

Reducing Resident Work Hours: Unproven Assumptions and Unforeseen Outcomes

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“There must be some way out of here,” said the joker to the thief.

“There is too much confusion, I can’t get no relief.

Businessmen, they drink my wine, plowmen dig my earth,

None of them along the line know what any of it is worth.”

“No reason to get excited,” the thief he kindly spoke,

“There are many here among us who feel that life is but a joke,

But you and I, we’ve been through that, and this is not our fate,

So let us not talk falsely now, the hour is getting late.”

—Bob Dylan

In the 25 years that I have been teaching in New York, graduate medical education has changed a great deal. Clearly, much has improved. However, the recent restrictions in work hours are an ominous development because of their effect on both patient care and the education of our future physicians (Table). Organizations that do not thoroughly understand the nature of graduate medical education are promulgating these restrictions. The forces cannot be dismissed; they include our governing bodies (1), state and federal government (2), and the public (3).

The restriction of work hours was codified in New York with the unfortunate death of a young woman, Libby Zion, the daughter of a well-known journalist. At the time of her death, work hours had already been reduced substantially. My mentors had described living in the hospital with only an occasional weekend off. By the time I began my residency, the call schedule was every third night. These changes, which evolved over the decades, were not mandated by outside agencies.

In the Libby Zion case, both the New York State Department of Health’s analysis and the court transcript from the subsequent malpractice suit did not provide convincing evidence that work hours played a role (4). Her death was related more to a lack of knowledge and a failure of effective supervision. The media, however, found the work hour issue to be a very popular topic. Public outrage about long work hours and their relation to medical mishaps still exists today.

The Bell Commission, created by the New York State Department of Health and the governor to study the case and postgraduate medical education, correctly concluded that increased supervision of residents was needed but incorrectly attributed equal culpability to long work hours (5). The state legislature made their recommendations into

Table. Key Points

The Accreditation Council on Graduate Medical Education has mandated a reduction of resident work hours.
Reduced resident work hours do not improve patient care.
Reduced resident work hours are detrimental to graduate medical education.
Work hours must be re-evaluated.

law. Training programs in New York have been grappling with compliance since 1989.

Medical errors have not been reduced by changes in work hours; they are still commonplace today (6). In several studies, performance has decreased with sleep deprivation. Physicians are no exception (7). However, no sound evidence proves that long work hours are an important factor in actual medical errors (8). In fact, I contend that the opposite is true. Patient care suffers with work hour reductions.

At my institution, the reduction in work hours led to increased program size to cover patients at night. These night float rotations are staffed with residents who cover many patients for brief periods. Information transfer about the patients is frequently inadequate. Thus, despite their best intentions, residents may have little real understanding of complex cases and very little personal investment in them. In most cases, when a resident is consulting on a sick patient in the middle of the night, it is the first time the two have met. Some observers contend that more medical errors occur at night with these “fresh” residents than with residents who worked through the night (9). However, here the data are also limited.

Furthermore, because of the increased program size, intimacy was lost. Residents did not get to know their fellow residents or faculty as well as they did in smaller programs. Night float in particular is a depersonalizing experience. Even in the best of programs, there is little or no opportunity to develop a sense of community, and interaction with faculty is limited. There is a loss of contact with personal social support systems.

Reducing work hours limits the numbers of patients that residents care for and the extent of residents’ involvement with individual patients. By limiting the diversity, intensity, and continuity of physician–patient interactions, our residents will probably have gaps in their clinical skills. These skills are not reflected in in-service or board certification examinations. They deal with recognizing patterns

and discerning the very sick patients from the not-so-sick patients.

Reduced work hours marginalize our average and weaker residents. We are now telling our residents that they must go home. We are enforcing the idea that is perfectly acceptable to leave a sick patient in the midst of a medical emergency. The changes reduce the likelihood that our housestaff will understand what we as educators want them to understand about professional responsibility. Residents who may be ambivalent about commitment to patients now find ample reason to limit their involvement.

In implementing these changes, the profession is suggesting that continuity is not important. However, continuity of care is one of our most valued tenets. Resident's work hours are longer than most other professions because continuity requires time devoted to patients and cannot be achieved otherwise. The old system rewarded those who sacrificed their free time for continuity of patient care. The new system rewards them for nonprofessional behavior, admonishes them to leave on time, and criticizes them if they want to stay to help their sickest patients in an acute crisis.

The 3 years of residency training mark the most important period in the professional development of an internist. The learning curve is at its steepest; professionalism evolves; and it is a time when physicians develop habits, both good and bad. Even the most vocal advocates of reducing work hours would question their stance if they thought the numbers of well-trained physicians entering the workforce each year would decrease. Concerned educators like myself contend that reduced work hours do just that.

Nevertheless, the Accreditation Council on Graduate Medical Education (ACGME) has established guidelines that further restrict work hours, and there is a universally frenzied scramble among program directors to comply (10). New York has begun fining hospitals that do not fully comply with the legislation. Recently, one of the most prestigious internal medicine training programs in the

United States lost accreditation because it did not reduce work hours. Few in the medical community believe that this program is graduating residents who are less capable than programs that strictly adhere to the ACGME requirements about work hours.

The ACGME has been in the forefront in developing many educational innovations, including its requirements relating to professional competencies. Despite potential public criticism, the ACGME needs to reconsider its stance on resident work hours. The pendulum has swung too far—further work hour reductions are harmful to the future of our profession, and “the hour is getting late.”

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