

DYING TO SLEEP: USING FEDERAL LEGISLATION AND TORT LAW TO CURE THE EFFECTS OF FATIGUE IN MEDICAL RESIDENCY PROGRAMS

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Sawyer: Dr. Nossett, I'm going to start with you. You've not only seen it all, you say you've done it. And in fact, you once fell asleep yourself while delivering a baby?

Nossett: That's correct.¹

INTRODUCTION

The exhausting work schedules of resident physicians in the United States create an array of grave safety problems for medical residents and the public at large. In addition to residents' personal and emotional difficulties and the compromised quality of health care, the incidence of motor vehicle accidents that occur after residents leave work is alarming.²

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¹ Interview by Diane Sawyer with Dr. Angela Nossett, Chief Resident, Harbor UCLA Medical Center (ABC television broadcast, June 18, 2002).

² See Lisa M. Bellini et al., *Variation of Mood and Empathy During Internship*, 287 JAMA 3143 (2002) (finding that "enthusiasm at the beginning of the internship gave way to depression, anger and fatigue"). In addition, a recent study found that the rate of accidents involving anesthesia residents was more than twice the national average. See R.T. Gear et al., *Incidence of Automobile Accidents Involving Anesthesia Residents After On-Call Duty*

To combat this crisis and other problems related to resident work hours, New York created the Bell Regulations, which limit the number of hours residents may be scheduled.³ In addition, on November 6, 2001, Congressman John Conyers of Michigan introduced the Patient and Physician Safety and Protection Act of 2001 (PPSPA) as an amendment to Title XVII of the Social Security Act.⁴ The bill, still far from gaining sufficient support to

Cycles, 87 ANESTHESIOLOGY 938 (1997). Of note is the fact that the research was limited to accidents occurring after on-call shifts. According to a 1991 mail survey, residents typically work continuously with little or no sleep for an average of 56.9 total hours twice a week. See Public Citizens Health Research Group et al., *Petition to OSHA* (April 30, 2001), available at <http://www.citizen.org/publications/release.cfm?ID=6771>. This number is above and beyond their other assigned shifts, which can cumulate up to as many as 136 out of the 168 hours in a week. See L. Lagnado, *Hospitals Overwork Young Doctors in New York*, WALL ST. J., May 19, 1998, at B5.

³ 10 N.Y. COMP. CODES R. & REGS. tit. 10, § 405.4(b)(6)(ii) (2002). These regulations were created in response to uproar from the Libby Zion case in New York City. See *infra*, note 29 (discussing the Libby Zion case). The New York State Health Commissioner put together a panel, led by Dr. Bertrand Bell, Professor at Albert Einstein College of Medicine, to investigate conditions in New York's teaching hospitals. See Leslie K. Kohman, "Beat the Clock": Will There be Time in the New Millennium to Train Surgeons and Care for Patients, CardioThoracic Surgery Network, (June 4, 2002), available at <http://www.ctsnet.org/doc/5821>. Hence, the panel became known as the Bell Commission. *Id.* In 1989, the recommendations of the commission became part of the New York State Health Code. *Id.* See also H.R. 1852, 210th Leg. (N.J. 2002). On June 20, 2002, the New Jersey Assembly unanimously voted to pass a bill limiting residents' work hours. Press Release, Committee of Interns and Residents, NJ Assembly Passes Bill to Limit Resident Work Hours, available at [www.cirdocs.org/news/217 breakingnewspage.htm](http://www.cirdocs.org/news/217_breakingnewspage.htm) (last visited May 20, 2003); see also H.R. 390 (P.R. 2002).

⁴ H.R. 3236 IH, 107th Cong. (2001). Amongst its findings, the bill states that scientific literature demonstrates that the excessive work hours of resident physicians produce harmful effects on both patient care and the health of resident physicians. *Id.* Furthermore, the bill points out that residents work an "excessive number [] of hours," which is "inherently dangerous for patient care and the lives of physicians," that "sleep deprivation of the magnitude seen in residency training programs leads to cognitive impairment," and that scientific research demonstrates that the "excessive hours worked by resident-physicians lead to higher rates of medical error, motor vehicle accidents,

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be passed into law, is based in large part on the New York regulations.⁵ Both state regulations and federal legislative action support the view that employers need to better control the scheduling of their employees to prevent foreseeable risks to others.⁶ If New York serves as a guide, however, regulations may not be sufficient. The New York regulations have proven to have limited effectiveness, as hospitals routinely violate work

depression and pregnancy complications.” *Id.*

⁵ See 10 N.Y. COMP. CODES R. & REGS, tit. 10, § 405.4(b)(6)(ii) (2002). The PPSPA is consistent with the recognition that industries affecting public safety warrant federal regulation. For example, transportation industries are subjected to strict federal limits on the number of hours airplane pilots, truck drivers, train conductors and seamen are permitted to work. 14 C.F.R. § 121.471 (2003) (limiting flight times for all flight crewmembers); 49 C.F.R. § 395.3 (2003) (setting maximum driving times for motor vehicle carriers); 49 C.F.R. §§ 228.21 (2003) (imposing civil penalties for violating hours of service regulations for railroad employees), 49 C.F.R. § 228.23 (2003) (imposing criminal penalties for falsifying reports or records of hours of service for railroad employees); 46 U.S.C. § 8104 (2003) (setting work hour regulations for seamen). In 1999, the European Union agreed to limit the length of the work week for residents to forty-eight hours. Paul R. McGinn, *Europe Will Limit Resident Hours*, MED. STUDENT JAMA (Sept. 20, 1999), available at http://www.amaassn.org/scipubs/msjama/articles/vol_282/no_13/europe.htm; David Villar Patton et al., *Legal Considerations of Sleep Deprivation Among Resident Physicians*, 34 J. HEALTH L. 377 (2001). The authors found that in Israel, a system of longer residency programs with fewer hours during the residency “substantially enables Israel’s doctors to permit room for their own human needs, and in turn, provide compassionate and humane care as a matter of habit.” *Id.* at 386, citing Jesse Lachter, *Looking at the Training of House Staff*, 319 NEW ENG. J. MED. 718, 719 (1988). Additionally, they report that New Zealand residents may work up to only sixteen hours consecutively, with a weekly maximum limited to seventy-two hours. *Id.* Emergency room residents may work no more than ten consecutive hours, with up to fifty hours per week. *Id.* Finally, Denmark, Norway and Sweden residents work thirty-seven to forty-five hours per week; in the Netherlands they are limited to forty-eight hours per week. *Id.* at 387.

⁶ See Gene P. Bowen, *Wherein Lies the Duty? Determining Employer Liability for the Actions of Fatigued Employees Commuting From Work*, 42 WAYNE L. REV. 2091, 2092 (1996) (stating that the “notion behind such legislation appears to be recognition of an employer’s duty to monitor the work schedules of its employees to avoid creating a safety hazard to others”).

hour standards.⁷

In addition to formal regulations, the deterrent effect of the tort system might also be utilized to “encourage” hospitals to adjust residents’ training and employment.⁸ Specifically, in the realm of third-party liability, a person struck by a sleep-deprived resident that has fallen asleep at the wheel on the way home from work may be able to sue the hospital on a theory of negligence. Although this specific claim has never been successfully tried, analogous case law and public policy suggest such a claim is legally sound and could, if triumphant, improve resident training methods and working conditions in the United States. But, ultimately, the question remains whether that is the best alternative.

Part I of this note reviews the ever-expanding landscape of scientific evidence on fatigue and its effect on human capabilities, patient care and the lives of residents. Part II introduces the elements of the New York statute, evaluates its effectiveness and briefly examines the proposed federal legislation. Part III explores whether utilizing the deterrent force of the tort system is a wise alternative or supplement to regulatory attempts to change residency working conditions. While acknowledging that the majority of courts reject imposing third-party liability on the employer, this section focuses on three analogous cases that support liability under certain circumstances. Furthermore, Part III utilizes workers’ compensation cases in a similar fashion. Part IV synthesizes direct negligence and workers’ compensation case law and argues that, within these cases, principles emerge that support a finding of negligence in the resident-employee context.

⁷ See, e.g., New York State Department of Health, *State Health Department Cites 54 Teaching Hospitals for Resident Working Hour Violations* (June 26, 2002), [hereinafter Health Department Cites 54 Teaching Hospitals] available at http://www.health.state.ny.us/nysdoh/commish/2002/resident_working_hours.htm.

⁸ See *Boston Medical Center, et al.*, 330 N.L.R.B. 152 (1999) (holding that medical residents are employees within the meaning of Section 2(3) of the National Labor Relations Act, notwithstanding that they also possess aspects of students).

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Part V recognizes that third-party tort liability offers compelling benefits, but concludes that enforced public regulation of resident work hours proposes far less frightening costs and maintains the benefits of well-rested physicians.

I. FATIGUE: WHAT IT IS AND WHAT IT DOES

Two commonly cited consequences of medical resident fatigue are reduced quality of patient care and a negative impact on the health of residents.⁹ In addition, motor vehicle crashes, particularly after on-duty shifts, have also garnered attention in discussion of residents' work hours.¹⁰ To understand the reasons, it is important to first understand the nature of fatigue.

Human beings have a biological need to sleep, and sleep deprivation causes the brain to signal to the body the need to sleep.¹¹ Sleepiness is a specific term "relating to reduced alertness as a result of increased pressure to fall asleep."¹² Whether lacking sleep for twenty-four consecutive hours ("sleep loss"), or receiving inadequate sleep over a period of time

⁹ Included in Congress' findings in support of this bill were that residents work "an excessive number [] of hours" that is "inherently dangerous for patients and the lives of [] physicians," that "sleep deprivation of the magnitude seen in residency training programs leads to cognitive impairment" and that scientific research demonstrates that the "excessive hours worked by resident-physicians lead to higher rates of medical error, motor vehicle accidents, depression and pregnancy complications." H.R. 3236, *supra* note 4, at § 2.

¹⁰ See, e.g., R.T. Gear et al., *supra* note 2, at 3A; James M. Lyznicki, et al., *Sleepiness, Driving, and Motor Vehicle Crashes*, 279 JAMA 23 (1998); Carole L. Marcus & Gerald M. Loughlin, *Effect of Sleep Deprivation on Driving Safety in Housestaff*, 19 SLEEP 763 (1996).

¹¹ See Lyznicki et al., *supra* note 10, at 1908. "The sleep process involves a demand or obligatory component related to an individual's prior amounts of rest and work, and a circadian component related to 2 intervals of increased sleepiness and lowered performance are experienced during each 24-hour period." *Id.*

¹² *Id.* at 1909. "Sleepiness is a normal manifestation of the biological need for sleep, just as hunger signals the need to eat and thirst to drink." *Id.*

(“chronic partial sleep restriction”), the harmful impact on cognitive performance is similar.¹³ Fatigue is a feeling of physical and mental weariness resulting from exhaustion.¹⁴ A lack of adequate sleep, therefore, inevitably causes fatigue.

The implications are frightening in light of the highly complex duties of resident physicians, as the necessary skills of job performance inevitably suffer. Studies prove that motor skills such as the manual dexterity of surgical residents are vulnerable to the effects of fatigue.¹⁵ One study of emergency residents demonstrated “reductions in the comprehensiveness of history and physical examination documentation” and a decline in completion time for clinical task and accuracy tests.¹⁶ Beyond the psychomotor skills required for the job, the long hours of

¹³ Sigrid Veasey et al., *Sleep Loss and Fatigue in Residency Training*, 288 JAMA 1116 (2002). The authors report that “performance testing of vigilance (responsiveness to simple repeated tasks) and serial mathematical calculations were equally affected by 24 hours of total sleep loss and 1 week of sleep restriction to 5 hours per night.” *Id.* at 1116-17. The studies discussed revealed that “cognitive performance [] of healthy young adults who were sleep deprived . . . [are] below the mean.” *Id.* at 1117. Furthermore, verbal processing and complex problem solving abilities were impaired, as evidenced by the finding that, “[l]earning for both complex cognitive and procedural tasks can decrease by up to 50% when sleep loss occurs. . . .” *Id.* In a study observing the training experience of junior and senior residents, “[p]erformances on simulated electrocardiogram, short term recall of a list of things to do, and reaction times all deteriorated after being on call; these postcall performance deficits were similar for junior and senior residents, suggesting a lack of adaptation over time to the sleep-deprived state.” *Id.* The authors also pointed out, however, that these types of studies must be controlled for factors that affect sleepiness such as the intake of caffeine and other stimulants, warm ambient temperature, reduced body temperature and recent food intake. *Id.*

¹⁴ See AMERICAN HERITAGE DICTIONARY 665 (3d ed. 1992). See also Lyznicki et al., *supra* note 10, at 1909 (defining fatigue as “a more complex phenomenon that may be defined as the decreased capability of doing physical or mental work, or the subjective state in which one can no longer perform a task effectively”).

¹⁵ Veasey et al., *supra* note 13, at 1117.

¹⁶ *Id.*

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residency training have also been found to cause depression, anxiety and anger.¹⁷ Finally, and perhaps most significantly, as the long hours of residency training compound the effects of fatigue, residents consistently lose vigor and empathetic concern for patients.¹⁸

The increased incidence of motor vehicle crashes after work, especially after on-call shifts, additionally manifest from fatigue in resident physicians.¹⁹ One study compared sleep deprivation

¹⁷ See, e.g., Bellini et al., *supra* note 2, at 3143.

¹⁸ *Id.*; see also Amer Ardati, *Don't Overwork Physicians, Imperil Public*, DETROIT NEWS, Feb. 13, 2002 (quoting a resident physician in a Columbia Presbyterian case study as stating, "if you're on two nights in a row, you want to do as little as possible. You give bad care."); Bellini et al., *supra* note 2, at 3146 (commenting that "results . . . at the end of [the one year] internship demonstrated a significant increase in personal distress coupled with a decrease in empathetic concern"); Public Citizen, *ACGME's Proposed Limits on Resident Physician Work Hours are Inadequate, Coalition Says* (Feb. 11, 2002), available at <http://www.citizen.org/pressroom/release.cfm?ID=1021> (quoting Dr. Ruth Potee, national president of CIR/SEIU and a third-year family practice resident at Boston Medical Center, who said, "The consequences of working excessive hours is serious, both to our patients and to ourselves. Auto accidents, complications of pregnancy, depression—all disproportionately impact resident physicians. . .").

¹⁹ See Veasey, *supra* note 13 at 1122 (finding that "the greatest documented danger of sleep loss for medical residents is the risk of motor vehicle crashes"); Carol Ann Campbell, *Hospital Residents Plead for More Rest—Two Lawmakers Hear the Tales of Fatigue*, STAR-LEDGER (Newark, N.J.), May 8, 2002, at 39 (quoting a resident at University of Medicine and Dentistry of New Jersey, who mentioned "[o]ne of our residents fell asleep in the parking lot and didn't wake up until the morning."); Sanjay Gupta, *Is Your Doctor Too Drowsy?*, TIME, Mar. 11, 2002 at 17 (quoting a surgeon stating that "[p]ractically every surgical resident I know has fallen asleep at the wheel driving home from work . . . I know of three who have hit parked cars. Another hit a 'Jersey barrier' on the New Jersey Turnpike, going 65 m.p.h."); Ivan Oransky, *Post-call Fatigue Poses Risk for Residents*, MED. STUDENT JAMA, May 24, 1999, available at http://www.ama-assn.org/scipubs/msjama/articles/vol_281/no_21/post.htm (stating that "[n]early every resident I know has either fallen asleep behind the wheel driving home after call or knows someone involved in a post-call crash"). See also AAA FOUND. FOR TRAFFIC SAFETY, WHY DO PEOPLE HAVE DROWSY DRIVING CRASHES? INPUT FROM DRIVERS WHO JUST DID (1999). Especially

among on-call housestaff and faculty members, including its effect on driving.²⁰ Forty-four percent of housestaff had fallen asleep at the wheel when stopped at a red light, versus twelve percent of the faculty.²¹ Twenty-three percent of housestaff fell asleep at the wheel *while driving*, versus eight percent for the faculty.²² Overall, a total of forty-nine percent of housestaff had fallen asleep at the wheel, with ninety percent of these incidents occurring after an on-call shift.²³ Similarly, the accident rate of anesthesiology residents surveyed in another study was more than twice the national average.²⁴ The solution seems simple. Because fatigue is a state of sleep deprivation, “[t]he most effective countermeasure . . . is sleep.”²⁵ Limitations placed on resident work hours provide the opportunity to catch up on sleep, presumably leading to less fatigue and, therefore, improved patient care and resident health and safety.

relevant to the residency discussion are the conclusions that work and sleep schedules are associated with car crashes, drivers in “sleep-crashes” are more likely to involve an atypical schedule, and that “working the night shift increases the odds of a sleep related (versus non-sleep-related) crash by nearly 6 times.” *Id.* at 50.

²⁰ Marcus & Loughlin, *supra* note 10. The study utilized an anonymous questionnaire mailed to pediatric residents and full-time faculty. *Id.* at 763. The questionnaire included general questions about being on call, participating in other types of nocturnal work, falling asleep while driving, traffic citations and motor vehicle accidents. *Id.* All incidents relating to falling asleep at the wheel occurred after on-call shifts. *Id.* The authors provided that “the study has the limitations of a retrospective questionnaire study . . . and it is possible that [housestaff] provided biased responses.” *Id.*

²¹ *Id.* at 764.

²² *Id.*

²³ *Id.*

²⁴ Gear et al., *supra* note 2. “Thirty-six-item questionnaires were mailed to anesthesia residents in training at the Hospital of the University of Pennsylvania . . . ask[ing] subjects to report on their own traffic accidents, near accidents, or traffic violations occurring during their residency which they attributed to post-call fatigue.” *Id.*

²⁵ Veasey et al., *supra* note 13, at 1122.

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II. THE PUBLIC REGULATION PATH

Convinced that the hazardous effects of sleep loss and fatigue for medical residents is a serious problem for patients and residents, New York decided to regulate the work hours of residents in its teaching hospitals.²⁶ However, states throughout the country have been slow to follow.²⁷ Nonetheless, the problem calls for attention, as evidenced by the current proposal to nationalize the substance of the New York regulations in the form of federal legislation.²⁸

A. New York State's Bell Regulations

The New York State Bell Regulations were largely motivated by the Libby Zion case in which sleep loss and fatigue were blamed for the alleged negligence of a resident physician.²⁹ A grand jury investigation attributed fault to the residency training system, as opposed to doctors or the hospital.³⁰ The regulations

²⁶ See *supra*, note 3 (providing a brief history of the New York Regulations).

²⁷ *Id.* (noting that only New Jersey and Puerto Rico have proposed such regulations).

²⁸ See *supra*, note 4 (discussing the PPSPA).

²⁹ See generally Dan Collins, *A Father's Grief, A Father's Fight*, L.A. TIMES, Feb. 1, 1995, at E1. In 1984, Libby Zion was brought to New York hospital after suffering from a high fever and earache. *Id.* She was given a dosage of Demerol despite her use of an anti-depressant drug, Nardil. *Id.* A mixture of the two drugs can be fatal, and Libby died within five hours. *Id.* Her father filed a lawsuit against the hospital. *Id.* The claim included a charge that the exhausted resident who prescribed the Demerol was negligent in failing to realize that the combination of the two drugs can prove fatal. *Id.*

³⁰ See Barbara A. DeBuono, *The Medical Resident Workload*, MED. STUDENT JAMA (Dec. 2, 1998) (quoting the grand jury as stating, "[t]he most serious deficiencies can be traced to the practice of permitting inexperienced physicians to staff emergency rooms and allowing interns and junior residents to practice medicine without supervision."), available at http://www.ama-assn.org/sci-pubs/msjama/vol_280/no_21/jms81019.htm.; see also Daniela Lamas, *Residency, Round the Clock: New Rules Seek to Ease Training Doctors' Fatigue*, MIAMI HERALD, Aug. 15, 2002, at E1.

are designed to protect resident health and patient care through scheduling and resident work hour limits.

First, the Bell Regulations provide that “the scheduled work week shall not exceed an average of eighty hours per week over a four week period.”³¹ While the cumulative hours of a given work week may exceed eighty, the four week average must meet the criteria.³² The regulations are flexible, therefore, in that they reasonably account for patient care needs that require a rigorous work week, while maintaining a four week average to allow adequate rest.

Second, “trainees shall not be scheduled to work for more than twenty-four consecutive hours.”³³ This section addresses the detrimental effects that result from sleeplessness but also recognizes the hospital’s need to provide round-the-clock patient care services to the public. Although twenty-four consecutive hours without sleep is arguably dangerous, the regulations at least set a clearly defined limit.³⁴

Third, the regulations provide that on-call duty shall not be included in the twenty-four and eighty hour limits, so long as “such duty is scheduled for each trainee no more often than every third night . . . [and] a continuous assignment that includes night shift on-call duty [must be] followed by a non-working period of no less than sixteen hours.”³⁵ On-call duty can demand extraordinarily long hours of work without sleep.³⁶ The

³¹ 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4(b)(6)(ii)(a) (2002).

³² 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4(b)(6)(ii)(a) (2002).

³³ 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4 (b)(6)(ii)(b) (2002).

³⁴ 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4 (b)(6)(ii)(b) (2002). *See also* Patton et al., *supra* note 5, at 380 (reporting that “researchers have even compared the effects of sleep deprivation to the effects of alcohol intoxication”).

³⁵ 10 N.Y. COMP. CODES R. & REGS., tit. 10, § 405.4(b)(6)(ii)(d)(2)-(3) (2002).

³⁶ *See, e.g.*, David Abel, *Bill Eyes Guidelines on Work Hours for Medical Residents*, BOSTON GLOBE, Nov. 10, 2001, at B1 (stating that a former resident of Baltimore’s Johns Hopkins Hospital abandoned her surgical training after falling asleep during a 60-hour shift without rest); Gupta, *supra*

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regulations mandate that hospitals at least spread out on-call shifts so residents can consistently obtain a reasonable amount of rest while completing their regular weekly schedules.

These seemingly realistic regulations account for hospitals' staffing needs while limiting the inherent sleep deprivation problems of residency training methods. New York hospitals, however, continue to schedule residents beyond the prescribed limits.³⁷ Although the Bell Regulations focus on reducing fatigue, enforcement of the prescribed limits has twice proven the regulations somewhat ineffective, both in 1998 and 2002.³⁸

note 19 at 73 (stating that "it [is] not unusual to work 40 hours in a row without rest").

³⁷ See Health Department Cites 54 Teaching Hospitals, *supra* note 7. These 2002 violations came four years after a first wave of sweeping inspection by the Department of Health. New York State Department of Health, *NYS Hospitals Fined for Violating Resident Work Hours* (June 18, 1998) [hereinafter NYS Hospitals Fined], available at <http://www.health.state.ny.us/nysdoh/commish/98/workhrs.htm>. The department issued a report based on a survey of twelve teaching hospitals "showing widespread abuse of resident work hour limits, particularly among surgical residents in New York City." *Id.* The report specifically found that all first year residents in the cardiovascular surgical program worked 110-130 hours per week. *Id.* Ten of eighteen surgical residents worked in excess of eighty-five hours per week. *Id.* Finally, residents were found to have worked until 8 p.m. after a thirty-six hour shift only to return to work at 6 a.m. the next day. *Id.*

³⁸ See *id.* (reporting the 1998 violations); Health Department Cites 54 Teaching Hospitals, *supra* note 7 (reporting the 2002 violations). The Department of Health contracted with IPRO, an independent not-for-profit corporation, to monitor resident working hours in New York State. IPRO, New York State Resident Work Hour Regulations (n.d.). As of May 2003, however, the annual report had not been published so it is difficult to assess whether IPRO has been more successful. Furthermore, the Accreditation Council for Graduate Medical Education ("ACGME"), the body in control of determining accreditation of teaching hospitals, announced its own enforceable guidelines applicable to residency programs beginning July 3, 2003. Accreditation Council for Graduate Medical Education, *Resident Duty Hours Language* (Feb. 13, 2003), [hereinafter Resident Duty Hours Language] available at http://www.acggme.org/DutyHours/dutyHoursLang_final.asp. Also mirroring in large part the New York State Bell Regulations, these guidelines seek to self-regulate the teaching hospitals with the enforcement

B. The Patient and Physician Safety and Protection Act of 2001

The PPSPA essentially mirrors the Bell Regulations in regard to specific regulation of residents' work hours and schedules.³⁹ Supported by findings drawn from scientific evidence asserting that the effects of fatigue manifest in compromised patient care and endangered resident health, the legislation appropriately recognizes that resident work hours need to be reduced.

For example, unlike the state regulations, however, the federal legislation contains unique enforcement mechanisms. The Act conditions receipt of federal funds on compliance with the work hour limits.⁴⁰ Furthermore, the Act provides an incentive to

mechanism of more frequent review of programs. *Id.* For example, during routine accreditation surveys in 1999, the ACGME issued citations for work hour violations to 11.7% of programs surveyed. Jay Greene, *More Residencies Cited for Work Violations*, AMNEWS, Mar. 6, 2000, available at http://www.ama-assn.org/sci-pubs/amnews/pick_00/prl20306.htm. ACGME officials stated that citations had been increasing over the past few years. *Id.* Nevertheless, "[t]o date, the ACGME has not withdrawn accreditation of any program solely for overworking residents." *Id.* Therefore, while setting limits for the number of hours residents are allowed to work in accredited hospitals recognizes the problem, lack of enforcement will have trouble solving it. In comparison, the New York State Department of Health attempts, as an external regulator, to implement a rational work environment for residency training programs. If the shortcomings demonstrated in the 1998 and 2002 reports are any indication of the problem of enforcement, truly internal enforcement by the ACGME is limited as well if enforcement has no teeth. *But see* Jaya Agrawal, *Resident Education and Safety*, 66 AM. FAM. PHYSICIAN 1569 (2002) (reporting that the Yale surgical residency program is at risk of losing accreditation unless changes are made with respect to the number of hours residents work).

³⁹ See generally H.R. 3236, *supra* note 2. Similarities include the eighty-hour work week, twenty-four consecutive hour limit and required time off between shifts. Compare 10 N.Y. COMP CODES R & REGS., tit. 10, § 405.4(b)(6)(ii) with H.R. 3236, § 3 (j)(1)(A).

⁴⁰ H.R. 3236, *supra* note 2, at § 3 (j)(1)(A). This distinction is found in an enforcement mechanism: ". . . [A]s a condition of participation under this title each hospital shall establish the following limits on working hours." *Id.* Thus far, assigning standards to the guarantee of federal funds as a

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hospitals that successfully conform to the new standards within five years.⁴¹

Like the Bell Regulations, which generated public attention by highlighting the conditions of residency programs, federal legislation could spark national awareness of the issues concerning residents—especially because it is likely that everyone, at some point in their lives, will rely on a resident physician in a time of need.⁴² The national community responding to the concerns of fatigue, coupled with the past success of tailoring federal funds to government standards and the financial incentive offered for compliance, indicates that the PPSPA takes what New York has attempted to achieve a step further.

While violations of the New York regulations are well documented, not all hospitals, or departments or specialties within hospitals, fail to comply.⁴³ Therefore, even though certain

conditioning device has proven successful. Dori Page Antonetti, *A Dose of Their Own Medicine: Why the Federal Government Must Ensure Healthy Working Conditions for Medical Residents and How Reform Should be Accomplished*, 51 CATH. UNIV. L. REV. 875, 913 (2002). The Balanced Budget Act of 1997 imposed residency program guidelines for federal funding on teaching hospitals in order to better serve public health. *Id.* By attaching conditions to federal grants, thus providing a powerful incentive for hospitals to follow such guidelines, the legislation proved successful in that all of the goals of the initiative were met. *Id.*

⁴¹ H.R. 3236, *supra* note 2, at § 4 (providing funds).

⁴² In fact, according to the results of the 2002 Sleep in America poll, conducted by the National Sleep Foundation, the respondents indicated, on average, the maximum amount of time a doctor should work is 9.8 hours per day. NATIONAL SLEEP FOUNDATION, 2002 “SLEEP IN AMERICA” POLL (2002). Eighty-six percent also stated that if they knew their doctor was working for twenty-four consecutive hours, they would feel anxious about their safety, and seventy percent would ask for another doctor. *Id.* at 26. Similar results reflected concern involving drowsy airplane pilots, and workplace overtime generally. *Id.* at 27-28; *see also*, Antonetti, *supra* note 40, at 909 (observing that “[n]ewspapers, documentaries, and popular television programs have shed light on the problem of excessive work hours during residency . . . expos[ing] a system previously hidden from the public eye, and . . . spark[ing] criticism and outrage”).

⁴³ *See, e.g.*, Anne Barnard & Liz Kowalczyk, *Medical Resident Workload*

hospitals may not maintain a perfect record, they have made strides in reducing residents' workloads.⁴⁴ Still, public regulation as a solution to problems resulting from the excessive work schedules of resident physicians is far from perfect, as demonstrated by the ability of hospitals to function while absorbing the costs of fines.⁴⁵ The PPPSA appropriates amounts to cover the "incremental costs incurred in order to comply with the requirements imposed by [the] Act."⁴⁶ Therefore, federal regulation that invests in the system it seeks to regulate is a step in the right direction.

Curbed, Big Impact Seen on Hub Hospitals, BOSTON GLOBE, June 13, 2002, at A1. Brigham and Women's Hospital has cut back the hours in their surgery program to eighty to eighty-five hours. *Id.* Dr. Michael Zinner, Chief of Surgery, planned to require doctors to sacrifice research time to help cover shifts, hire more physicians' assistants and provide additional training to nurses. *Id.* Brigham and Women's and Yale-New Haven Medical Center estimated that changing their surgery programs could cost \$1 million a year. *Id.*; see also Jay Greene, *Residencies Successful in Curbing Work-Hour Violations*, AMNEWS (July 30, 2001), available at http://ama-assn.org/sci-pubs/amnews/pick_01/prsc0730.htm.

⁴⁴ The regulations force hospitals to reduce resident physicians' workloads and assume financial burdens. For example, Jackson Memorial Hospital in Miami has dealt with the eighty hour week for more than six years, since residents unionized and bargained for change. See Lamas, *supra* note 30. While residents are not barred from working beyond the eighty hours, the hospital did hire "physician extenders," laboratory technicians, nurse practitioners and physician assistants. *Id.* This additional personnel may help to "fill the gaps," but it is noteworthy that the annual overtime budget ran out after four months. *Id.*; see also Jackie Jadrnak, *Residents Defend Schedule*, ALBUQUERQUE JOURNAL, July 8, 2002, at C1. Steve McKernan, CEO of the University of New Mexico Hospital, in responding to cutting resident work hours, "It's going to be more expensive. We've routinely been adding advance-practice nurses." *Id.* However, hiring more advance-practice nurses comes at almost twice the cost. *Id.* But see Agrawal, *supra* note 38.

⁴⁵ See Health Department Cites 54 Teaching Hospitals, *supra* note 7; NYS Hospitals Fined, *supra* note 37.

⁴⁶ H.R. 3236, *supra* note 2, at § 4. Compare Antonetti, *supra* note 40 (stating that in authorizing financial assistance, "the federal government may provide teaching programs with total funds up to \$1 trillion in 2003, \$800 million in 2005, \$400 million in 2006, and \$200 million in 2007").

REFORMING MEDICAL RESIDENCY PROGRAMS 659III. TORT LIABILITY FOR HOSPITALS AS AN ALTERNATIVE
DETERRENT

Regardless of good intentions, the enforcement problems in New York require creative thinking to accomplish the task of reducing resident work hours in the name of improved health care and healthier residents. When a fatigued resident commits a medical error that causes injury, a negligence claim arises and an explanation of why the negligence occurred is inconsequential. Therefore, while fatigue may increase the number of medical errors, the issue may be moot in the context of medical malpractice. When a resident falls asleep at the wheel after an exhausting shift, however, analogous case law illustrates that actual fatigue and its cause become a central theme in litigation.

A. *Robertson v. LeMaster*

In *Robertson v. LeMaster*, the Supreme Court of West Virginia found a railroad company liable for damages from an accident caused by an employee who fell asleep driving home from work.⁴⁷ After laboring for more than twenty-six hours at a train derailment site, the employee, LeMaster, finally insisted that he was too tired to continue working.⁴⁸ The employer suggested that if he would not work, he should go home.⁴⁹ Another railroad employee drove LeMaster to his car—LeMaster fell asleep with a lit cigarette in his hand during the ride.⁵⁰ On his way home he fell asleep at the wheel, resulting in an accident with Robertson.⁵¹

In his claim against the railroad, Robertson argued that the company “knew or should have known that its employee

⁴⁷ 301 S.E. 2d 563, 565 (W. Va. 1983).

⁴⁸ *Robertson v. LeMaster*, 301 S.E. 2d 563, 565 (W. Va. 1983).

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

constituted a menace to the health and safety of the public.”⁵² The railroad contended it had no duty, as a matter of law, to control an employee acting outside the scope of employment.⁵³ In the alternative, it argued that any negligence on its part was not the proximate cause of the injuries sustained, and the employee’s negligence was an independent intervening cause that cut the string of causation.⁵⁴

On the issue of duty, the *Robertson* court recognized that under traditional principles of tort law, an employer has no duty to control employees outside the scope of employment.⁵⁵ Nevertheless, the court asserted that the issue was not whether the employee was to be controlled, but, rather, “whether the [railroad’s] conduct prior to the accident created a foreseeable risk of harm.”⁵⁶ According to the Restatement (Second) of Torts, an affirmative act may give rise to a duty to use reasonable care if such an act creates an unreasonable risk of harm to another.⁵⁷ Here, requiring an employee to work unreasonably long hours, driving him to his vehicle and sending him on the highway in an exhausted condition satisfied the requirement for such an act.⁵⁸ In addition, the court considered “the likelihood of injury, the magnitude of the burden in guarding against it, and the consequences of placing that burden on the defendant.”⁵⁹ The court held that a reasonable jury could find that the employee, after working excessive hours, was in such an exhausted condition that driving caused a foreseeable and unreasonable risk of harm to motorists.⁶⁰ In the view of the Supreme Court of West Virginia, the duty analysis is primarily driven by foreseeability.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Robertson v. LeMaster*, 301 S.E. 2d 563, 565 (W. Va. 1983).

⁵⁵ *Id.* at 567.

⁵⁶ *Id.*

⁵⁷ RESTATEMENT (SECOND) OF TORTS § 321 (1965), *cited in Robertson*, 301 S.E.2d at 567.

⁵⁸ *Robertson*, 301 S.E.2d at 568-69.

⁵⁹ *Id.* at 568.

⁶⁰ *Robertson v. LeMaster*, 301 S.E. 2d 563, 570 (W. Va. 1983).

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The court also rejected the railroad's argument that the employee-driver's negligence constituted an intervening cause that broke the chain of causation as a matter of law.⁶¹ Robertson argued that LeMaster's negligent driving was caused by fatigue directly attributable to the employer's negligence in imposing unreasonable work hours.⁶² The plaintiff argued that the employer's negligence "reduced the capability of its employee to think and act as a reasonable person."⁶³ Further, the plaintiff argued that if the intervening cause can be reasonably anticipated, liability may be imposed on the defendant because "the risk created by the defendant may include the intervention of the foreseeable negligence of others."⁶⁴

Foreseeability of harm, as with duty, played a critical role in the court's analysis of causation, and the plaintiff won the day.⁶⁵ The employee arguably broke the chain of causation through his own negligence—that is, by deciding to drive while fatigued. Despite this fact, the court found it reasonable to attribute this seemingly independent decision to the negligence of the employer in requiring an unreasonable work schedule.⁶⁶ Since the alleged negligence of the employee did not "constitute a new effective cause and operate independently," such an intervening cause could not "relieve a person charged with negligence in connection with an injury."⁶⁷ Moreover, since the intervening cause could be anticipated after such unreasonable hours, the court held that the jury could conclude "LeMaster's negligent conduct was a direct result of the mental fatigue and physical

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* (quoting W. PROSSER, *THE LAW OF TORTS* (4th ed. 1971)).

⁶⁵ *Robertson v. LeMaster*, 301 S.E. 2d 563, 570 (W. Va. 1983). (stating that if "[t]he Defendant railway's negligence reduced the capability of its employee to think and act as a reasonable person . . . LeMaster's conduct would not constitute an intervening cause so as to relieve the railway company of liability").

⁶⁶ *Id.*

⁶⁷ *Id.* at 569 (quoting, *Lester v. Rose*, 130 S.E.2d 80 (1963)).

exhaustion attributable to the [employer's] negligence."⁶⁸ Therefore, the employer's creation of a poor judgment maker, the employee, outweighed any negligence on the part of LeMaster himself.⁶⁹

In the context of overworked medical residents, a hospital is likely to argue that the resident knew of his or her fatigue and weakened ability to drive safely, yet made the decision to drive home.⁷⁰ At that moment, the employee becomes a causal actor and, arguably, the cause of the accident.⁷¹ Applying *Robertson's* reasoning, however, by scheduling unreasonable hours and causing sleep deprivation, the hospital creates an environment in which the ability of a resident to make sound judgments is significantly damaged.⁷² As such, although the resident makes a

⁶⁸ *Robertson*, 301 S.E.2d at 570.

⁶⁹ The court reversed and remanded with instructions that reasonable persons may draw different conclusions from the evidence and facts of the record regarding responsibility for plaintiff's injuries. *Id.* Presumably, after the directed verdict of the lower court in favor of the employer was reversed, thus opening the door to potential liability, the case settled. *Id.* Therefore, although the court did not expressly hold that the railroad was negligent in working its employees for an excessive number of hours, its willingness to give a theory of negligence with third-party liability to the jury revealed that it considered the cause of action legally sound. Indeed, the court opined that "if the intervening cause is one which is to be reasonably anticipated, the defendant may be liable, for [t]he risk created by the defendant may include the intervention of the foreseeable negligence of others." *Id.* (quoting W. PROSSER, *THE LAW OF TORTS* (4th ed.) (1971)). Thus, in the employer-employee context, it appears that the employer *may* commit acts sufficient to create legal causation. *Id.* Resident physicians become exhausted and fall asleep at the wheel often because of excessive work hours. *See Lyznicki et al., supra* note 10. Therefore, assigning long hours as a condition of employment would seemingly swallow any negligence on the part of the resident-driver.

⁷⁰ *See Robertson*, 301 S.E. 2d at 569. In *Robertson*, the court articulated the employer's defense that it was not the proximate cause of the car accident occurring during the commute from work. *Id.* "The thrust of the [employer's] argument . . . is that the negligence of [the employee] constituted an independent intervening cause of the accident that broke the chain of causation." *Id.*

⁷¹ *Robertson v. LeMaster*, 301 S.E. 2d 563, 569 (W. Va. 1983).

⁷² *See Patton et al., supra* note 5, at 380 (observing "[s]ome researchers

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conscious, albeit distorted, decision to drive home despite feeling exhausted, a strong causal relationship exists between the creation of sleep deprivation through excessive scheduling and falling asleep at the wheel.⁷³

B. Faverty v. McDonald's

An appellate court in Oregon similarly analyzed third-party liability of an employer for injuries resulting from an automobile accident involving an employee who had worked long hours.⁷⁴ In *Faverty v. McDonald's*, the employee, a high-school student, worked at one of McDonald's fast food restaurants.⁷⁵ He worked his usual shift, 3:30 p.m. to 7 p.m.⁷⁶ He also worked a cleanup shift from midnight until 5 a.m. and continued to work yet another shift from 5 a.m. until 8:21 a.m., at which point he asked to leave because he felt sleepy.⁷⁷ Shortly after being allowed to leave, the employee began his trip home and either became drowsy or fell asleep at the wheel and caused the accident.⁷⁸ The plaintiff, Faverty, was injured and the employee died in the accident.⁷⁹ The plaintiff settled his claims against the employee's representatives and pursued a claim against McDonald's, alleging that McDonald's was negligent in scheduling its employee too many hours without allowing adequate time for rest.⁸⁰

As in *Robertson*, the employer's initial argument focused on the absence of duty.⁸¹ Specifically, McDonald's argued it could

have even compared the effects of sleep deprivation to the effects of alcohol intoxication").

⁷³ *Robertson*, 301 S.E. 2d at 569.

⁷⁴ *Faverty v. McDonald's*, 892 P.2d 703 (Or. Ct. App. 1995).

⁷⁵ *Id.* at 705.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Faverty v. McDonald's*, 892 P.2d 703, 705 (Or. Ct. App. 1995).

⁸¹ *Id.* at 706; *Robertson v. LeMaster*, 301 S.E. 2d 563, 565 (W. Va.

not be held liable as a matter of law because it had no duty to prevent an employee from working as many hours as the employee in this case did.⁸² The court disagreed.⁸³ Rather than analyzing whether the employee could or should be controlled, the court agreed with the plaintiff that liability depends on whether the employer created a foreseeable risk to a protected interest of the kind of harm that befell the plaintiff.⁸⁴ The court held that, even absent a special relationship, a defendant “is subject to a general duty to avoid conduct that unreasonably creates a foreseeable risk of harm to a plaintiff.”⁸⁵ Therefore, the court concluded that McDonald’s created a duty because it should have foreseen that an employee working three shifts in a twenty-four hour period posed a risk of harm for motorists when that exhausted employee drove home from work.⁸⁶

McDonald’s next argued that, even if subject to this general duty, there was no evidence that it knew or should have known that the employee was so fatigued that it could have foreseen the possibility of an accident.⁸⁷ The court rejected these arguments

1983).

⁸² *Faverty*, 892 P.2d at 706 (noting that the employer relied on Sections 315 and 317 of the Restatement (Second) of Torts). Section 315 of the Restatement provides that “there is no duty to control the conduct of a third person as to prevent him from causing physical harm to another unless . . . a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person’s conduct.” RESTATEMENT (SECOND) OF TORTS § 315 (1965). Section 317 provides an exception to Section 315’s general rule of nonliability for failing to control the conduct of third persons by placing the master under a duty to exercise reasonable care if the servant is either on the master’s premises or is using the master’s chattel at the time of injury. *Id.* at § 317. Since the accident that caused the injuries did not occur on the employer’s premises, and the employee was not at that time using the employer’s chattel, the exception provided by Section 317 did not apply. *Faverty*, 892 P.2d at 708. Therefore, the employer argued that the general rule of nonliability for the conduct of third persons should apply. *Id.*

⁸³ *Id.* at 706.

⁸⁴ *Id.* at 708.

⁸⁵ *Faverty v. McDonald’s*, 892 P.2d 703, 708 (Or. Ct. App. 1995).

⁸⁶ *Id.* at 710.

⁸⁷ *Id.* at 709.

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based on the facts.⁸⁸ Because McDonald's controlled all of the work assignments, the court concluded it knew how often its employees were working.⁸⁹ McDonald's had a policy against working high school students after midnight and, when necessary, it did so only once a week.⁹⁰ A similar company policy prohibited employees from working two shifts in one day.⁹¹ The court found that McDonald's knew of two recent accidents involving employees leaving work late and falling asleep at the wheel.⁹² There was also evidence that the employee was visibly fatigued, and the managers on staff that evening observed the employee throughout his shift.⁹³ Given these facts, the court determined that a reasonable jury could conclude that the employer knew or should have known that working its employee so many hours would negatively affect his ability to drive, and the employer should have foreseen the risk of a car accident after its employee worked three shifts in less than twenty-four hours.⁹⁴

Finally, McDonald's argued that since the employee "volunteered" for the cleanup project, it could not be negligent as a matter of law.⁹⁵ The court was not persuaded.⁹⁶ The court found

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Faverty v. McDonald's*, 892 P.2d 703, 709 (Or. Ct. App. 1995). The court observed, "According to at least one of [the employer's] managers, those policies were adopted and enforced out of concern that employees not become overly tired on the job." *Id.* Therefore, the employer's violation of a self-imposed policy factored in to the court's analysis in siding with the plaintiff.

⁹² *Id.*

⁹³ *Id.* at 710.

⁹⁴ *Id.* The existence of self-imposed shift limits indicated that the employer knew of the risk involved with overworking high school employees. *Id.* at 709 (stating that "according to at least one of [the employer's] managers, those policies were adopted and enforced out of concern that employees not become overly tired on the job").

⁹⁵ *Id.* at 710.

⁹⁶ *Id.*

that the employer affirmatively asked the employee to work, controlled all work assignments and penalized employees for not working as assigned.⁹⁷ Acknowledging the vulnerable position of employees hesitant to fill shifts and complete special duties, such as cleanup projects, the court noted that even if the employee volunteered the managers knew that assigning this shift to this employee would violate company policies.⁹⁸ In addition, the court seized upon the fact that the managers were aware of the employee's condition and compared the managers to "a bartender who serve[s] to a visibly intoxicated person who then cause[s] an automobile accident that harmed another" after that customer "volunteers" to pay for the drink.⁹⁹

⁹⁷ Faverty v. McDonald's, 892 P.2d 703, 710 (Or. Ct. App. 1995).

⁹⁸ *Id.* (stating that plaintiff did not "out of the blue, volunteer to take three shifts in one 24-hour period. Defendant affirmatively asked him to work those hours.").

⁹⁹ *Id.* Dram Shop Acts provide an illustrative example. *See, e.g.*, Michael L. Young, Note, *Reinventing the "Legislative Intent, or Rather the Legislative Mandate" on Dram Shop Liability in Missouri: A Look at Kilmer v. Mun*, 45 ST. LOUIS. U. L. J. 625 (2001). At common law, tavern owners "were not liable for injuries suffered by the patron or a third party because the proximate cause of the injuries was the patron's consumption of alcoholic beverages, and that patron's negligent driving or other behavior, not the tavern or restaurant owner's sale of the beverages." *Id.* at 629. Although the Prohibition Era's Dram Shop Act was repealed at the end of Prohibition in 1934, it remained a criminal offense to serve alcoholic beverages to minors or "habitual drunkards and the apparently intoxicated." *Id.* at 632. By the 1980s, however, in response to the terrible problems involved with drunk driving, Missouri, and many other jurisdictions abrogated the traditional proximate cause rule. *Id.* By 1983, the Missouri Court of Appeals found that "plaintiffs [including third parties] could bring a civil action against tavern owners by expanding the duty of care dram shop owners owe to the public when selling alcoholic beverages to their customers." *Id.* at 635. This was justified on the grounds that since an intoxicated person is more likely to cause harm than a sober person, "tavern owners [have] a duty of care to stop serving alcoholic beverages to intoxicated persons." *Id.* In 1985, however, Missouri became the only state to pass legislation that requires criminal conviction of a tavern owner before civil liability can be imposed. *Id.* at 639. Today, only a few states have no dram shop liability at all. *Id.* The Missouri courts have responded to passage of this law with judicially activist interpretation in creating broad areas of liability.

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Faverty illustrates the fact-sensitive nature of negligence cases. The court looked at the circumstances of the case to determine that a reasonable jury could find the employer negligent.¹⁰⁰ It is important to note that the fact that the employer in *Faverty* worked the employee beyond its own rules was crucial to the court's decision.¹⁰¹ Without such a policy and blatant violation, the court may not have reached the same result.¹⁰²

As significant as *Faverty* may be, the case provides little guidance as to what actually constitutes a reasonable work schedule. In concluding that liability was reasonable, the *Faverty* court found a duty arising out of the foreseeable risks of harm and consequences of employers' actions towards their employees.¹⁰³ Therefore, working an employee an unreasonable number of hours and thus creating a foreseeable risk of falling asleep at the wheel and causing an accident also creates a duty to prevent such harm.¹⁰⁴ The *Faverty* court's failure to provide any working guidelines however, renders the opinion open to the criticism that its decision was value-driven or merely an extraordinary case with abysmal decisionmaking on the part of the employer, thus supplying little precedential value.¹⁰⁵

See generally id.

¹⁰⁰ *Faverty*, 892 P.2d at 710.

¹⁰¹ *Id.*

¹⁰² *Id.* at 709-10. Similarly, the existence of a federal regulation does not necessarily give rise to negligence per se. *Parker v. R & L Carriers, Inc.*, 560 S.E.2d 114 (Ga. Ct. App. 2002). In *Parker*, the employee, a truck driver, violated the Federal Motor Carrier Safety Regulations by driving beyond the number of hours permitted. *Id.* The court found that irrelevant to the employee's running a red light. *Id.* at 115. "The proximate cause of the accident was the failure to yield the right of way, not the failure to follow federal regulations. [The employee's] inattention or fatigue *may have explained* his failure to yield the right of way . . . but whether his fatigue *violated a federal regulation* is irrelevant." *Id.*

¹⁰³ *Faverty v. McDonald's*, 892 P.2d 703, 710 (Or. Ct. App. 1995).

¹⁰⁴ *Id.*

¹⁰⁵ *See Lesser v. Nordstrom, Inc.*, Nos. CIV. A. 96-8121, CIV. A. 97-6070, 1998 U.S. LEXIS 12607 *13 (E.D. Pa. Aug. 14, 1998) (holding that an employee's twelve-hour shift, as opposed to her normal ten hours, does not

create “a genuine issue of material fact concerning whether there was ‘a foreseeable risk of harm which the employer had a duty to guard against’”); *Hershman v. New Line Prods., Inc.*, No. B145028, 2001 WL 1470360 at *3 (Cal. App. 2 Dist., Nov. 20, 2001) (stating that “a 19-hour shift and 70 hours in the preceding five days was not enough of a factual basis upon which to impose liability”). The majority of courts are hesitant to impose third-party liability on employers for the tortious acts of employees during the commute. *See, e.g.*, *McNeil v. Nabors Drilling USA, Inc.*, 36 S.W.2d 248 (Tex. App. 2001). In *McNeil*, the court refused to impose liability on the grounds of an absence of a legally recognized duty to third parties. *Id.* at 251. The employee received less than fifteen hours of sleep over the course of four days at the employer’s drilling rig site. *Id.* at 249. On the fourth day, the employee decided to drive home to rest, instead of utilizing the on-site sleeping quarters provided by the employer. *Id.* The employee neither complained to supervisors about his lack of sleep, nor discussed his plan to rest at home. *Id.* During the drive, after making stops at a store, car wash and another drilling rig, he fell asleep at the wheel and crashed into the plaintiff, injuring her. *Id.* The court began its analysis by determining whether an “employer assumes a duty over its employee’s off-duty conduct when the employer is aware of the employee’s incapacity and affirmatively attempts to control the employee.” *Id.* at 250. Lacking sufficient knowledge of the employee’s state of fatigue, the duty question was dismissed. *Id.* at 251. Furthermore, the court stated that employers are not legally required to “monitor their employees before allowing them to leave work”, and employers implementing safety policies “to prevent employee incapacity do not assume a duty to third parties.” *Id.*; *see also* *D’Amico v. Christie*, 518 N.E.2d 896 (N.Y. 1987). In comparing *Otis Engineering v. Clark*, *infra* pp. 21-24, the court noted that it had not come across sufficient facts in which the employer “virtually placed its employee behind the wheel.” *Id.* at 902. Since the employer could not have reasonably controlled the employee’s conduct, “plaintiffs [] failed to demonstrate any legal duty in the existing law of this State that [the employer] can be said to have breached.” *Id.*; *Depew v. Crocodile Enterprises, Inc.*, 73 Cal. Rptr.2d 673 (Cal. Ct. App. 1998). The employee worked 17.5 hours, then another six hours after he had sixteen hours during which he did not have to work. *Id.* at 678. During the drive home, the employee caused an automobile accident with the plaintiff. *Id.* The court concluded “there was an insufficient causal nexus between [the employee’s] employment and [plaintiff’s] death.” *Id.*

However, the fact-sensitive nature of negligence cases permits liability to be imposed under certain circumstances. *See* *Faverty v. McDonald’s*, 892 P.2d 703 (Or. Ct. App. 1995); *Otis Engineering v. Clark*, 668 S.W.2d 307 (Tex. App. 1983); *Robertson v. LeMaster*, 301 S.E.2d 563 (W. Va. 1983). Therefore, a plaintiff is well-advised to assert the existence of egregious work

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Nonetheless, even if the line to draw for an excessive work schedule is usually difficult, if not impossible, *Faverty* demonstrates that egregious circumstances can give rise to third-party liability.

conditions that give rise to fatigue, knowledge of such fatigue on the part of the employer and then, pursuant to such knowledge, affirmative conduct in releasing or sending the employee out on the road. *See Bowen, supra* note 6. In discussing this duty issue, the difficulty seems to arise at the inability to determine the nature of such duty. *Id.* at 2103. On the one hand, a finding of negligence could be grounded upon nonfeasance—"failure to prevent the employee from leaving in an incapacitated state"—or, in the alternative, misfeasance—"allowing, if not requiring, the employee to work long hours and then setting the visibly exhausted employee on the road to drive home." *Id.* The *Robertson* and *Faverty* courts relied upon the latter. *Id.* at 2104. The nonfeasance path severely limits third-party liability by requiring the employer to stop the employee from driving home. Moreover, it "ignores the possibility that the employer has voluntarily entered an affirmative course of action affecting the interests of one of its employees and has thereby assumed a duty to act with reasonable care." *Id.* at 2105. On the other hand, the concept of misfeasance recognizes the causal relationship between the affirmative act of imposing a grueling work schedule and the hazard of driving an automobile in an exhausted state. "The *Robertson* court seemed to suggest that the duty arose sometime during the excessive work period, while the *Faverty* court seemed to suggest that the duty arose as early as the point of scheduling." *Id.* at 2109. In synthesizing *Faverty*, Bower suggests that the court should have been more explicit: "The employee's schedule was excessive, he became visibly incapacitated, he asked to go home, and he was released—end of analysis." *Id.* at 2110. Without such precise instruction, applying these principles to the hospital-resident scenario raises similar problems. On the one hand, hospitals have for years administered residency programs that are grueling, in which residents become incapacitated and leave work to drive home after a long shift. *See Marcus & Loughlin, supra* note 10. Therefore, if the case is one of negligent scheduling, the hospital is negligent on a weekly, if not daily, basis. On the other hand, if the scheduling is not excessive on its face, and liability depends on the existence of an employer's affirmative act that creates a foreseeable danger to others, the release of the visibly incapacitated employee constitutes negligence. In that case, employer liability has a stronger case because the employer not only caused the incapacitation but also failed to guard against it. This is in line with the theory of misfeasance.

C. Otis Engineering Corp. v. Clark

In *Otis Engineering Corp. v. Clark*, an appellate court in Texas adopted the *Robertson* reasoning and held that an employer has a duty to prevent employees under its control from causing a foreseeable risk of harm to others.¹⁰⁶ In *Otis*, an employee with a history of drinking on the job was visibly intoxicated at work.¹⁰⁷ After he returned from his dinner break, his supervisor suggested that he go home and escorted him to his car.¹⁰⁸ The supervisor asked if he could make it home and the employee replied that he could.¹⁰⁹ Thirty minutes later, the employee caused an accident that killed two women.¹¹⁰ The employee's blood alcohol level was so high that an expert opined that "100% of persons with that much alcohol in their systems exhibit signs of intoxication observable to the average person."¹¹¹ The supervisors were aware of his intoxication and that he was in no condition to drive.¹¹² Furthermore, the employer maintained a nurses' station for ill or disabled employees.¹¹³ Nonetheless, the supervisor chose to send the employee out on the highway.¹¹⁴

¹⁰⁶ 668 S.W.2d 307, 311 (Tex. App. 1983).

¹⁰⁷ *Otis Engineering Corp. v. Clark*, 668 S.W.2d 307, 308 (Tex. App. 1983).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.* Larry and Clifford Clark brought a wrongful death action against the Otis Engineering Corporation after the Clarks' wives were killed in the automobile accident involving one of Otis' employees. *Id.*

¹¹¹ *Id.* at 308.

¹¹² *Id.*

¹¹³ *Otis Engineering Corp. v. Clark*, 668 S.W.2d 307, 308-09 (Tex. App. 1983).

¹¹⁴ *Id.* at 308. Clark contended that the affirmative act of the employer of sending home an employee known to be intoxicated imposed a duty on the employer to act in a nonnegligent manner. *Id.* at 309. Not only were there alternatives, but the affirmative act also subjected other motorists to the dangers of an accident on the highway. *Id.* at 311. The court noted the availability of an on-site nurses' station, and the options of calling a taxi or the police, and contacting the family for transportation. *Id.* Otis asserted that an

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Echoing *Robertson*, the court recognized that an employer is ordinarily liable only for the off-duty torts of employees committed either on the employer's premises or with the employer's chattels.¹¹⁵ The court opined, however, that all persons have a general duty not to engage in any affirmative act that may worsen a situation.¹¹⁶ "[P]ersuaded by the logic" of *Robertson* and other decisions that focus the duty inquiry on foreseeability,¹¹⁷ the court articulated a standard of duty:

[w]hen, because of an employee's incapacity, an employer exercises control over the employee, the employer has a duty to take such action as a reasonably prudent employer under the same or similar circumstances would take to prevent the employee from causing an unreasonable risk of harm to others.¹¹⁸

Accordingly, the court remanded for the jury to decide whether Otis acted as a reasonable and prudent employer in light of the surrounding facts and circumstances.¹¹⁹

A vigorous dissent in *Otis* expressed concern that placing a duty on the employer for injuries involving off-duty employees reaches too far.¹²⁰ Noting the affirmative conduct of the employer in *Robertson*, the dissenting judge found no such affirmative act on the part of Otis and viewed the issue as a matter of

employer owes no duty to Clark and motorists in general. *Id.* at 309.

¹¹⁵ *Id.* at 311.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 311.

¹¹⁹ *Otis Engineering Corp. v. Clark*, 668 S.W.2d 307, 311 (Tex. App. 1983). After the employer initially won on summary judgment, the court of appeals reversed and remanded. *Id.* at 307. The employer took an appeal to the Texas Supreme Court. *Id.* The supreme court affirmed the holding of the court of appeals, which recognized the availability of alternative measures at the employer's discretion, including a nurse station or a possible phone call to the employee's wife. *Id.* The court also noted the obviously foreseeable consequences of sending its visibly intoxicated employee on the road to drive home. *Id.*

¹²⁰ *Id.* (McGee, J., dissenting) (stating that "the majority has placed an impractical and unreasonable duty upon all employers").

nonfeasance because the employer failed to prevent the employee from driving home.¹²¹ Hence, the dissent forewarned “[i]f this rationale is followed, any omission will be regarded as an affirmative act,” thus opening the door to infinite liability.¹²² This “slippery slope” argument foresees an overly expansive scheme of liability and erosion of individual responsibility for one’s actions.¹²³

While the dissent presented valid concerns, the argument hinged on the fact that in *Otis* the employee, as opposed to the employer, created the perilous situation.¹²⁴ In other words, the employee became intoxicated independent of any actions by the employer.¹²⁵ Therefore, according to the dissent, liability should not be placed on an employer when they played no part in contributing to the employee’s debilitating condition.¹²⁶ This reasoning is obviously inapplicable, however, when the employer is the cause of the condition.

D. The Workers’ Compensation Parallel

Workers’ compensation cases also provide helpful analysis of the question of third-party liability.¹²⁷ The issue for workers’

¹²¹ *Id.* at 315. In *Robertson*, the employee’s exhaustion was caused by the affirmative act of the employer in requiring the employee to work a grueling number of hours; here, such an affirmative act was not present. *Id.* Since the employer in *Otis* played no role in generating the employee’s incapacity, that is, drunkenness, *Robertson* was distinguishable. *Id.* “It is an unfair type of circuitous reasoning to say that [the employer] engaged in an ‘affirmative act’ when it ‘affirmatively’ failed to fire [the employee], or restrain him,” after becoming aware of his intoxication. *Id.*

¹²² *Id.* The dissent concluded that, “[i]n an attempt to do justice in this one case, the majority has placed an impractical and unreasonable duty upon all employers.” *Id.* at 318.

¹²³ *Id.* at 319.

¹²⁴ *Otis Engineering Corp. v. Clark*, 668 S.W.2d 307, 308 (Tex. App. 1983).

¹²⁵ *Id.*

¹²⁶ *Id.* at 312.

¹²⁷ For example, in *Van Devander v. Heller Electric Co.*, the Circuit

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Court of the District of Columbia rejected the employer's argument that a compensation award should not be extended to injuries sustained while the employee was proceeding to or from work. 405 F.2d 1108, 1110 (D.C. Cir. 1968). The "Coming and Going" rule excludes injuries suffered during the commute to and from work from workers' compensation because that activity is considered outside the scope of employment. *Id.* However, the rule addresses only ordinary and routine hazards that are incident to travel. *Id.* The court distinguished the "Coming and Going" rule from "unusual hazards arising out of foreseeable and abnormal consequences of requiring an employee to remain at work for 26 hours." *Id.* In essence, because falling asleep at the wheel was a direct result of working long hours, the accidental injury arose out of and in the course of employment. *Id.* Therefore, the court found a causal nexus between the employer's excessive demands of employment and the employee's injury that resulted from employment-induced exhaustion. *Id.* Accordingly, the employee was compensated because his "fatigue was a consequence of 26 hours of uninterrupted employment without rest and this was the proximate cause of his falling asleep while driving home." *Id.* Since *Van Devander*, formal exceptions to the rule have evolved. Specifically, the Supreme Court of Missouri held that the "special hazard" exception provides for recovery for injuries outside the scope of employment, if "there is a peculiar or abnormal exposure to a peril, whose risk is incident to or inseparable from the scene of employment." *Snowbarger v. Tri-County Electrical Cooperative*, 793 S.W.2d 348 (Mo. 1990). In *Snowbarger*, the employee worked eighty-six out of the 100.5 hours preceding the accident, which the court found constituted exposure to an abnormal peril. *Id.* at 350. Because the employee fell asleep at the wheel on the way home from work, the court found that his physical exhaustion was attributable to the employer's working conditions. *Id.* The court stated that *Snowbarger* "encountered an abnormal exposure to an employment related peril because he worked eighty-six out of the 100.5 hours preceding his fatal accident; his physical exhaustion engendered an unusual risk of an automobile accident . . . [t]he condition was incident to his employment." *Id.* Therefore, the fact "that the accident happened after he had driven approximately twenty-two miles . . . [did] not change its cause: the unusually long overtime hours he had worked." *Id.* Finally, *Deland v. Hutchings Psychiatric Ctr.* affirmed the decision of the New York State Workers' Compensation Board that falling asleep at the wheel was connected to the extreme demands of employment. 203 A.D.2d 776 (N.Y. App. Div. 1994). The employee had worked twenty-eight out of forty hours. *Id.* at 777. The court found that driving home after such an exhausting schedule was a reasonably anticipated hazard. *Id.* It further found that the long hours created the exhaustion which caused the accident. *Id.* Therefore, the *Deland* court reasoned that the excessive number of hours worked in less than

compensation law is whether an injury arises out of and in the course of employment.¹²⁸ An employee's commute is generally considered outside the scope of employment since the "hazards [employees] encounter in such journeys are not incident to the employer's business."¹²⁹ However, the exception to the rule is premised on recognizing the causal link between hazardous or dangerous employment conditions and an automobile accident that occurs during the trip home from work.¹³⁰ As such, courts have found that an employee's car accident on the way home from work is directly caused by employment fatigue and sufficiently connected to employment to permit recovery.¹³¹ The exception requires a finding that the employment conditions were such that the risk of an accident of this kind was foreseeable.¹³² If so, an injury occurring outside of or away from work is brought back under the umbrella of workers' compensation coverage because the risk of such injury never left the workplace.¹³³

When assessing the validity of a claim against a hospital by a third-party injured by an exhausted employee leaving work, the narrow "special hazard" exception of workers' compensation law provides an analogous causal nexus between a hospitalemployer that overworks residents to the point of extreme fatigue and an accident caused by a resident who fell asleep at the wheel. This doctrine, customized for injuries sustained on a commute for the purpose of workers' compensation coverage, provides a

a two day period caused the accident. *Id.*

¹²⁸ See *Van Devander*, 405 F.2d at 1110; *Snowbarger*, 793 S.W.2d at 349; *Deland*, 203 A.D.2d at 777.

¹²⁹ *Van Devander*, 405 F.2d at 1110.

¹³⁰ *Id.*

¹³¹ See, e.g., *Van Devander*, 405 F.2d at 1110; *Snowbarger*, 793 S.W.2d at 350; *Deland*, 203 A.D.2d at 778.

¹³² See generally *supra* note 129 (setting forth case law illustrating this exception).

¹³³ *Snowbarger v. Tri-County Electrical Cooperative*, 793 S.W.2d 348, 350 (Mo. 1990) (stating that "[a] condition may also exist where there is a peculiar or abnormal exposure to a peril, whose risk is incident to or inseparable from the scene of employment . . . [the employee's] physical exhaustion engendered an unusual risk of an automobile accident").

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theoretical basis of causation when exhausted residents cause accidents after leaving work.

E. Putting it All Together

Case law indicates that a tiered analysis of duty and causation, issues that seem to inevitably merge with one another in intensely fact-driven cases, determines a finding of negligence.¹³⁴ Nonetheless, foreseeability of harm, or at least foreseeability of a risk of harm, is a standard principle that both issues share.¹³⁵ “Duty is measured by the scope of the risk which negligent conduct foreseeably entails.”¹³⁶ On the other hand, these cases all involved egregious circumstances, not the least of which was an affirmative act on the part of the employer that played a direct causal role in the harm suffered.¹³⁷ The *Otis* dissent instructively argued that because the employer did not commit an affirmative act, it should not be held responsible for harm that resulted.¹³⁸ By relying on this distinguishable fact, however, the dissent actually left itself open to placing liability

¹³⁴ See *supra* Part III.A-D (discussing third-party liability).

¹³⁵ *Id.*

¹³⁶ F. HARPER & F. JAMES, *THE LAW OF TORTS* § 18.2 (1956).

¹³⁷ See *generally supra* Part III.A-D (setting forth case law examining third-party liability). Consider also that Texas courts have not extended the *Otis* holding to find employer liability. See *Nat'l Convenience Stores Inc. v. Matherne*, 987 S.W.2d 145, 151 (Tex. App. 1999) (finding that without “evidence of actual or constructive knowledge [that the employee] was incapacitated by fatigue . . . [the employer] could not have breached any duty to prevent [the employee] from driving”); *Moore v. Times Herald Printing Co.*, 762 S.W.2d 933, 935 (Tex. App. 1998) (finding no evidence that the employer had knowledge of the employee’s incapacity and did not act affirmatively sufficient to control the employee’s actions); *J & C Drilling Co. v. Salaiz*, 866 S.W.2d 632, 639 (Tex. App. 1993) (concluding that the employer did not take any affirmative action to place the employee on the road in a fatigued state; in fact, the employer provided a trailer for rest at the work site).

¹³⁸ *Otis Engineering v. Clark*, 668 S.W.2d 307, 318 (Tex. App. 1983) (McGee, J., dissenting) (noting that the employer did not intoxicate the employee).

on a hospital that *does* create the dangerous situation—namely, working a resident to the point of exhaustion.¹³⁹ The *Otis* dissent's reasoning leads to the conclusion that, when an employer creates fatigue which causes an accident, liability should or could be imposed.¹⁴⁰

IV. ANALYSIS AND APPLICABILITY OF CASE LAW TO MEDICAL RESIDENTS

An affirmative act of requiring an employee to work an excessive number of hours may open the door to employer liability.¹⁴¹ To establish a *prima facie* case of negligence, the defendant must have breached a duty owed to the plaintiff.¹⁴² Although no hospital has been found liable for injuries sustained by a motorist involved in an accident with a fatigued resident who fell asleep at the wheel, the aforementioned case law provides encouraging signs that a claim could succeed in the context of medical residency programs.

A. A Hospital's Duty to Schedule Residents with Reasonable Care

A common thread in cases discussing an employer's liability to third parties is that if a risk or hazard arising out of employment is reasonably foreseeable, a duty is triggered on the part of the employer to prevent such a risk.¹⁴³ As a general

¹³⁹ *Id.* at 318.

¹⁴⁰ *Id.*

¹⁴¹ *See supra* Part III (setting forth cases involving employer liability for third parties).

¹⁴² *See, e.g.,* Robertson v. LeMaster, 301 S.E.2d 563, 566 (W. Va. 1983). The court stated, “[i]n order to establish a *prima facie* case of negligence . . . it must be shown that the defendant has been guilty of some act or omission in violation of a duty owed to the plaintiff. No action for negligence will lie without a duty broken.” *Id.* (citing Parsley v. General Motors Acceptance Corp., 280 S.E.2d 703 (W. Va. 1981)).

¹⁴³ *See, e.g.,* Robertson, 301 S.E.2d at 568. The Robertson court was

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proposition, if an employer affirmatively requires its employee to work to the point of excessive fatigue, it becomes reasonably foreseeable that the employee may fall asleep at the wheel after work and cause an accident.¹⁴⁴ Similarly, a hospital arguably creates a duty to act with reasonable care when scheduling residents beyond set limits because of the foreseeability that an exhausted resident will cause an accident driving home from work.¹⁴⁵

Literature and studies by the medical community highlighting the inherently dangerous nature of resident physician training and employment methods as they pertain to operating an automobile also put the hospitals on notice of this problem.¹⁴⁶ This information, if not produced by doctors and researchers actually working at or with the hospital,¹⁴⁷ is at least available to employer-hospitals. Hospitals regularly schedule residents for an excessive number of hours, despite medical evidence that

confronted with the question of whether the existence of a duty is the product of foreseeability. *Id.* After examining the evidence, the court determined that “the [employer] could have reasonably foreseen that its exhausted employee . . . would pose an immediate risk of harm to other motorists.” *Id.* See also *Faverty v. McDonald’s*, 892 P.2d 703, 708 (Or. Ct. App. 1995). (stating that a defendant is “subject to the general duty to avoid conduct that unreasonably creates a foreseeable risk of harm to a plaintiff”).

¹⁴⁴ See *supra* Part III (discussing analogous case law).

¹⁴⁵ See, e.g., Gear et al., *supra* note 2, at 2 (questioning anesthesiology residents and finding a greater accident rate amongst residents than the national average); Lyznicki et al., *supra* note 10 (assessing driver sleepiness and highway crashes and reviewing recent recommendations to limit hours-of-service regulations for commercial motor vehicle drivers); Marcus & Laughlin, *supra* note 10 at 766 (concluding that “an increased incidence of falling asleep at the wheel when driving home [after an on-call shift] probably result[s] in increased traffic citations and motor vehicle accidents”).

¹⁴⁶ See Gear et al., *supra* note 2; Lyznicki et al., *supra* note 10; Marcus & Laughlin, *supra* note 10.

¹⁴⁷ See Amended Complaint for Plaintiff, *Brewster v. Hong*, No. 98 L 008806 (Ill. Ct. Cl. 2002). The second count of the plaintiff’s complaint points out, “Defendant [Hospital] operated its own Sleep Disorder and Research Center” and generally argues that hospitals should be aware of the problems associated with fatigue and motor vehicle accidents. *Id.*

“residents are 6.7 times more likely to have a motor vehicle accident due to falling asleep at the wheel during their residency than before their residency.”¹⁴⁸ Therefore, these scheduling practices constitute an affirmative act triggering a duty to prevent the risk of motor vehicle accidents.

In light of the hospital’s knowledge of resident fatigue and its detrimental effect on driving a vehicle, in conjunction with ever-expanding medical evidence, it is foreseeable that residents will fall asleep at the wheel and pose a danger to the general public.¹⁴⁹ Not only is it foreseeable because overworked and fatigued employees are at risk of falling asleep at the wheel and causing accidents, but residents are especially prone to accidents as a result of their difficult and irregular schedules that produce irregular sleeping patterns.¹⁵⁰ Since the hospital creates the hazardous condition, they arguably owe a duty to those who are at risk when a resident leaves the hospital after, for instance, a thirty-six hour on-call shift.¹⁵¹

B. Culture of Resistance

There is pressure placed on residents to endure long hours and stick by their patients, even if assigned to them towards the end of a shift, based upon the prevailing notion that long work hours breed good doctors.¹⁵² This culture is, for several reasons,

¹⁴⁸ See Public Citizens Health Research Group et al., *supra* note 2, at 5.

¹⁴⁹ See, e.g., Lyznicki et al., *supra* note 10.

¹⁵⁰ See Veasey et al., *supra* note 13 (recognizing the impact of irregular sleeping patterns experienced by medical residents).

¹⁵¹ Analogous case law is illustrative, see, e.g., *Robertson v. LeMaster*, 301 S.E. 2d 563, 570 (W. Va. 1983); *Faverty v. McDonald’s*, 892 P.2d 703, 710 (Or. Ct. App. 1995).

¹⁵² See Marcus & Loughlin, *supra* note 10, at 766. “Stated reasons include maintaining continuity in patient care, instilling a sense of responsibility in residents, and increasing the learning opportunities for residents.” *Id.* See also Sarah Avery, *Residents May Get Shorter Shift*, NEWS & OBSERVER (Raleigh, N.C.), June 22, 2002, at A1. According to Dr. John Weinerth, Director of Graduate Medical Education at Duke University, “[i]f you are only on for eight hours, is that enough time to follow a patient’s

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resistant to work hour reform for resident physicians.¹⁵³ Residents, akin to the position of an apprentice, are dependent on their supervisors for positive evaluations.¹⁵⁴ Fatigue is perceived

illness through to some sort of conclusion? Some illnesses are quick; some take a long time.” *Id.* This supports the school of thought that properly trained doctors need to get the “hands-on experience of tending to patients through the progression of an illness or injury.” *Id.* See also Sean McLinden, Editorial, *Education, Not Ego, is Behind Medical Residents’ Long Hours*, PITTSBURGH POST-GAZETTE, June 29, 2002, at A10.

Learning, through observation, how a disease progresses is essential to acquiring the skills necessary to accurately detect and manage that disease in unsupervised settings. The [“]index of suspicion,[”] the most valuable tool available to the physician, is most sharply honed through the process of caring for patients.

Id.

¹⁵³ See Sandra G. Boodman, *Waking up to the Problem of Fatigue Among Medical Interns*, L.A. TIMES, Apr. 16, 2001 at S1. Residency work hours and the training in general has not changed since its inception 100 years ago. *Id.* Doctors maintain that the grueling schedules are necessary to train future doctors, citing the need “to subordinate needs for sleep and food to the unpredictable and often consuming demands of patient care.” *Id.* Surgeons insist that long hours are conducive to quality patient care because they “benefit patients by fostering a ‘community of care’ that forges a bond between doctors and patients.” *Id.* One Harvard-trained surgeon stated, “[s]urgeons are built differently. [Becoming impervious to exhaustion is] a part of the selection process in surgery.” *Id.* He was also quoted as dismissing complaints about fatigue as “whining.” *Id.*; see also David Abel, *Bill Eyes Guidelines on Work Hours for Medical Residents*, BOSTON GLOBE, Nov. 10, 2001 at B1. Many hospital administrators and doctors feel that the current scheduling practices of residency training programs are designed to force young doctors to make decisions under pressure. *Id.* Faverty briefly touched on this type of environment that exists in the fast-food setting by rejecting the employer’s assertion that the employee “volunteered” for the overnight clean-up shift. *Faverty v. McDonald’s*, 892 P.2d 703, 710 (Or. Ct. App. 1995). The court found that the employee did not merely volunteer for the shifts, but rather, that the employer affirmatively asked him to work the shifts. *Id.* The court rejected this “spin on the evidence” and recognized that the employer controlled such duties and penalized employees for failing to fulfill them. *Id.*

¹⁵⁴ Boodman, *supra* note 153. “Residents are a captive population afraid to complain—or to admit they are exhausted—because their careers depend on

as a weakness in medicine and residency training programs.¹⁵⁵

An Illinois case involving an allegation of negligence on the part of the hospital for a car accident caused by a fatigued resident provides a good example.¹⁵⁶ According to the complaint, the resident in question remained at the hospital from her thirty-third to thirty-seventh hours solely because she felt she “*had* to stay longer than just [her] usual sign-out time.”¹⁵⁷ Narrowly classifying such actions as voluntary, thus constituting a separate causal source, ignores the prevalent feeling amongst residents that hospitals expect them to remain almost indefinitely at the hospital to care adequately for their patients.¹⁵⁸ While the hospital in the Illinois case will likely argue that the resident voluntarily remained at the hospital, the unreasonably high expectations hospitals place on residents commonly create fatigue-related motor vehicle crashes.¹⁵⁹ Still, a court may disagree with

the goodwill of their supervisors, particularly their residency directors.” *Id.* A resident’s future hinges on the recommendation received from his or her senior physician. *Id.*

¹⁵⁵ *Id.* See also Marc Siegel, Editorial, *Commentary Training Rxzzzzz Medical Residents Need Good Supervision, Not More Sleep*, L.A. TIMES, July 1, 2002, at B11. According to Mr. Siegel, Assistant Professor of Medicine at New York University:

[t]he age-old caste system for residency training is based on role modeling and continuity of patient care, where fledgling interns learn responsibility by doing rounds with their supervising residents and following through with their patients. It is incorrect to assume that sleep deprivation alone is what can lead to untoward patient outcomes. The greater risk lies with poorly motivated residents who lack adequate guidance.

Id.

¹⁵⁶ See Brewster, *supra* note 147.

¹⁵⁷ *Id.* (emphasis added).

¹⁵⁸ See, e.g., Boodman, *supra* note 153. See also Carl T. Hall, *Doctors See Loopholes in the Limits on Workweek*, S. F. CHRON., June 16, 2002, at A4 (quoting a third-year resident at San Francisco General as saying, “[y]ou don’t talk about it[.] If you complain, you would be perceived as not being tough enough, or of being lazy, or not motivated to learn and do more and be enthusiastic. It would be seen as having a bad attitude.”).

¹⁵⁹ See *supra* Part I (discussing fatigue and residency training programs).

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Faverty's acknowledgment that employees feel pressure from management to complete shifts.¹⁶⁰ Moreover, expectations felt by residents may be difficult to document and prove in court.

On the other hand, residents are also aware of their fatigued conditions. Indeed, the individual resident likely knows better than any supervisor just how tired she feels and has the option of resting at the hospital or calling a taxi service or family member for transportation.¹⁶¹ Nonetheless, an independent decision to drive home, if it is to be classified as such, does not change the fact that hospitals schedule grueling hours.¹⁶² While a fatigued resident is at least partly responsible for his or her decision to drive, the hospital, as an employer, is responsible for placing the resident in a position to make such a decision, let alone exercise good judgment in a sleep-deprived condition.¹⁶³ In the future, in recognition of these circumstances, courts may be willing to view the hospital and resident as joint tortfeasors and assign responsibility to both parties.

¹⁶⁰ *Faverty v. McDonald's*, 892 P.2d 703, 710 (Or. App. 1995) (stating that the employee "did not, out of the blue volunteer to take three shifts . . . [d]efendant affirmatively asked him to work those hours").

¹⁶¹ As a practical matter, whether a resident will arrange for transportation every time he or she feels nervous about fatigue is debatable. It is certainly possible that residents will ignore their exhausted bodies and drive home simply because they have been in the hospital for thirty-six hours and understandably want to get home.

¹⁶² See, e.g., *Public Citizens Health Research Group et al.*, *supra* note 2; see also *Brewster*, *supra* note 147. Still, an employer would seemingly have to know more than that the general nature of residency training is exhausting. Rather, a plaintiff would need to show that the employer knew of a specific employee's fatigue when they left work. While an industry awareness of fatigue supports the conclusion that change, perhaps through legislation, is necessary to alleviate the problem, imposing liability on employers for employees who are fatigued in general likely pushes the concept of third-party liability past its breaking point.

¹⁶³ *Robertson v. LeMaster*, 301 S.E. 2d 563, 570 (W. Va. 1983) (holding that if the intervening cause, here, the fatigued resident, "is one to be reasonably anticipated, the defendant may be liable, for '[t]he risk created by the defendant may include the intervention of the foreseeable negligence of others' (quoting W. PROSSER, *THE LAW OF TORTS* (4th ed.) (1971)).

C. Third-Party Liability and Residency Training Programs

Imposing third-party liability upon hospital employers would produce some favorable results, but also has dangerous implications. On the one hand, tort liability can deter harmful conduct—here, the excessive scheduling of resident physicians that causes fatigue. On the other hand, imposing broad liability on health care institutions can upset their ability to provide vital services.

1. Arguments in Favor of Imposing Tort Liability on Hospitals

Tort liability is appropriate if it positively addresses and deters harmful conduct.¹⁶⁴ In the medical residency context, the pertinent issue is whether finding a hospital liable to a motorist struck by a resident during the trip home from work can solve the fatigue-related problems of residency training.

The fundamental philosophical premise of compensation supports such liability.¹⁶⁵ If hospitals are immune from liability, innocent motorists struck by fatigued residents are left to absorb the cost of their injuries. Given the cost of medical education, residents are an unlikely source for large damage awards.¹⁶⁶

¹⁶⁴ See, e.g., Jennifer H. Arlen, *Compensation Systems and Efficient Deterrence*, 52 MD. L. REV. 1093, 1096 (1993) (asserting that, in a strict liability context, “[p]otential injurers forced to pay the full social costs of the risks that they create face efficient incentives to reduce risk by caretaking and decreasing activity frequency to the efficient levels”).

¹⁶⁵ Indeed, the *Robertson* court briefly discussed the history and aims of tort law before assessing the facts at hand. *Robertson*, 301 S.E.2d at 610. Desiring to promote the principle that victims of tortious conduct should be compensated for their losses, *Robertson* recognized that contemporary courts have abandoned the pro-defendant bias of the industrial revolution and furthered “the modern trend to expand the concept of duty in tort cases.” *Id.*

¹⁶⁶ For example, the average pay for residents at the University of New Mexico Hospital is \$35,000 to \$36,000. See Jackie Jadrnak, *Around the Clock Work*, ALBUQUERQUE J., Sept. 22, 2002, at A1. In another example illustrating the financial condition of residents during their training period, a heart surgeon explained that after ten years of training, he accumulated

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Imposing liability on hospitals would compensate victims for the harm suffered.

Furthermore, policy considerations suggest that imposing liability on hospitals for the tortious acts of residents during their commute is a wise choice. The basic formula in deciding whether any act is negligent was initially laid down by Judge Learned Hand in *United States v. Carroll Towing Co.*¹⁶⁷ Articulating what is essentially an equation of cost effectiveness, reflecting the overall goal of American tort law, Hand stated that if the burden of precaution in guarding against the risk of injury outweighs the probability of harm together with the severity of the injury, it simply is not negligent to allow the possibility of injury to occur.¹⁶⁸ Here, the likelihood of injury is high, as documented by medical studies.¹⁶⁹ The gravity of harm resulting from all automobile accidents is obviously severe. Therefore, the question is whether it is more cost effective for hospitals to allow these inevitable accidents, or whether the tort regime should impose liability on hospitals to deter them from their current employment and resident training methods. Since a substantial portion of these accidents are preventable and result in serious injury and loss of

\$300,000 of debt resulting in \$3,000 per month loan payments. See Liz Kowalczyk, *Heart Surgeons Suffer Long Hours, Less Pay*, BOSTON GLOBE, June 30, 2002, at A1.

¹⁶⁷ 159 F.2d 169 (2d. Cir. 1947). A docked barge in New York harbor broke away from its pier at a time when the employee responsible for the vessel was inexcusably absent. *Id.* at 173-74. The barge set off a chain reaction of damage to other vessels and property in the harbor, thus implicating a potentially wide range of liability for the owner of the barge. *Id.* at 170-71. The court formulated the cost-benefit analysis to account for the unpredictable and inevitable nature of accidents, such as the “occasions when every vessel will break from moorings.” *Id.* at 173.

¹⁶⁸ *Id.*

¹⁶⁹ See, e.g., Gear et al., *supra* note 2 (finding that anesthesiology residents experience automobile accidents at a rate twice the national average); Marcus & Loughlin, *supra* note 10 (finding that “residents frequently fall asleep at the wheel when driving post-call”); Veasey et al., *supra* note 13 (stating that “the greatest documented danger of sleep loss for medical residents is the risk of motor vehicle crashes”).

life, the burden of precaution for the hospitals—adjusting their scheduling for resident physician—is a worthy change. On the other hand, the cost of such an adjustment, not to mention an unpredictable third-party liability damage award, must also be considered.¹⁷⁰

2. Arguments Against Imposing Tort Liability on Hospitals

Imposing third-party liability on employers in general, and hospitals in particular, also has negative implications.¹⁷¹ First, there is the risk of expanding liability to employers in general to an undesirable degree. Second, there is a risk of reduced quality of care due to hospitals' attempts to avoid liability. Finally, hospitals subject to unpredictable tort judgments could disrupt necessary community services.

The potential for unlimited liability represents a glaring concern for imposing liability on the employer for injuries occurring outside the place of employment.¹⁷² Under those circumstances, the world becomes an employer's plaintiff once the nature or demands of a job become laborious to the degree of

¹⁷⁰ See *supra* notes 42-43 (setting forth the financial implications hospitals face when adjusting to work hour limits).

¹⁷¹ Hospitals, unlike the general employer population, provide a vital service to their communities. As such, health care institutions regularly receive different treatment in the eyes of the law. For example, Congress amended the National Labor Relations Act with Health Care Amendments in 1974, implementing additional safeguards to prevent strikes and picketing that could disturb patient care services. 28 U.S.C. § 158 (2003). The amendments mandate that a labor organization shall provide a health care institution not less than a ten day notice before engaging in any strike, and any employee who engages in a strike within the notice period shall lose his status as an employee. *Id.*

¹⁷² See, e.g., *Harrington v. Brooks Drugs, Inc.*, 808 A.2d 532 (N.H. 2002). Arising out of the workers' compensation context, the court rejected plaintiff's argument that the commute after an overnight shift posed as a hazard, thus constituting an exception to the "going and coming" rule. *Id.* at 536. The court was unprepared to "impose upon employers of overnight or late shift employees liability greater than that borne by employers whose employees work a more traditional nine-to-five schedule." *Id.*

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posing a foreseeable risk of harm to others. Establishing an appropriate point at which to draw such a line is difficult, if for no other reason than that labor, whether repairing a derailed train or providing patient care services, is exhausting or at least taxing.¹⁷³ Even in light of increasing volumes of medical and scientific data pointing to exhausted resident physicians, it is a precarious proposition to impose third-party liability on an employer in any context, especially where the tortious act occurs after and outside of employment.¹⁷⁴

In the health care context, third-party liability could lead to a reduction in health care services. Hospitals provide a necessary, vital service to the public at large, including emergency care.¹⁷⁵ Imposing third-party liability could cause a reduction in quality of care by forcing a hospital to choose between providing comprehensive patient care services around the clock and sending residents home to ensure reasonable working hours.¹⁷⁶

Public regulation seemingly strikes the best balance between the needs of a hospital with those of the residents. Tying funding to compliance, as in the proposed federal regulation, can more effectively deter hospitals from inappropriate scheduling than the penalty-driven New York regulations.¹⁷⁷ Moreover, expensive

¹⁷³ See AMERICAN HERITAGE DICTIONARY 1004 (3d ed. 1992) (defining labor as “physical or mental exertion, especially when difficult or exhausting; work”).

¹⁷⁴ Even the aforementioned cases that did approve of third-party liability support this notion by virtue of their strict holdings and need for egregious circumstances that give rise to employer knowledge of incapacity and affirmative action. See *supra* Part III (examining analogous case law permitting third-party liability).

¹⁷⁵ Recognizing the emergency nature of hospital services and their necessity to the community, the PPSPA provides that the work hour limitations and requirements of the Act “shall not apply to a hospital during a state of emergency.” H.R. 3236, *supra* note 4, at § 3 (j)(1)(C).

¹⁷⁶ Even if a tort claim could successfully change residency programs to the extent that they reduce work hours, less work hours for residents presents financial challenges for the hospital as well. See *supra* notes 42-43 (discussing the economic impact of limited work hours).

¹⁷⁷ See *supra* Part II (examining the New York regulations and proposed

lawsuits against hospitals could lead to increased medical costs, shrunken patient care services or even bankruptcy of a health care institution.¹⁷⁸

CONCLUSION

The training of resident physicians in the United States creates serious problems for patient care and the health of residents. Public regulation, though limited in some respects, demonstrates society's desire to tackle this acknowledged problem. Enforcement is a critical component for any type of regulation. In this light, the PPSPA will likely operate more effectively than the penalty driven Bell Regulations because its enforcement mechanisms, conditioning federal funding and providing financial incentives to conform, and provision of additional payments from the federal government have more teeth than the Bell Regulations.

In the alternative, the deterrent affect of tort law is a more powerful method to affect change, at the cost of potential financial burdens. That potential is compounded in light of the unpredictable nature of tort liability on hospitals and employers generally. Furthermore, case law illustrates the difficulty in deciding what constitutes unreasonable scheduling or work hours, an issue the Bell Regulations and PPSPA settle by implementing work hour limits.¹⁷⁹

Therefore, the PPSPA is a viable method to reduce work hours for residency training because such a change will save human life and promote medical and economic efficiency in the form of healthy, proficient doctors. If it cannot, an unfortunate motorist-turned-plaintiff may someday change the way medical residents are trained.

federal legislation).

¹⁷⁸ Even public regulation presents serious financial concerns for the health care industry. *See supra*, note 43-44 (setting forth examples of hospitals adjusting to work hour limits).

¹⁷⁹ *See generally* H.R. 3236, *supra* note 4.