Learning Lessons
The Libby Zion Case Revisited

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Resident duty hours have been a point of debate for many years, because fatigue was thought to be the culprit for medical errors. The Libby Zion case precipitated the movement to restrict and limit work hours for residents. It’s important to ask whether this is truly the only conclusion that should be drawn from the case.

Libby Zion was an 18-year-old college student admitted by a New York City hospital in 1984 with a fever and an earache. Six hours after admission she was dead. The care Libby received included restraints and a narcotic (1). This treatment was administered primarily by an emergency room resident and an intern; an attending physician did not see Libby. Libby’s father, New York Times journalist Sidney Zion, requested an investigation into his daughter’s death, and a grand jury investigation was convened.

The grand jury brought no criminal charges, but instead indicted a medical education system that allowed overtired, unsupervised residents and interns to treat a seriously ill patient with only sedatives and restraints. Among the grand jury’s recommendations were these:

- Hospitals should staff emergency departments with physicians who have at least 3 years of training and who are specifically qualified to evaluate patients on an emergent basis.
- Junior residents and interns should be supervised by attending physicians at all times.
- The New York Department of Health should promulgate regulations limiting the number of hours worked by interns and residents in teaching hospitals (1).

In response to the grand jury recommendations, the New York State Health Department appointed an ad hoc advising committee—the Bell Commission—to make specific proposals to implement the grand jury’s recommendations. The committee received testimony from representatives of several of the most influential organizations responsible for graduate medical education, including the American College of Physicians and American Medical Association (2).

The majority of witnesses who testified before the Bell Commission opposed the imposition of any quantitative restriction on resident hours and professed several reasons for leaving the existing on-call schedule intact. First, decision-making and execution of complex technical tasks under the duress of extreme fatigue are the “sine qua non” of medical practice. As F. Davidoff, MD, from the American College of Physicians testified, “It would be unrealistic to expect residents to absorb the realities of caring for their equally fragile and needy patients if their working hours were fixed according to an arbitrary schedule, however well intended” (3). Second, continuity of care requires that the same resident who admits or operates on a patient should follow the patient through his or her illness, meaning the resident must not relinquish the case to another physician even after 24 h. According to the testimony of J. Albers, MD, of the American Medical Association: “The care of my patients is enhanced when the physician who initially evaluated them after admission to the hospital cares for them for an extended period of time” (4). Third, the cost of hiring additional nurses, laboratory personnel, and transport personnel would be prohibitive (5).

The Bell Commission issued its recommendations, including the following proposal: “Individual residents who have direct patient care responsibilities in areas other than the ED shall have a scheduled work week which will not exceed an average of 80 h per week over a 4-week period, and should not be scheduled to work as a matter of course more than 24
consecutive hours with one 24-h period of non-working time per week” (2).

In 1989, the New York State Health Department incorporated these regulations into its hospital code. The revised regulations recommended that: 1) residents’ work hours must not exceed 80 h/week; 2) residents may not work more than 24 consecutive hours; 3) there may be exceptions to the 24-h shift rule if patient care would be compromised; 4) scheduled rotations must be separated by 8 h off; and 5) residents must be given 1 day off per week (6).

In 1987, the Accreditation Council on Graduate Medical Education (ACGME) appointed a task force on resident hours and supervision to review current educational conditions regarding resident supervision and resident work hours. The imposition of such specific work rules had never before been a part of ACGME’s role. They issued directives to the individual resident review committees, suggesting that the following policies would help to achieve an appropriate educational environment:

- Residents should be allowed to spend, on average, at least 1 full day out of 7 out of the hospital.
- Residents, on average, should be assigned on-call duty in the hospital with no more frequency than every third night.
- There should be adequate backup if sudden, unexpected patient care causes resident fatigue that may jeopardize patient care during or following on-call periods (7).

Review of these recommendations implies that the ACGME task force wanted to allow individual programs significant freedom to determine how they would implement the proposed recommendations. The ACGME, therefore, charged each of the residency review committees to outline specific standards for each specialty, presumably using the limitations. The ultimate impact of the efforts to reduce resident hours nationally remains uncertain. At present, no clear-cut standards exist for the regulation of resident hours. Within an individual residency program, call schedules still vary among various hospital rotations.

As a result, a key question to be addressed for trainees is the potential for expanded liability for the conduct of fatigued residents. Both the discrepancy in standards across the states and among specialties, as well as the possible delay in enforcement or implementation of applicable proposals, may leave resident-physicians exposed to liability. Negligence is the failure to possess and exercise the requisite degree of skill and knowledge in caring for a patient (8). The standard against which the physician’s performance is measured is established by expert testimony on the accepted principles of diagnosis, management, or therapy for a given medical condition. Let us limit the discussion to negligence in terms of resident-physician liability. Assuming a hospital has instituted measures to limit resident hours, can the liability be shifted to the resident if he or she knowingly violates the work duration limit, thereby, absolving the hospital of liability? First, ACGME’s policy to limit resident hours and enforce the policy would be thwarted if the liability were shifted to the resident. Second, the legal doctrine of respondent superior establishes that employers are responsible for the negligent acts of their employees (9). However, the resident might be found negligent for continuing to function in a sleep-deprived state. Such malpractice claims may continue to follow residents through their attempts to become board certified and obtain licensure. The sobering prospect of bearing liability for mistakes they make when they have exceeded the work time limits should deter residents from ignoring such rules. The personal and professional degradation experienced during malpractice litigation should be another deterrent, even if there is no personal financial responsibility.

The Libby Zion case led to a national crusade to reform the workload of young doctors. Although the exact facts can be difficult to discern long after the event, reports suggest that Libby had a history of depression and cocaine use and that she was admitted to the New York hospital with fever, chills, and agitation (10). Her condition remained undiagnosed, but 2 young doctors gave her a painkiller, sedative, and restraints—a plan that a senior clinician approved over the phone.

Would a senior physician have been able to put the pieces of the Libby Zion puzzle together? The Libby Zion case focused on residents’ sleep deprivation, but missed the white elephant in the room—young, inexperienced doctors should not be expected to make complex diagnoses. That fact is why they are physicians in training in the first place. Sleep deprivation is 1 issue, but the larger issue is the extent of focused oversight and teaching provided in the development of young physicians.

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8. Harvey v Fridley Medical Center, PA, 315 NW2d (Minn 1982).


**RESPONSE: Understand Your Talents, Accept Your Limitations**

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Dr. Patel’s paper gives us the history of the Libby Zion case, and subsequent activities, eventuating in the current restriction on work hours for physicians-in-training. His recitation of the investigative grand jury findings of that case shows that the hours worked by the physicians-in-training were not the main conclusion. The grand jury’s first recommendations deal with the role of more experienced physicians and their oversight of trainees. It seems the clear need to improve direct trainee supervision by experienced physicians almost immediately became lost in the subsequent discussions of consequences of restricted trainee working hours. The Bell Committee’s Chair wrote an editorial in *The Journal of the American Medical Association* titled “Supervision, Not Regulation of Hours, Is the Key to Improving the Quality of Patient Care” (1). If the educational system for physicians-in-training has not changed much since the 1990s (except for restricted hours), then it must be up to the individual trainee to protect his or her patients by taking the lessons of the original case and the recommendations of the panels that reviewed it.

Critically important to learning as a physician-in-training is identifying those situations in which your experience and competence are not yet up to the task. All physicians have trod that path, and it cannot be seen as a weakness to ask for help in making a diagnosis or doing a procedure. The self-awareness and confidence to ask for help from others should be a trait of every mature physician. Respecting trusted colleagues for asking for such help is a critical feature of a good physician community.

Our most basic ethical mandate is to value the safety and welfare of our patients as our primary obligation. We cannot be ashamed or embarrassed to ask for help, because the patients trust us to keep them safe. That means each physician must gain experience under the tutelage of experts until the teacher is satisfied with the competence of the trainee. “See one, do one, teach one” is a wry, cute saying, but it is anathema to proper patient care. Trainees should not need to shoulder the burden of getting proper supervision. However, if appropriate “constant” supervision by senior physicians is not forthcoming, then the trainee must ask for that teaching and apply himself/herself to become competent in the time needed. Understand your talents and your capabilities, but also accept the limits to your skills. Your patients will benefit from your honesty and introspection.

**REFERENCE**

1. Bell BM. Supervision, not regulation of hours, is the key to improving the quality of patient care. JAMA 1993;269:403-4.