Moonlighting Policy and Practice in Family Practice Residencies

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Moonlighting by residents is a controversial, but little-studied topic. A survey on moonlighting policy and practice was sent to all family practice residency program directors, and an 87 percent response rate obtained. Moonlighting is permitted by 97 percent of nonmilitary programs and is generally thought of by program directors as a positive educational experience. It is practiced by over two thirds of the second- and third-year residents in programs that monitor moonlighting. These residents spend an average of 28 hours each month moonlighting. The most commonly used moonlighting sites are hospital emergency rooms, followed by coverage for private practice physicians. Seventy percent of programs require approval for extracurricular work activity. Only 23 percent of residencies limit moonlighting for all residents, but 47 percent have had occasion to deny moonlighting privileges to individual residents.

Moonlighting is any extramural professional activity. For residents and residency programs, many potential benefits and risks exist. Essentially dormant for a decade, this controversial topic needs open evaluation and policies that reflect current practice and thinking.

An article in *The New Physician* in 1973[1] pointed out that moonlighting was at that time prohibited by many programs, but was engaged in surreptitiously by a large number of residents. In 1974 Dr. Max Michael, then immediate past-president of the Association for Hospital Medical Education, surveyed 350 directors of medical education at community hospitals about moonlighting policy and attitudes. He found that 42 percent of directors at hospitals without medical school affiliations and 57 to 60 percent of directors at hospitals with medical school affiliations favored moonlighting.[2] In that same year, the Association of American Medical Colleges stated that "moonlighting is inconsistent with the educational objectives of house officer training and is a practice to be discouraged."[3]

The following year, in 1975, the American Medical Association supported resident control over moonlighting with a policy stating that house officer time off is personal business and becomes the concern of the residency program only if the resident's performance is compromised.[4]

Recently, Kelly and Sharp[5] compared the clinical experience of a resident seeing patients in the family practice center with his clinical experience while moonlighting in several small emergency rooms and a franchised fee-for-service practice. They found that moonlighting greatly increased the volume of the resident's outpatient experience. In addition, moonlighting provided much more exposure to urgent and emergency patient problems.

Current Association of American Medical Colleges statistics show that about one half of all residencies have moonlighting policies, and two thirds of those with moonlighting policies allow the practice.[6] *The 1984 Directory of Family Practice Residency Programs* reveals that 84 percent of family practice residencies allow moonlighting at other hospitals, while 56 percent allow it at the parent hospital.[7] A recent survey of pediatric residency directors by Moss[8] found that 70 percent of directors allow moonlighting and 48 percent reserve the right to approve moonlighting plans. Over one in seven pediatric residencies had a built-in moonlighting opportunity. The recently completed survey described below provides further information on family practice residency moonlighting policy and practice.

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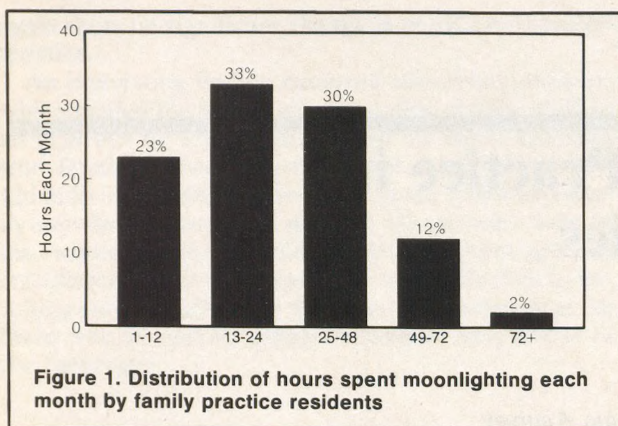

Figure 1. Distribution of hours spent moonlighting each month by family practice residents

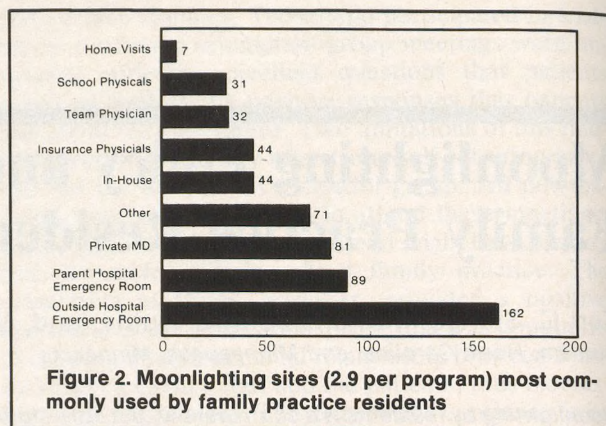

Figure 2. Moonlighting sites (2.9 per program) most commonly used by family practice residents

METHODS

A questionnaire* was sent to all 384 family practice residency program directors. Program directors were asked to respond to 18 questions on their moonlighting policy and attitudes and the moonlighting practice of their residents.

RESULTS

Of the 384 surveys mailed, 334 were returned, for a response rate of 87 percent. Ninety-two percent of responding programs permit moonlighting. When the 17 responding military programs (none of which allow moonlighting) are excluded, 97 percent of nonmilitary family practice residencies permit moonlighting.

Seventy percent of programs require their residents to obtain approval for moonlighting activities, and 61 percent of programs monitor their residents' moonlighting activity. Residents are required to supply their own malpractice insurance for moonlighting in 81 percent of programs.

Only 23 percent of residencies limit the number of hours a resident may moonlight. Among those programs with a limit, the mean number of hours permitted each month is 41. Of those programs with no specified limit on moonlighting time, the vast majority stipulated that educational performance within the residency not be compromised by extracurricular work activity. In fact, 47 percent of programs had had occasion to deny moonlighting privileges to individual residents. Twenty percent of programs restrict moonlighting to certain rotations, and a number of directors parenthetically noted that moonlighting is limited to certain rotations on a practical level, by the small number of free hours on some demanding rotations. Of those residencies that permit moonlighting, it is allowed in all three years by only 9 percent of programs, while 87 percent of programs allow only second- and third-year residents to moonlight. In 23 percent of residencies, there is an integrated moonlighting experience in which residents perform extra work for pay under the auspices of the program.

Of the programs that monitor resident moonlighting, 178 responded with sufficient data to analyze the percentage of residents moonlighting. Only 5 percent of first-year, but 69 percent of second-year, and 78 percent of third-year residents moonlight. A mean of 28 hours each month is spent moonlighting by these residents, with the distribution of hours shown in Figure 1. The most commonly used moonlighting sites are depicted in Figure 2, with "other" including such areas as family planning clinics, weight loss clinics, and urgent care centers.

The majority of program directors (77 percent) feel that moonlighting enhances education, while 6 percent feel that it detracts from education, and 6 percent feel that it has no effect on education. Eleven percent of directors noted that the educational benefit of moonlighting depends on the circumstances and the individual.

Sixty-four percent of residency directors felt that over the past four years the percentage of residents moonlighting has remained the same, and the remainder of directors were equally divided as to whether moonlighting activity has increased or decreased. Fifty percent of directors observed that residents with higher medical school debts moonlight more than residents with lower medical school debts. A number of residency directors noted that other factors (family size, mortgage, etc) were equally important for many residents in determining the amount of moonlighting.

DISCUSSION

Moonlighting is nearly universally permitted by nonmilitary family practice residencies. The high percent-

*Available from the authors upon request.

age of family practice residencies permitting moonlighting may reflect the perception by family practice program directors that moonlighting is a positive educational experience. Kelly and Sharp[5] have given a basis for this feeling: moonlighting does seem to provide additional patient volume and experience in acute care—both of which can be useful adjuncts to the more chronic, continuous care that makes up the majority of patient encounters at the family practice center. In addition, moonlighting can promote in the resident a sense of self-confidence and an increased ability to accept responsibility. The most common moonlighting site (emergency rooms) provides this acute care experience, while the next most popular option (covering for private physicians) may help the resident to choose eventual practice options with a more experienced eye.

Potentially detrimental aspects of moonlighting include scheduling conflicts with residency work, lack of adequate supervision, and fatigue, with compromise of a resident's regular or moonlighting duties. Malpractice coverage must be carefully arranged. Added time away from family and leisure may provide an additional stress for residents, particularly when financial or other incentives encourage excessive moonlighting. That nearly one half of residency programs have found it necessary to deny moonlighting privileges to individual residents points out the existence of these negative effects on some residents.

Medical students are finishing school with increasingly large debts. In 1983 the average debt for the 86 percent of graduating students reporting indebtedness was $23,600. Twenty percent of students had a $30,000 to $50,000 debt, while 5 percent of students owed more than $50,000.[9] There may be an increased incentive to moonlight among residents with higher levels of medical school debt, although only a little more than one half of residency directors have noticed this tendency. Clearly, many factors go into a resident's decision to moonlight, and extra income is a very real incentive. A resident who "needs" to moonlight to pay off a large medical school debt may have difficulty in limiting his moonlighting to accommodate personal and residency program needs.

It is likely that the increasing supply of physicians may decrease moonlighting opportunities in the future. As of now, however, residency directors have noticed no recent change in moonlighting frequency by residents.

A moonlighting experience in which residents may voluntarily work extra hours for extra pay under the auspices of the residency program has been used successfully by a number of programs. Such plans take many forms, from covering the parent hospital emergency room during off hours, to working evening or Saturday clinics at the family practice center, to a loose affiliation with outlying hospitals or community physicians for off-hours coverage. These arrangements can help obviate the supervision and malpractice insurance problems that can occur with other moonlighting sites, and can even provide the residency program with additional income if so arranged.

The data on moonlighting policy presented from the survey of program directors are direct and therefore reasonably reliable. The information on resident moonlighting activity represents the director's indirect observation and is therefore more subject to bias and underreporting of moonlighting activity by residents. A future survey of residents could provide harder data on moonlighting practice and might also address attitudinal factors and the influence of debt and other variables on the decision to moonlight.

The ability to balance the positive and detrimental consequences of moonlighting depends on the individual resident and his circumstances. Organized monitoring of moonlighting activity by the program may help an astute director or resident advisor to allay problems in an early stage; however, the potential for conflict with the resident's right to determine how his free time is spent may be heightened by monitoring. An established limit for moonlighting hours by all residents may be useful, but individualization and a clearly delineated expectation that moonlighting not interfere with residency activity are probably more beneficial. Clearly, judgment and discretion are required of both program directors and residents in choosing the timing, amount, and location of moonlighting activity.

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