Moonlighting by psychiatric residents remains controversial, with debate surrounding the ethical, legal, financial, and educational risks involved in the practice. The authors present a literature review of resident moonlighting, which encompasses the policy positions of various organizations responsible for graduate medical education; surveys of various groups and specialties regarding the prevalence, form, and justification for moonlighting; and models of moonlighting programs in several institutions. The authors conclude with specific proposals for research regarding psychiatric resident moonlighting and, more importantly, emphasize the need for research on the effects of moonlighting on resident performance and education. (Academic Psychiatry 1994; 18:189-196)

Moonlighting—defined as additional work beyond one's regular employment—has a history as long as work itself. The term originally was used to describe persons who, in order to avoid paying rent, exited their residence "by moonlight," and later came to identify other unsavory characters, such as smugglers and prostitutes, whose employment necessitated the cover of darkness (1). By 1900, moonlighting merely meant working an extra job, generally at night, but something of the original dark and secretive nature of the activity has persisted to the present. The practice of moonlighting by physicians has a shorter, but equally controversial history, with proponents and detractors vigorously debating the ethical, legal, financial, and educational risks and benefits involved (2,3).

In resident education, moonlighting by psychiatric house officers is similarly viewed with ambivalence by those responsible for the educational process—training directors, chairpersons, other faculty, hospital administrators, and residents themselves (4,5). This ambivalent attitude toward resident moonlighting has caused training directors to adopt a variety of responses, sometimes encouraging, often ignoring, occasionally banning, or more commonly, lamenting but allowing their residents to moonlight (6).

A review of the literature on house officer moonlighting is surprisingly sparse in

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content: of 37 articles from mostly refereed sources, the majority are editorials. About one-third report survey data regarding some aspect of house officer moonlighting, and only four describe specific programs or practices in this area. The preponderance of editorials may reflect the controversy involved; the paucity of data-based information may be a reflection of the unwillingness of educational systems to examine in-depth a discomfiting but widely practiced activity such as moonlighting. Early editorials are unequivocal in their portrayal of moonlighting by resident physicians as a “practice to be discouraged,” with statements endorsing residency education as “full-time,” and considering “moonlighting as a symptom of a diseased residency, to which a cure must be found” (7). More recent opinions note the prevalence of the practice (8-13) and recommend methods to address the administrative (14-19), financial (20-22), educational (23,24), and legal (25,26) ramifications of house officer moonlighting.

POLICIES

As might be expected, given the potential effects of moonlighting on resident education and hospital function, a number of professional organizations, accreditation agencies, and licensing authorities have taken official policy positions with respect to resident moonlighting. The American Association of Medical Colleges (AAMC) has taken a strong negative stance on moonlighting, consistent with its pro-education position. In 1974, the AAMC Executive Council adopted a resolution stating that moonlighting is “inconsistent with the educational objectives of house officer training” and that institutions that permit moonlighting should take great care to preserve the educational character of their graduate programs (18). Such care should include an approval process via the hospital governing board and attention to the individual, personal, educational, and financial needs of any house officers permitted to moonlight. In 1988, the AAMC Executive Council re-endorsed this position, stating, “Accrediting institutions, medical schools, teaching hospitals, residency program directors, and faculty should work actively to halt moonlighting” (27). This occurred as part of a more comprehensive AAMC position statement about total resident work hours, at least partially in response to the report of the Bell Committee in New York State, which made recommendations for setting maximum resident work hours in the wake of the Libby Zion case (28).

Other organizations have taken somewhat different positions with respect to moonlighting house officers. In 1974, the American Medical Association (AMA) House of Delegates (substitute resolution 53) stated that (29)

The specifics of off-duty hours and extramural activities should be negotiated between house staff and their employers. As a basic human right, house staff may spend this time in any way they see fit, provided primary institutional responsibilities are not compromised. Any disciplinary action related to extramural work must accord due process. The house staff contract or agreement should provide that a member of the house staff is free to use his off-duty hours as he/she sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement. Such activity should not interfere with obligations to the institution or to the effectiveness of the educational program to which he/she has been appointed.

This policy, supported by the AMA-Resident Physician Section, was re-endorsed in 1992, and today represents the AMA’s official policy on moonlighting and residents (30). The AMA has also taken a position on total resident work hours, asking the Accreditation Council for Graduate Medical Education (ACGME), which is responsible for residency accreditation, to require the Residency Review Committee (RRC) in each