenomenon within the context of collectives, settings, and circumstances to better capture the social dimensions of what is happening. Returning to the study by Byrne and colleagues,[4] residents may fear jeopardizing their program's accreditation status, but we find it difficult to imagine that they would do so in an environment where faculty and program directors do not also share that fear and, furthermore, do not display that fear by communicating messages to residents (explicitly and/or tacitly) that it is the resident's fault if the program experiences an adverse reaction. How is it that residents have come to take on this moral burden? This is a question about fear as a social practice rather than as an individual phenomenon. And lest we pass by this point too quickly, the ability to inflict fear upon others is prima facie evidence of power.

Data that link falsification of duty hour reports to one's programmatic home (the third of the 5 core findings listed above) is notable because it, too, moves us from thinking about work pressures and lying as an individual act to something anchored in group practice. Why neurology? Is it something about clinical neurology that produces too many patients or patients with high acuity and/or complexity, or are we looking at cultural tensions that exist within many residency programs? In turn, are duty hour violations, and their related lies, idiosyncratic responses to situational tensions or do they exist (within certain residency programs or specialties) as normatively sanctioned ways of responding to those tensions? Similarly, are programs with high percentages of residents who falsify duty hour data those where residents saw others violating these standards? In sum, are duty hour violations, along with lies about those violations, private or public acts? Are they individual or group responses?

The fact that most residents did not know about the ACGME stipulation that allows a resident to remain beyond the stated limits to care for a single patient, and were not aware of anyone who had requested this exemption (the fourth core finding), raises not only the question about how residency programs instruct their residents on the nuances of duty hour regulations (as opposed to making residents fearful), but also the degree to which acts of patient care unfold in some isolated or invisible fashion. Here, too, we raise the issue of residency training as a process of socialization, rather than as a cognitive inculcation of individuals in aggregate activity, and thus the degree to which peer and superordinate actions need to be examined for how they influence others.

The fact that duty hour limits apply only to residents and not to faculty (the fifth core finding) means, among many things, that what residents see being role modeled is not duty hour compliance, but rather the opposite. It is care for patients unrestricted by duty hour limitations, which, in this study, is cast as the practice of altruism. Once again, we return to the issue of social and/or group context. As such, what we have in this study is not so much an issue of conflicting values at the individual level, as it is a study of conflicted values where 1 group of licensed practitioners (residents) is being trained by another group of licensed practitioners (attendings, mentors, role models) for whom duty hours do not apply and whose patient care actions may, in fact, model a different (potentially more altruistic) value set. Moreover, the 2 action sets (shackled compliance versus unrestricted altruism) are causally connected. At the end of the day, residents are quite aware that work *they do not complete* may be turfed to their seniors or superiors, leading to yet another cycle of tensions.

Conclusions

The study by Byrne and colleagues[4] is emblematic of a host of broader issues facing residency training. Rather than start—but then stop—with the issue of competing values (an important issue in its own right), we need to spend more time critically examining how faculty, as individuals and as a collective (eg, faculties of medicine), collaborate to structure the best learning environment for their residents. In turn, we need to explore how this collective can best work with their regulatory partners to facilitate adherence to the important, yet inherently conflated, goals of safe patient care and quality resident education—all on behalf of the public.

None of this will be straightforward. Nor are we blessed with a bevy of helpful precedents. The social history of duty hours is a narrative of historical errors. It is, truth be told, a case study in both nonresponsiveness and irresponsible inaction. Its narrative tracks how a single local crisis (the death of Libby Zion) created a quasilocal (New York) response, followed by decades of circling-the-wagon nonresponses by a larger noncommunity—all culminating in the imposition of top-down (eg, ACGME) regulations, which were themselves driven by external (eg, federal

government) threats. This is not a model to emulate. Nor is it a model that can be sustained as still other regulatory tensions, such as the aforementioned clashes over maintenance of certification or the latest ACGME initiative (the Clinical Learning Environment Review), begin to percolate their way through the professional and educational environment.

At minimum, residency programs need to organize themselves as collectives within their organizational settings. Program directors may know a few colleagues or may caucus at national meetings, but this is not enough (as history shows) to form the basis of collegial/collective responses to the myriad problems facing medicine today. At its core, professionalism is less an individual attribute than it is an attribute of the body professional. It is a shared belief system,[16] from which programs need to organize. If cross-specialty collaboration within a given organizational setting (as a first step) proves too difficult (a telling state of affairs in its own right), then specialty-based programs need to form their own consortia to share best educational practices and to wrestle with the macroissues facing training. To do nothing is to trap us within our present state of affairs, where top-down regulatory action produces outcries of resistance, quasiorganized deviance, and mountains of academic publications—the latter of which appear to benefit only the academic careers of the authors (and which, interestingly enough, is a counter incentive for the kind of collective action we are proposing here).

It is within this space, between the formal rules and the other-than-formal practices (both informal and hidden) where our residents (and medical students) spend the bulk of their formative time and much of what they are now learning about (what it means to be a successful resident/medical student) may be quite at odds with what it means to be a good physician.

The relationship of residents to each other, of residents to faculty, and of programs to accrediting bodies brings us back to the macrolevel and to the article's conclusions. Byrne et al[4] call for a systems-based and nonpunitive approach to improving the training environment and training for residents in how to "minimize the chance that they might behave unprofessionally," all to better ensure duty hour compliance. These recommendations, while well-intentioned, seem vague and a tad misdirected. We do not think that residents need more education on duty hours. Rather, they need a learning environment that is both internally coherent and consistent with core professionalism principles. The notion that residents, as an undifferentiated body, are incapable of monitoring their fatigue, and of placing the needs of patients as the preeminent interest, seems to be at odds with the "new" structure and meaning of residency training.

The unilateral reach of duty hours, in that they apply to all residents irrespective of their specialty, their level of training, or their status of entrustability, seems at odds with the ACGME's new accreditation system and its focus on the graduated progression of becoming trustworthy as a professional.[17] Rather than more training, or a call for unspecified, systems-based responses, we urge the ACGME to place duty hours within its new accreditation system and begin the hard work of exploring how both residents—and faculty—learn to master the complexities and conundrums that characterize medical work. This will include the challenge of what it means to regulate self and others in the service of patients, and, ultimately, how to design optimal learning environments so that future physicians can be trained as professionals rather than as bureaucratic functionaries and technicians.

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