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Federal Whistleblower Protection: A Means to Enforcing Maximum-hour Legislation for Medical Residents

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**FEDERAL WHISTLEBLOWER PROTECTION:
A MEANS TO ENFORCING MAXIMUM-HOUR
LEGISLATION FOR MEDICAL RESIDENTS**

Robert Neil Wilkey[†]

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I. SUMMARY BACKGROUND AND PROPOSED FEDERAL REFORM

A recent report in the *Annals of Internal Medicine* reveals a wide array of statistical evidence indicating that an increasingly significant number of medical residents are experiencing depressive symptoms, increasing cynicism, and decreasing humanism.¹ A similar report compiling data from a comprehensive

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1. See Virginia U. Collier et al., *Stress in Medical Residency: Status Quo after a Decade of Reform*, 136 ANNALS INTERNAL MED. 384, 384 (2002); see also Robert E. Condon, *Fatigue and Resident Performance*, 75 AM. C. SURGEONS BULL. NO. 5, 15 (1990) (discussing similar findings in the early 1990s).

study indicates that “burnout” is common among resident physicians and is associated with sub-optimal patient care practices.² Although these reports provide a cursory assessment of the current state of affairs governing medical residents, descriptive firsthand accounts from various medical residents are even more compelling. An orthopedic surgery resident provides the following account:

I was operating post-call after being up for over 36 hours and was holding retractors. I literally fell asleep standing up and nearly face-planted into the wound. My upper arm hit the side of the gurney, and I caught myself before I fell to the floor. I nearly put my face in the open wound, which would have contaminated the entire field and could have resulted in an infection for the patient.³

Another pediatric resident provides a similar account of how the demanding workload also resulted in near malpractice:

As a resident in the Pediatric ICU, we are expected to be awake, alert, and cognizant for 36-hour shifts. After a long night on call, I mistakenly ordered an oral medication to be given via the IV one afternoon. As a result, the patient’s breathing slowed down to the point of requiring oxygen. I was mortified the next day. I can honestly say I do not even remember writing the order . . . but I did! I was so exhausted that the whole afternoon was a blur⁴

Accounts such as these have prompted immediate action among both law and policy makers. In fact, during the 107th Session of Congress, the Patient and Physician Safety and Protection Act of 2001 (the “PPSP Act”) was introduced.⁵ Introduced by Rep. John Conyers, the purpose of the legislation is to amend Title XVIII of the Social Security Act to reduce work hours and increase the supervision of resident physicians to ensure

2. See Tait D. Shanafelt et al., *Burnout and Self-Reported Patient Care in an Internal Medicine Resident Program*, 136 ANNALS INTERNAL MED. 358, 362 (2002).

3. AM. MED. STUDENT ASS’N, WORK HOUR STORIES FROM THE FRONTLINES: HOW PATIENTS AND RESIDENTS ARE AFFECTED, available at http://www.amsa.org/hp/rwh_cov.cfm (last visited Aug. 17, 2003).

4. *Id.*

5. See Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. (2001). As of August 4, 2003, there are both House and Senate versions of the Act pending before various committees. See Patient and Physician Safety and Protection Act of 2003, H.R. 1228, 108th Cong. (2003); S. 952, 108th Cong. (2003).

the safety of patients and resident physicians.⁶ Specifically, the PPSP Act provides the following provisions to ensure its legislative goals.

First, the Act restricts the maximum hours per week and the maximum shift length that a resident may work. As the Act sets forth, residents “may work no more than a total of 80 hours per week and 24 hours per shift.”⁷ Additionally, the maximum-hour limit cannot be averaged.⁸ Second, it establishes a minimum time off between shifts of ten hours.⁹ Third, the Act provides for a maximum on-call time period by stating that residents “shall not be scheduled to be on call in the hospital more often than every third night.”¹⁰ Fourth, the Act explicitly provides for a mandatory off-duty time to include twenty-four hours off per week and one weekend off per month with no averaging.¹¹ Fifth, the Act does not provide for any exemptions for particular resident specialties.¹²

Administratively, government entities such as the Occupational Safety and Health Administration (OSHA) have received petitions with a similar proposal for resident hour reform.¹³ For the most part, the OSHA petition is consistent with the proposed PPSP Act.¹⁴

The PPSP Act has received unprecedented support from a number of organizations, such as the American Medical Student Association (AMSA), Committee of Interns and Residents, Public Citizen Health Research Group, Center for Patient Advocacy, Physicians Committee for Responsible Medicine, and the Union of

6. H.R. 3236.

7. H.R. 3236, § 3(a)(2); *see also* H.R. 1228, § 3(a)(2), S. 952, § 3(a)(2).

8. *See* H.R. 3236, § 3(a).

9. H.R. 3236, § 3(a)(2); *see also* H.R. 1228, § 3(a)(2), S. 952, § 3(a)(2).

10. H.R. 3236, § 3(a)(2); *see also* H.R. 1228, § 3(a)(2), S. 952, § 3(a)(2).

11. Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. § 3(a)(2) (2001). Recent versions of the PPSP Act provide that resident “shall have at least 1 full day out of every 7 days off and 1 full weekend off per month.” *See* Patient and Physician Safety and Protection Act of 2003, H.R. 1228, 108th Cong. § 3(a)(2) (2003); S. 952, 108th Cong. § 3(a)(2) (2003).

12. H.R. 3236, § 3(a)(4).

13. *See* Letter from Anandev Gurjala et al., Petition to the Occupational Safety and Health Administration Requesting That Limits Be Placed on Hours Worked by Medical Residents (HRG Publication No. 1570) (Apr. 30, 2001), *available at* http://www.citizen.org/publications/print_release.cfm?ID=6771 (last visited Aug. 17, 2003).

14. *Id.* *See also* PUBLIC CITIZEN, COMPARISON OF PROPOSALS TO LIMIT RESIDENT WORK HOURS, *available at* <http://www.citizen.org/documents/1633attachment.PDF> (last visited Aug. 17, 2003) [hereinafter COMPARISON].

American Physicians and Dentists.¹⁵ Although there were strong supporters of the PPSP Act as it was proposed to the Congress, groups such as the American Medical Association (AMA), Association of American Medical Colleges (AAMC), and the Accreditation Council for Graduate Medical Education (ACGME), presented hybrid, less-stringent versions of the bill.¹⁶

For example, both the ACGME and AMA proposals advocate that the maximum hours per week be more than the eighty-hour limit set forth in the PPSP Act. The ACGME proposal allows for a maximum of eighty-eight hours per week, which may be averaged over four weeks.¹⁷ The AMA proposal recommends that the maximum-hour limit be set at eighty-four hours averaged over two weeks.¹⁸ Additionally, both the ACGME and AMA proposals set the maximum shift length at thirty hours rather than twenty-four hours as set by the PPSP Act.¹⁹

The greatest point of divergence between these alternative proposals and the PPSP Act regards the question of enforcement. Both the PPSP Act and an OSHA petition provide for civil penalties for non-compliance, public disclosure of violating hospitals, and whistleblower protection. In contrast, the AMA, AAMC, and ACGME vehemently reject such enforcement measures.

Legal scholars have recently written extensively on the implications of maximum-hour legislation on medical resident reform.²⁰ Other scholars have written extensively on the various

15. See Patient and Physician Safety & Protection Act of 2001 Source List, at <http://www.amsa.org/hp/rwhspeak.cfm> (last visited Aug. 17, 2003).

16. See COMPARISON, *supra* note 14.

17. See *id.*; see also ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., REPORT OF THE ACGME WORK GROUP ON RESIDENT DUTY HOUR REQUIREMENTS, available at http://www.acgme.org/DutyHours/dutyhrs_index.asp (last visited Aug. 17, 2003) [hereinafter ACGME proposal]. On July 1, 2003, the ACGME approved formal institutional standards for resident duty hours. See Press Release, Accreditation Council for Graduate Med. Educ., ACGME Duty Hours Standards Now in Effect for All Residency Programs (July 1, 2003), available at http://www.acgme.org/Media/news7_1_03.asp (last visited Aug. 17, 2003).

18. See COMPARISON, *supra* note 14; see also AM. MED. ASS'N HOUSE OF DELEGATES, REPORT OF REFERENCE COMMITTEE C, at 8-11 [hereinafter AMA Proposal], available at <http://www.ama-assn.org/ama1/upload/mm/annual02/RefcomC.Annot.doc> (last visited Aug. 17, 2003).

19. See ACGME Proposal, *supra* note 17; AMA Proposal, *supra* note 18.

20. See Dori Page Antonetti, Comment, *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 (2002); Lindsay Evans, Commentary, *Regulatory and Legislative Attempts at Limiting Medical Resident Work Hours*, 23 J. LEGAL MED. 251 (2002); Patrick Knott and Kathleen Ruroede, *One*

methods upon which such reforms can be institutionalized.²¹

This paper does not assess the various implications of such proposals for maximum-hour legislation of medical residents or examine the various costs and benefits of such measures.²² Rather, this paper intends to address the various methods by which such maximum-hour legislation can be enforced. Part II of this paper examines current state and federal legislative mandates that regulate and enforce medical resident working conditions.²³ Part III assesses the various non-legislative measures, such as hospital bylaws and guidelines that attempt to enforce resident training, working hours, and working conditions.²⁴ Much of the discussion in this section focuses on the role of the ACGME in enforcing specific work-hour standards of medical residency programs. Part IV sets forth the proposition that providing whistleblower protection for medical residents is an effective means of enforcement—in particular, that such protection is relatively more effective than either civil fines or discretionary oversight by the ACGME.²⁵ Overall, the intent of this paper is to demonstrate that whistleblower protection can be a superior method of enforcement to ensure that any proposed maximum-hour legislation is effectively administered.

II. STATE AND FEDERAL LEGISLATIVE APPROACHES

A. *The New York State Model*

New York State is the preeminent advocate of legislative mandates regulating medical resident working conditions. The death of an eighteen-year-old college student resulting from an overworked medical resident prompted immediate reform in the early 1990s.²⁶ In 1998, the New York State Department of Health

Solution for Managing Risks During Cutbacks in Residency Training Programs, 11 RISK 35 (2000).

21. See Evans, *supra* note 20.

22. See COMPARISON, *supra* note 14 (for a comprehensive overview of the cost and benefits of maximum-hour legislation for medical residents).

23. See *infra* Part II.

24. See *infra* Part III.

25. See *infra* Part IV.

26. See Antonetti, *supra* note 20, at 888; see also Dominic A. Sisti, *ZZZZZZZZZ Sleep Deprived Residents and Social Control in the Clinic*, AM. J. BIOETHICS (Nov. 12, 1998) (discussing that the medical resident administered a drug that contraindicated with the college student's scheduled medication, which caused

issued a report that training physicians in New York hospitals were working hours that “far exceed the limits” set by the state to protect patients.²⁷ Shortly thereafter, the New York State Legislature amended the state health code, limiting medical residents to an eighty-hour workweek, as averaged over a four-week period.²⁸ Additionally, such amendments implement a per se prohibition of on-call shifts of more than twenty-four consecutive hours.²⁹ Other provisions included setting maximum-hour limits for residents with on-duty assignments in emergency rooms to no more than twelve consecutive hours.³⁰

New York State also adopted a number of enforcement mechanisms to ensure compliance. First, the role of monitoring is delegated to the hospitals. In particular, hospitals are responsible for monitoring the number of hours accumulated by residents involved in dual employment or “moonlighting.”³¹ Second, physicians are in charge of supervising residents in their specialty and such supervision is required on-site, seven days a week, twenty-four hours a day.³² Also, an attending surgeon is required to personally supervise all surgical procedures, including general anesthesia.³³ Third, the New York State Health Department monitors compliance through “routine surveys and complaint and incident investigations.”³⁴ The most significant method of enforcement, however, comes through the department’s wielding of punitive fines. In the early stages of reform, the department was

the student to suffer fatal respiratory failure), *available at* <http://www.bioethics.net/er/erbioethics.php?task=view&articleID=438> (last visited Aug. 17, 2003); R.M. Parker, *The Libby Zion Case: One Step Forward or Two Steps Backward?* 318 *NEW ENG. J. MED.* 771 (1988).

27. See N.Y. Dep’t of Health, *Health Department Releases Residency Review Report* (May 18, 1998) (on file with author); see also Barbara A. DeBuono and Wayne M. Osten, *The Medical Resident Workload: The Case of New York State*, 280 *JAMA* 1882, 1882 (1998) (citing that report is based upon an intensive four-day survey during which the health department sent unannounced random inspection teams into New York-based teaching hospitals. The data compiled was based on information from health department staff interviews of 563 residents and 211 supervising physicians, verification of 519 medical records, and the calculation of the working hours for 391 residents based on work schedules, interviews, and direct observation).

28. See 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4(b)(6)(ii)(a) (2001).

29. See *id.* § 405.4(b)(6)(ii)(b).

30. See DeBuono & Osten, *supra* note 27, at 1883.

31. *Id.* at 1882.

32. *Id.*

33. *Id.*

34. *Id.* at 1882-83.

authorized by state law to levy fines of up to \$2000 per violation.³⁵ More recently, under Governor George Pataki's Health Care Reform Act of 2000, fines on teaching hospitals for noncompliance of resident working hours have increased, up to a maximum of \$6000 per violation.³⁶ Hospitals cited for recurring violations may face a maximum fine of \$25,000 for a second offense and \$50,000 for a third offense.³⁷

Unfortunately, such sweeping reforms have been compromised or ignored, or have received very little enforcement by hospital administrations.³⁸ The primary reason that such reforms have yet to be institutionalized is due to what some have described as "fruitless self-monitoring" and the "refusal of the medical profession to adapt to changes."³⁹ Although New York State has set up an elaborate citation process, which has resulted in the administration of significant fines, there are indications that most residency programs continue to disobey the regulations.⁴⁰

Even more recently, strong evidence has suggested that such mechanisms have not translated into better working conditions for medical residents. For instance, as recently as June 26, 2002, the New York State Health Department issued a report citing that since November of 2001, fifty-four of the eighty-two teaching hospitals inspected in the state were cited for violations related to resident working hours.⁴¹ As a result, some argue that the threat of inspections and the probability that a fine may be assessed are not sufficient deterrents to residency programs. As one doctor described, "the regulations attempted to change the culture of medical residencies [but] failed to achieve that goal."⁴²

Despite New York State's apparent failure, it is only fair to

35. See Press Release, N.Y. Dep't of Health, NYS Hospital Fined for Violating Resident Work Hours (June 18, 1998), at <http://www.health.state.ny.us/nysdoh/commish/98/workhrs.htm> (last visited Aug. 17, 2003).

36. See Press Release, N.Y. Dep't. of Health, State Health Department Cites 54 Teaching Hospitals for Resident Working Hour Violations (June 26, 2002), at http://www.health.state.ny.us/nysdoh/commish/2002/resident_working_hours.htm (last visited Aug. 17, 2003).

37. *Id.*

38. See Esther B. Fein, *Flouting Law, Hospitals Overwork Novice Doctors*, N.Y. TIMES, Dec. 14, 1997, at A1 (discussing how New York hospitals consistently fail to comply with the new standards and reforms limiting medical resident work hours).

39. *Id.*

40. *Id.*

41. See Press Release, *supra* note 36.

42. See Antonetti, *supra* note 20, at 889 n.72.

point out that the state still stands alone as an advocate for maximum-hour legislation governing medical residency programs.⁴³ Other states, such as Maine, have gradually extended maximum-hour legislation to nurses, but have refused to afford similar protection to medical residents.⁴⁴ Despite New York's leadership role in this area, such regulations have been largely ineffective.⁴⁵ Specifically, critics of New York State's maximum-hour legislation have pointed to the various loopholes that allow hospitals to continue scheduling residents without fear of reprisal.⁴⁶ Also, substantial evidence indicates that a significant number of hospitals continue to operate in noncompliance with the provisions of the legislation.⁴⁷

B. Federal Government Oversight

From a federal perspective, the primary governmental organization that oversees the rules and regulations affecting medical residents is the Department of Health and Human Services (HHS).⁴⁸ The Agency for Healthcare and Research and Quality (AHRQ) is an operating division within HHS, with the mission to "support research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services."⁴⁹ In 1999, the AHRQ began an extensive effort to research the problem of medical errors.⁵⁰ The net result of their research concluded that

43. It is important to note that an increasing number states, such as Delaware, Pennsylvania, and New Jersey, are beginning to follow New York's lead. See, e.g., AM. MED. STUDENT ASS'N, THE RESIDENT WORK HOUR ISSUE: STATE EFFORTS, at <http://www.amsa.org/hp/rwhefforts.cfm> (last visited Aug. 17, 2003). Other states have developed overtime protection for nurses and other health care professionals. See SERV. EMPLOYEES INT'L UNION, STATE LEGISLATION AT A GLANCE (June 18, 2002). For example, a Minnesota statute specifically protects health care employees from being discriminated against or penalized for reporting a violation of federal or state law or a professionally recognized national clinical or ethical standard. MINN. STAT. § 181.932, subd. 1(d) (2002).

44. See Antonetti, *supra* note 20, at 890.

45. See Press Release, *supra* note 36.

46. See Antonetti, *supra* note 20, at 889.

47. *Id.*

48. See U.S. DEP'T OF HEALTH & HUMAN SERVICES, INTRODUCTION, available at <http://www.hhs.gov/about/> (last visited Aug. 17, 2003).

49. See Agency for Healthcare Research & Quality, *AHRQ Profile: Quality Research for Quality Healthcare*, AHRQ Publ'n No. 00-P005 (Mar. 2001), available at <http://www.ahrq.gov/about/profile.htm> (last visited Aug. 17, 2003).

50. See Agency for Healthcare Research and Quality, *Medical Errors: The Scope*

“long hours, fatigue, and stress” are factors that significantly impair physicians and their ability to perform.⁵¹ The AHRQ’s research culminated in an announcement by the HHS to allocate nearly \$50 million to finance new research projects to “reduce medical errors and advance patient safety.”⁵² Unfortunately, despite the extensive research and resources dedicated to assessing the problems associated with resident working conditions, the federal government has yet to adopt a standardized policy.⁵³

Various reasons are given as to why the federal government is hesitant to adopt such a standardized policy. First, the underlying purpose of residency programs is to further the clinical education of novice doctors.⁵⁴ The purpose of such programs is significant in relation to the application of federal labor policy because the assumption of oversight by the Department of Labor or OSHA requires the existence of an employment relationship.⁵⁵ OSHA still has not decided, for the purposes of regulation, whether medical residents are employees.⁵⁶ Thus, until the Department of Labor or OSHA officially determines that a medical resident is an “employee,” it is questionable whether protections afforded general employees would extend to this segment of the medical field.

Second, a significant level of oversight is delegated to the ACGME.⁵⁷ The fundamental purpose of the ACGME is to collaborate with hospitals in establishing educational standards involving accreditation, duty hours, and resident supervision.⁵⁸ A more thorough examination of the role of the ACGME is provided

of the Problem, AHRQ Publ’n No. 00-P037, available at <http://www.ahrq.gov/qual/errback.htm> (last visited Aug. 17, 2003); see also Antonetti, *supra* note 20, at 902-04 (discussing the various role of the AHQR).

51. Antonetti, *supra* note 20, at 903.

52. See Press Release, Agency for Healthcare and Research Quality, HHS Announces \$50 Million Investment to Improve Patient Safety (Oct. 11, 2001), available at <http://www.ahrq.gov/news/press/pr2001/patsafpr.htm> (last visited Aug. 17, 2003).

53. See Antonetti, *supra* note 20, at 891-94.

54. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., MISSION STATEMENT, available at <http://www.acgme.org/About/mission.asp> (last visited Aug. 17, 2003).

55. See Antonetti, *supra* note 20, at 894; see also Occupational and Safety and Health Act of 1970, 29 U.S.C. § 653(a) (1994).

56. See Antonetti, *supra* note 20, at 895.

57. See *infra* Part III.

58. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME HIGHLIGHTS ITS STANDARDS ON RESIDENT DUTY HOURS—MAY 2001, available at <http://www.acgme.org/New/OSHAReponse.asp> (last visited Aug. 17, 2003).

in Part III. In short, residency programs may be accredited only if they adhere to the “essentials” of accredited residencies.⁵⁹ The ACGME is a significant entity in that the federal government, in lieu of adopting national legislation regulating medical resident programs, has largely delegated such duties to this “quasi-governmental” body.⁶⁰ As a result, the ACGME has historically established itself as an organization, separate from the federal government, to which states give wide deference in terms of approving resident training programs.⁶¹

III. NON-LEGISLATIVE STANDARDS

A thorough assessment of the various ways in which medical resident working conditions are regulated would be incomplete without discussing various non-legislative standards, such as hospital bylaws and guidelines governing resident training, hours, and working conditions. As mentioned above, the ACGME requires that “[i]nstitutions must ensure that their GME programs provide appropriate supervision for all residents, as well as a duty hour schedule and work environment, that is consistent with proper patient care, the educational needs of the residents, and the applicable Program Requirements.”⁶²

Based on the ACGME’s general standards, teaching institutions usually draft program-specific policies. For instance, the University of Iowa College of Medicine⁶³ has adopted the Policy

59. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., SECTION I GRADUATE MEDICAL EDUCATION INFORMATION, REVIEW AND ACCREDITATION OF GRADUATE MEDICAL EDUCATION PROGRAMS, available at <http://www.acgme.org/GmeDir/sect1info.asp> (last visited Aug. 17, 2003).

60. See Michael J. Frank, Note, *Safeguarding the Consciences of Hospitals and Health Care Personnel: How the Graduate Medical Education Guidelines Demonstrate a Continued Need for Protective Jurisprudence and Legislation*, 41 ST. LOUIS UNIV. L. J. 311, 322 (1996).

61. *Id.* at 321.

62. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., INSTITUTIONAL REQUIREMENTS OF THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, at II.D., available at <http://www.acgme.org/IRC/Ircpr900.aspwww.acgme.org> (last visited Aug. 17, 2003). In fact, the ACGME has attempted to develop a formal procedure upon which complaints may be brought against a particular residency program. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME PROCEDURES ADDRESSING COMPLAINTS AGAINST RESIDENCY PROGRAMS, available at <http://www.acgme.org/ResInfo/complaint.asp> (last visited Aug. 17, 2003).

63. The University of Iowa College of Medicine is not alone here. In fact, nearly all hospitals with residency programs are required by the ACGME to adopt similar policies, schedules, and protocols. See ACCREDITATION COUNCIL FOR

on the Supervision and Assignment of House Staff, General Statement of Scheduling, and Departmental Statements.⁶⁴ The policy provides a number of guidelines for supervising medical residents. First, it establishes formal supervision and assignment protocols for departmental programs.⁶⁵ Program directors, “in consultation with the faculty and in accord with the recommendations of the Association of American Medical Colleges and requirements of the applicable Residency Review Committee, will maintain guidelines for ensuring proper supervision and assignment of each house staff member in the program.”⁶⁶ Supervision and assignment protocols generally include policies that specify the level of supervision and specific faculty who exercise oversight on residents at each level of training.⁶⁷ Additionally, these protocols set forth guidelines assigning residents based on “specialty, intensity of patient care responsibilities, level of experience, and educational requirement.”⁶⁸ To ensure compliance with the supervision and assignment protocols, the college defers to the Residency Review Committee, which conducts regular reviews to determine “compatibility and completeness.”⁶⁹

The General Statement of Scheduling essentially sets forth the call and rotation schedules for the academic year.⁷⁰ Additionally, such scheduling sets forth “house call”⁷¹ schedules by specialty and year of residency. For instance, for first-year and second-year orthopedic residents, “house call” is usually every fifth or sixth night, but may be every third or fourth night.⁷² For third-year residents, “house call” schedules encompass the trauma rotation where a resident is on call from 8:00 a.m. to 5:00 p.m. each

GRADUATE MED. EDUC., THE ACGME STANDARDS ON RESIDENT DUTY HOURS, *available at* <http://www.acgme.org/About/roleAcgme.asp> (last visited Aug. 17, 2003) (citing that all accredited residency programs must adopt specific standards and guidelines).

64. *Id.*; *see also* UNIV. OF IOWA HEALTH CARE, SUPERVISION AND DUTY HOURS (approved Jan. 4, 1989), *available at* <http://www.uihealthcare.com/depts/housestaffaffairs/supervisionandduty.html> (last visited Aug. 17, 2003).

65. *See* UNIV. OF IOWA HEALTH CARE, *supra* note 64.

66. *Id.*

67. *Id.*

68. UNIV. OF IOWA HEALTH CARE, *supra* note 64.

69. *Id.*

70. *Id.*

71. The term “house call” refers to the requirement that residents are to be on-call and must stay within the hospitals. *See id.*

72. *Id.*

weekday with no more than three nights and one weekend day per week.⁷³

Despite the breadth and thoroughness of these standards, substantial evidence suggests that the ACGME has failed to effectively enforce such measures. First, the ACGME is in an extremely difficult position to oversee, discover, and then cite such residency programs that force residents to work excessive hours.⁷⁴ With nearly 7800 accredited medical residency programs, including nearly 110 specialty and sub-specialty programs,⁷⁵ the lack of sufficient oversight resources requires that the ACGME rely on individual residency program administrators to establish uniform guidelines and standards.⁷⁶

Second, determining violations based on self-reporting methods such as surveys or questionnaires is problematic because medical staff and residents are reluctant to report the hospitals where they work for fear that their programs would lose accreditation.⁷⁷ Additionally, there is a real concern among residents that the loss of accreditation would significantly hinder the prospects of becoming a licensed physician.⁷⁸

Third, the oversight power of the ACGME is essentially a collaboration with five other medical organizations: the American Board of Specialties, the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.⁷⁹ In turn, each of these organizations appoints a representative to the ACGME.⁸⁰ Thus, the oversight power of the ACGME is essentially diffused among the participating organizations.⁸¹ In fact, as one council member expressed, "the ACGME needs to act in a more independent manner . . . the control of the parents inhibits the ACGME from acting in areas [it] needs to Act [sic]."⁸²

Fourth, past experience demonstrates that the ACGME rarely

73. *Id.*

74. See Sidney M. Wolfe, *Public Citizen Petitions OSHA to Limit Residents' Working Hours*, HEALTH LETTER, June 1, 2001, available at 2001 WL 12240092.

75. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., THE ROLE OF ACGME, available at <http://www.acgme.org/> (last visited Aug. 17, 2003).

76. *Id.*

77. See Antonetti, *supra* note 20, at 894.

78. *Id.*

79. See Frank, *supra* note 60, at 322.

80. *Id.*

81. *Id.*

82. *Id.*

finds violations, and if it does, the likelihood that a medical resident program will lose accreditation is close to nil. In fact, the ACGME has yet to remove accreditation of any medical residency program for violation of work-hour requirements.⁸³ Advocates of medical resident work reform argue that the ACGME guidelines are perceived by practitioners as “weak, voluntary, and different for each specialty.”⁸⁴ Thus, the very culture of the medical profession promulgates a perception of the standards as superficial, amendable, and rarely enforceable.⁸⁵ Some describe ACGME’s regulations as varying widely by the type of postgraduate programs addressed, with some program requirements peppered liberally with the word “must” and others merely indicating targets deemed “desirable.”⁸⁶ Advocacy groups have articulated that such a failure is due to the “shoddy enforcement of the current weak guidelines.”⁸⁷

An example of this can be seen in Massachusetts hospitals where voluntary codes regulating resident work hours were recently adopted as prescribed by ACGME guidelines.⁸⁸ The code essentially established that residents should work a maximum of eighty “active patient care” hours per week.⁸⁹ Despite the voluntary code drafted in accordance with ACGME guidelines, both physicians and residents considered other duties to fall outside the eighty-hour-per-week prohibition.⁹⁰ Such duties included drawing blood, completing reports on laboratory results, and writing notes in patients’ charts.⁹¹ Thus, despite the guidelines voluntarily adopted, the eighty-hour prohibition can be easily “translated” into a 110-hour workweek.⁹² The above example is indicative of the ineffectiveness of ACGME guidelines in maintaining and enforcing

83. See Evans, *supra* note 20, at 257.

84. See Wolfe, *supra* note 74.

85. *Id.*

86. See Dominic Papandria, *A Review of Issues Surrounding the Regulation of Postgraduate Physician Work Schedules*, AM. MED. NEWS (Sept. 3, 2001).

87. See Letter from Peter Lurie and Sidney M. Wolfe, Letter to the Accreditation Council for Graduate Medical Education on Medical Resident Duty Hours (HRG Publication No. 1633) (Aug. 1, 2002), available at <http://www.citizen.org/publications/release.cfm?ID=7191> (last visited Aug. 17, 2003).

88. See Joshua M. Sharfstein, *Asleep on the Job*, NEW REPUBLIC, June 21, 1999, at 17.

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

favorable working conditions for medical residents.

A. Criterion-Based Exception Approach

Despite the apparent ineffectiveness of ACGME guidelines, many states have refused to abandon such a non-legislative approach to enforcing maximum-hour standards for medical residents.⁹³ For instance, the University of Minnesota Medical School's Graduate Medical Education Administration (UMSS) has embraced the institutional requirements as set forth by the ACGME.⁹⁴ In particular, UMSS adheres to the ACGME's proposed maximum of eighty-eight hours per week for medical residents.⁹⁵

Minnesota's approach to enforcing maximum-hour standards is unique in that individual medical programs have the burden of demonstrating particular circumstances sufficient to allow residents to work beyond a set maximum-hour workweek. The Graduate Medical Education Committee (GMEC)⁹⁶ is explicitly delegated authority to "review and endorse" requests from medical programs in granting an exception to the eighty-eight-hour-per-week standard.⁹⁷

A number of criteria have been developed by UMSS before GMEC may approve requests for exceptions to the weekly limit on duty hours. First, requests for an exception must be based on "sound educational rationale."⁹⁸ Again, the burden is placed on

93. See ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., LIST OF ACGME ACCREDITED PROGRAMS AND SPONSORING INSTITUTIONS, *available at* <http://www.acgme.org/adspublic/main.asp> (last visited Aug. 17, 2003) (citing state-by-state programs accredited by the ACGME).

94. See UNIV. OF MINN. MED. SCH., GRADUATE MEDICAL EDUCATION, MISSION STATEMENT & GOALS FOR GRADUATE MEDICAL EDUCATION, *available at* http://www.med.umn.edu/gme/GME%20Office/mission_statement_goals.html (last visited Aug. 17, 2003).

95. *Id.*

96. See UNIV. OF MINN. MED. SCH., GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC), INTRODUCTION, *available at* <http://www.med.umn.edu/gme/gmec/index.html> (last visited Aug. 17, 2003).

97. See UNIV. OF MINN. MED. SCH., GRADUATE MED. EDUC. ADMIN., GRADUATE MEDICAL EDUCATION COMMITTEE CRITERIA FOR EXCEPTIONS TO DUTY HOUR REQUIREMENTS (approved Jan. 24, 2003) [hereinafter GMEC Criteria], *available at* <http://www.med.umn.edu/gme/> (last visited Aug. 17, 2003). See also UNIV. OF MINN. MED. SCH., GRADUATE MED. EDUC. ADMIN., REQUEST FOR EXCEPTIONS TO DUTY HOUR REQUIREMENTS (approved Dec. 16, 2002), *available at* <http://www.med.umn.edu/gme/> (providing the actual form to be used when making a request for an exception) (last visited Aug. 17, 2003).

98. See GMEC Criteria, *supra* note 97.

the medical program seeking an exception to clearly demonstrate the educational value of increasing the duty hours, the rationale in doing so, and whether or not the increase in hours will actually contribute to resident learning.⁹⁹ Second, programs requesting an exception must be prepared to demonstrate that there are sufficient faculty support and resources to monitor the additional duty hours.¹⁰⁰ Such criteria are met where a requester of an exception makes a showing that faculty and residents “collectively” understand their responsibility to patients and where faculty schedules are arranged so as to provide “continuous supervision and consultation.”¹⁰¹ Third, the requester needs to sufficiently satisfy that there is an established plan of action in the event that the resident becomes sleep-deprived.¹⁰² This is met where the requester demonstrates that the supervising faculty can recognize signs of fatigue and has a specific plan to counteract any potential negative effects.¹⁰³ Finally, any exception to the limit on duty hours must have some nexus to clinical needs.¹⁰⁴ The requester has the burden of demonstrating that the limit imposed would actually be detrimental to clinical training and education.¹⁰⁵

Although UMMS’s criteria exception approach is unique, it is still uncertain whether or not this is an effective method of enforcing maximum standards.¹⁰⁶ For instance, once GMEC grants such an exception, it is unclear what role GMEC has in ensuring compliance with the established criteria. From the resident’s perspective, it is equally uncertain what role he or she has in requesting an exception or enforcing the maximum-hour standards. For example, it may be apparent in some circumstances that a medical resident may be just as qualified to determine whether or not the granting of an exception is appropriate.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

102. *See* GMEC Criteria, *supra* note 97.

102. *Id.*

103. *Id.*

104. *Id.*

105. *See id.*

106. Since the GMEC Criteria were only approved in January 2003, it is still premature to determine the actual effectiveness of such an approach to enforcing maximum-hour standards.

IV. WHISTLEBLOWER PROTECTION

A. *Legislative Statutes*

The failure to impose fines for overtime violation, such as in New York State, and the lack of effective oversight by the ACGME have prompted the federal government to assess more innovative approaches to enforce maximum-hour legislation for medical residents.¹⁰⁷ Central to the question of enforcement is whether or not whistleblower protections would result in more favorable working conditions for medical residents.¹⁰⁸ This paper posits that extending whistleblower protection to medical residents gives them an incentive to disclose working condition violations and encourages them to assume a regulatory or oversight role.

The use of whistleblower protection as a means to enforce particular labor statutes, laws, or legislative mandates is not new. Originating from the act of English bobbies alerting the public and other law enforcement officials of a commission of a crime by blowing a whistle, the notion of a whistleblower is consistent with common-law ideals.¹⁰⁹ Integral to the conceptual framework embodied in whistleblower protection is the probability that employers will retaliate against employees in the form of harassment, demotion, or termination.¹¹⁰ In fact, within the United States, the relationship between whistleblower protection and retaliatory discharge is well documented.¹¹¹ The application of whistleblower protection to health professionals is not a new concept either.¹¹²

107. See generally Joan Corbo, Note, *Kraus v. New Rochelle Hosp. Medical Ctr.: Are Whistleblowers Finally Getting the Protection They Need?* 12 HOFSTRA LAB. L.J. 141 (1994) (examining state whistleblower statutes and the limited nature of New York's whistleblower statute).

108. See generally Bruce D. Fisher, *The Whistleblower Protection Act of 1989: A False Hope for Whistleblowers*, 43 RUTGERS L. REV. 355 (1991) (assessing the extent that whistleblower protection actually constitutes an assurance of protection and changes working conditions).

109. *Winters v. Houston Chronicle Publ'g Co.*, 795 S.W.2d 723, 727 (Tex. 1990).

110. See Lois A. Lofgren, Comment, *Whistleblower Protection: Should Legislatures and the Courts Provide a Shelter to Public and Private Sector Employees Who Disclose the Wrongdoing of Employers?* 38 SAN DIEGO L. REV. 316, 317 (1993).

111. See DANIEL P. WESTMAN, WHISTLEBLOWING: THE LAW OF RETALIATORY DISCHARGE (BNA 1991); Martin H. Malin, *Protecting the Whistleblower from Retaliatory Discharge*, 16 U. MICH. J.L. REF. 277, 280 (1981).

112. See generally Corbo, *supra* note 107, at 152-53. See also MINN. STAT. §

The proposed PPSP Act contains a specific section dedicated to providing whistleblower protection.¹¹³ Section 3(c) of the proposed act sets forth the following:

(1) IN GENERAL—A hospital . . . shall not penalize, discriminate, or retaliate in any manner against an employee with respect to compensation, terms, conditions, or privileges of employment, who in good faith . . . individually or in conjunction with another person or persons—

(A) reports a violation or suspected violation of such requirements to a public regulatory agency, a private accreditation body, or management personnel of the hospital;

(B) initiates, cooperates or otherwise participates in an investigation or proceeding brought by a regulatory agency or private accreditation body concerning matters covered by such requirements;

(C) informs or discusses with other employees, with a representative of the employees, with patients or patient representatives, or with the public, violations or suspected violations of such requirements; or

(D) otherwise avails himself or herself of the rights set forth in such section or this subsection.¹¹⁴

The act also formally defines when an employee is deemed to act in “good faith” if the employee reasonably believes “(A) that the information reported or disclosed is true; and (B) that a violation has occurred or may occur.”¹¹⁵

The insertion of such whistleblower protection is the product of similar legislation, introduced in the same session of Congress.¹¹⁶ The intent of the Patient Safety and Health Care Whistleblower Protection Act of 2001 (hereinafter Whistleblower Protection Act) is “[t]o prohibit discrimination or retaliation against health care

181.932, subd. 1(d) (2002) (specifically providing whistleblower protection to health care workers).

113. See Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. § 3(c)(1) (2001). See also Patient and Physician Safety and Protection Act of 2003, H.R. 1228, 108th Cong. § 3(c)(1) (2003); S. 952, 108th Cong. § 3(c)(1) (2003).

114. Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. § 3(c)(1) (2001).

115. H.R. 3236, § 3(c)(2).

116. Patient Safety and Health Care Whistleblower Protection Act of 2001, H.R. 2340, 107th Cong. (2001).

workers who report unsafe conditions and practices which impact on patient care.”¹¹⁷ In general, section 2(a) of the Act states that:

[n]o person shall retaliate or discriminate in any manner against any health care worker because the worker (or any person acting on behalf of the worker) in good faith—

- (1) engaged in any disclosure of information relating to the care, services, or conditions of a health care entity;
- (2) advocated on behalf of a patient or patients with respect to care, services, or conditions of a health care entity; or
- (3) initiated, cooperated, or otherwise participated in any investigation or proceeding of any governmental entity relating to care, services, or conditions of a health care entity.¹¹⁸

A significant question is whether a medical resident would also be afforded whistleblower protection under this Act. In section 6(2), the framers of the legislation specifically define “health care worker” to include a physician, intern, or resident.¹¹⁹ Thus, the Whistleblower Protection Act and section 3(c) of the PPSP Act set forth the basic legislative framework for extending whistleblower protection to medical residents.

B. *Incentive-Based Disclosure*¹²⁰

The imposition of whistleblower protection is an effective enforcement mechanism for maximum-hour legislation among medical residents for a number of reasons. First, medical residents who complain about excessive hours are clearly at risk for retaliation. In fact, the fear of retaliation comes from two sources: program directors and fellow residents who fear that their program

117. H.R. 2340, § 2(a).

118. *Id.*

119. *Id.* Compare *id.* with MINN. STAT. § 181.931, subd. 1 (2002) (defining the term “employee” as “a person who performs services for hire in Minnesota for an employer” but making no specific provision for medical residents).

120. The various incentives that are embodied in the language of the PPSP Act and the Whistleblower Protection Act are what I have dubbed “Incentive-Based Disclosure.” Essentially, by providing sufficient confidentiality requirements and the possibility of asserting private causes of action against retaliatory parties, the proposed legislation attempts to provide sufficient incentives for medical residents to disclose working violations that will offset any foreseeable costs incurred as a result of retaliation.

will lose accreditation.¹²¹ The extension of whistleblower protection provides some level of counterweight to these possible threats of retaliation.¹²²

The whistleblower protection may also act as a sufficient incentive for overworked medical residents to file complaints. For instance, under the PPSP Act, “a post graduate trainee or physician resident may file a complaint with the Secretary of Health and Human Services concerning a violation of such requirements [where] [s]uch a complaint may be filed anonymously.”¹²³ Similarly, under the Whistleblower Protection Act, strict confidentiality requirements exist. As section 3 of the Act sets forth, “[t]he identity of a health care worker . . . shall remain confidential and shall not be disclosed by any person except upon the knowing written consent of the health care worker.”¹²⁴

Additionally, both the PPSA Act and the Whistleblower Protection Act intentionally define “good faith” disclosures extremely broadly, giving much deference to both the subjective judgment and perception of the medical resident. For instance, the test of “good faith” under the Whistleblower Protection Act is whether the medical resident,

reasonably believes that—(1) the information is true; and (2) the information disclosed by the [resident]—(A) evidences a violation of any law, rule, or regulation, or of a generally recognized professional or clinical standard; or (B) relates to care, services, or conditions which potentially endangers one or more patients or workers to the public.¹²⁵

An additional incentive for medical residents to report violations is an explicit provision by the Whistleblower Protection Act, which provides for a private cause of action. Section 4 of the Act essentially allows any health care worker who believes retaliation or discrimination occurred as a result of disclosure “may file a civil action in any Federal or State court of competent

121. Lurie & Wolfe, *supra* note 87.

122. For discussions of various types of whistleblower protection, see Malin, *supra* note 111, and Lofgren, *supra* note 110.

123. See Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. § 3(b)(2) (2001).

124. See Patient Safety and Health Care Whistleblower Protection Act of 2001, H.R. 2340, 107th Cong. § 3 (2001).

125. See H.R. 2340, § 2(e); see also H.R. 3236, § 3(c) (for similar provisions).

jurisdiction.”¹²⁶ Under the same Act, civil penalties of up to \$10,000 may be granted for a finding of each violation.¹²⁷ Thus, the protection of a medical resident in the form of confidentiality and private causes of action eliminates the possible costs of retaliation from disclosure.

C. Grass-roots Oversight

The second way in which whistleblower protection provides effective enforcement mechanism to maximum-hour legislation is through grass-roots oversight.¹²⁸ If sufficient incentives exist to protect against the threats of retaliation, medical residents could adopt a regulatory role in the enforcement of maximum-hour legislation. In fact, both interns and resident physicians voice the concern that excessive hours impair their performance, blaming large-scale failure of the medical community in addressing this issue.¹²⁹ As one advocate states:

Ten years ago, the AMA called for voluntary compliance within the medical community as a means of addressing the issue of fatigued residents In the intervening decade, the only marginal progress has been lax regulations that are rarely enforced by the medical community’s own accrediting agency. Where the medical community has failed, the government must intercede to protect both patient and physician.¹³⁰

Additionally, a quasi-grass-roots reform movement has formed within organizations such as AMSA,¹³¹ an organization with 30,000 in-training physicians. Medical resident survey data compiled by the AMSA indicate that 60% of obstetric/gynecologic residents

126. See H.R. 2340, § 4(a)(1).

127. See H.R. 2340, § 4(b).

128. See, e.g., ADVOCACY ACTION COMM., AM. MED. STUDENT ASS’N, at <http://www.amsa.org/adv/advocacy.cfm> (last visited Aug. 17, 2003) (discussing examples of various grass-roots advocacy issues among medical student organizations).

129. See Papandria, *supra* note 86.

130. See Press Release, American Medical Student Ass’n, *AMA Response to Resident Work Hour Problems Inadequate, Says Med Student Organization; Federal Regulations Needed* (June 18, 2001), available at <http://www.amsa.org/news/pr/01/0618.cfm> (last visited Aug. 17, 2003).

131. *Id.* See also Press Release, American Medical Student Ass’n, *Medical Students Mark Historic Work Hours Reform with Call for Whistleblower Protection, Public Accountability* (June 30, 2003), available at <http://www.amsa.org/news/pr/03.0630.cfm> (last visited Aug. 17, 2003).

cited the hours worked as compromising the quality of care to patients, 30% to 40% indicated that their time was spent on non-educational activities, 41% attributed their most-serious mistakes made in the previous year to fatigue, and 45% with less than four hours of sleep per night reported committing medical errors.¹³² The AMSA has an active legislative lobby center located in Washington, D.C., and regularly publishes the findings of such medical resident surveys.

Reform movements, such as the one led by AMSA, demonstrate the magnitude to which medical residents and interns are willing to take upon themselves a regulatory oversight role. Such reforms will compensate for the failure of traditional regulatory institutions such as the ACGME.

Extending whistleblower protection to medical residents also makes sense because medical residents are situated in the most competent position to determine when such violations occur.¹³³ Under the PPSP Act, hospitals would be required to give medical residents notice of “their rights . . . [under the Act] including methods to enforce such rights (including so-called whistleblower protections); and the effects of their acute and chronic sleep deprivation both on themselves and on their patients.”¹³⁴ Thus, as long as medical residents understand their enforcement rights, there is an inherent constraint on the extent that residency programs could deviate from maximum-hour legislation. Additionally, the extension of whistleblower protection would provide residents the impetus to develop micromanaged oversight committees and discussion groups to determine program violations.¹³⁵ Also, graduating medical students have an interest in knowing which residency programs are abusive versus those that protect the future residents.¹³⁶

132. See AM. MED. STUDENT ASS’N, LIMIT ON RESIDENT HOURS: SUPPORT H.R. 3236, available at <http://www.amsa.org/hp/rwhfact.cfm> (last visited Aug. 17, 2003).

133. See Collier et al., *supra* note 1 (providing factual accounts of residents observing and experiencing violations of maximum-hour guidelines).

134. See Patient and Physician Safety and Protection Act of 2001, H.R. 3236, 107th Cong. § 3(a)(2) (2001).

135. See, e.g. AM. MED. STUDENT ASS’N, ADVOCACY ACTION COMMITTEE—RAISING THE AWARENESS & BREAKING DOWN BARRIERS, available at <http://www.amsa.org/adv/advocacy.cfm> (last visited July 13, 2003) (illustrating various advocacy and organized medical student groups).

136. See Lurie & Wolfe, *supra* note 87.

D. Institutional Submission

Finally, the extension of whistleblower protection to medical residents forces resident program administrators into a position requiring their close attention to resident work hours. For instance, instead of being subject merely to scheduled inspections, hospitals will have to determine if conditions within the work environment will result in disclosure of a violation. Not surprisingly, hospitals vehemently oppose extending whistleblower protection to medical residents.¹³⁷

A significant concern among medical practitioners is that by providing medical residents whistleblower protection and the right to file suits, a hospital's ability to effectively deliver health care may be severely compromised. In particular, there is concern that both physicians and patients may be deterred from disclosing specific information in reports, records, and charts in the fear that it may be subpoenaed at a future date.¹³⁸

Another concern with extending whistleblower protection is the issue of discretion: medical residency programs have educational requirements that may necessitate time commitments that cannot be met under a maximum-hour regime.¹³⁹ Additionally, organizations such as the AMA view the extension of whistleblower protection as an impediment to the management and internal affairs of hospitals. Finally, in an era of rising health care costs, shrinking funds at teaching facilities and increasing legal malpractice insurance premiums, critics contend that whistleblower protection would aggravate an ailing health care system.¹⁴⁰

V. CONCLUSION

With the selection of whistleblowers Coleen Rowley, Sherron Watkins, and Cynthia Cooper as *TIME* magazine's 2002 Persons of the Year, the role of the whistleblower has become personified to

137. See, e.g., AM. MED. STUDENT ASS'N, RESIDENT WORK HOUR ISSUE DEBATE SHEET, available at <http://www.amsa.org/hp/resworkdebate.cfm> (last visited Aug. 17, 2003) (suggesting that hospitals do not think that the extension of whistleblower protection will be an adequate incentive for self-reporting among residents).

138. See Statement for the Record Submitted by the American Academy of Family Physicians, House Comm., Ways and Means, Subcomm. on Health (Sept. 10, 2002).

139. See Papandria, *supra* note 86.

140. *Id.*

unprecedented levels.¹⁴¹ The disclosures by these whistleblowers have compelled Congress to respond, leading to enactment of legislation such as the Sarbanes-Oxley Act, the FBI Reform Act, and the Congressional Whistleblower Act.¹⁴²

The structure of the proposed PPSP Act presents an interesting question: should the federal government employ the use of whistleblowers or protection thereof to enforce labor-based legislation? Medical residents are undeniably experiencing excessive hours of work, resulting in fatigue and exponentially increasing the risk of harm to both patients and residents themselves. Although New York State has provided a template for reform, it is still highly questionable whether routine inspections and the imposition of fines have necessarily translated into concrete change.

Federal agencies such as the AHRQ, the Department of Labor, and OSHA purport to provide an unlimited set of federal enforcement resources. Unfortunately, as this paper sets forth, the government has historically deferred to private quasi-regulatory agencies, such as the ACGME, to enforce such labor standards. But the ACGME lacks resources, oversight authority, and any formal mechanism to effectively enforce maximum-hour standards for medical residents. Furthermore, the ACGME's requirement that residency programs implement independent guidelines and standards has been thwarted by discretionary institutional deviations. The University of Minnesota Medical School's criterion-based exception approach appears to be a unique method of enforcing the ACGME maximum-hour standards and may serve as a template for other states to follow, but this is still highly uncertain given the infancy of such an approach.

Whistleblower protection in section 3 of the PPSP Act is an innovative tool to ensure enforcement of maximum-hour legislation. The very nature of extending whistleblower protection to medical residents creates a form of incentive-based disclosure. Efforts by organizations, such as AMSA, explicitly demonstrate that residents are willing to take upon themselves such regulatory roles. The extension of whistleblower protection ensures that medical residents are collectively able to compensate for the failure of

141. Reaction of Sen. Patrick Leahy to *TIME* Magazine's Selection of 3 Whistleblowers as Persons of the Year, U.S. NEWSWIRE, Dec. 22, 2002, *available at* 2002 WL 101759570.

142. *Id.*

traditional methods of enforcement. Such protection will translate into institutional submissiveness where residency program administrators will inherently be more apt to adhere to maximum-hour restrictions because violations would likely be disclosed.

The extension of whistleblower protection to medical residents is by no means a panacea to current abusive working conditions. Roles exist for the federal government, the states, and institutional organizations such as the ACGME. Whistleblower protection provides one subtle yet effective regulatory tool that could undoubtedly result in enforcement of labor standards and ultimately better working conditions for medical residents.