

How Many Hours Is Enough? An Old Profession Meets a New Generation

Sigmund Freud said that the two most important things in life are *arbeit* (work) and *liebe* (love)—in that order. Three essays in this issue (1–3) address fundamental themes about work: How hard should one work? What does it mean to be a professional? How can one find meaning in work and still lead a full life?

The catalyst for these essays is the 2002 ruling by the Accreditation Council for Graduate Medical Education (ACGME) that restricts residency work hours to less than 80 hours per week—on average—and less than 30 hours of continuous coverage at any one time (4). The authors view this change through different prisms. Charap (1), a seasoned, male faculty member, laments the new restrictions as harmful to continuity of care, housestaff bonding, and medical education. Furthermore, he asserts that the restrictions will have the most negative effect on weaker residents (1). By contrast, for Skeff and colleagues (2), the new restrictions enable long-needed innovations. In the spirit of creative destruction, tearing down the old system will allow residencies to re-examine educational programs and create new learning about teamwork, system improvement, and self-care of and by patients (2). Without the ACGME stimulus, these worthy goals would remain submerged under the inertial tide of business as usual. Finally, Glines (3), a female resident in family practice, reminds us of the sacrifices residents must make even when working in systems that meet the new requirements. Even a “slimmed-down” residency requiring less than 80 hours per week is engrossing and fatiguing and narrows one’s life experience, as manifested in restricted physical activity, limited social life, and poor eating habits (3).

How can the same phenomenon engender such different responses? One reason is that residency itself has changed dramatically in the past 4 decades; thus, physicians from different eras recall vastly different experiences. In effect, while the length of the residency week decreased (from an every-other-night schedule to every fourth night or less), the work became more stressful—modern diagnostic and therapeutic technologies greatly expanded what we can do and to whom we can do it, business pressures forced less acute care out of the hospital setting, and constant paging interruptions disrupted workflow (5). The result for residents is heightened intensity of patient care, less control over time, and lower margin for error—all inherently stressful.

Another reason is the changed composition of residents. Medicine has evolved from a dominantly male profession to one equally represented by both sexes. Because many female residents are considering becoming or already are parents, their home responsibilities add an extra dimension to their lives and create a stronger pull away from the

residency than occurs for most men. Furthermore, few residents—men or women—have the home support that a traditional “wife” provided in years past.

Moreover, the effect of residency hours remains largely unknown. The stimulus for the ACGME restrictions was concern for quality of care. The logic was to avoid an inflection point at which extra work time jeopardizes quality. But the 80-hour/30-hour rule is arbitrary because of the unknown interaction between fatigue and errors. Different people probably have different inflection points, and the onset of fatigue may vary depending on life circumstances. Some “iron men and women” sail through long hours at high function, while others may be residency Pickwickians, tailing off after a smaller workload. Similarly, the different cultures of the 26 specialties fostered discrepant residency lifestyles. Indeed, about 25 years ago, colleagues and I studied differences in work hours among residents at University of California, San Francisco, and found almost a 3-fold difference among specialties. Some surgical subspecialties averaged almost 120 hours per week—as incredible as that may seem—and a few non-intensive specialties involved only 40 hours. These findings were considered so inflammatory that our hospital director persuaded us not to publish them.

Ideally, solid evidence could determine a scheduling model that balances the benefits of longer hours (better continuity and fewer fumbled handoffs when patients are passed from one resident to another) with the benefits of shorter hours (less fatigue and more resilience) and help us derive appropriate guidelines for sensible schedules. However, such evidence does not exist. The difficulties of obtaining it may mean that we will never know the proper balance and that these tensions will remain irreconcilable.

Another uncertainty is what residents will do with their new spare time. The regulators envisioned that the freed-up hours would be used for regeneration. But given the reality that medical student debt has soared—the average graduate owes more than \$100 000 at the start of residency—many residents may merely ratchet up their medical workweek by moonlighting at other sites (6).

We know that young physicians’ push for reduced work hours reflects strong social forces that affect professionals in other fields. As Zuger (7) described: “Once regulated largely by the conscience of the individual practitioners, many fields are becoming constrained and corporatized by governmental and professional structures, resulting in the professional’s loss of autonomy, status, and the respect of the public.” The logical response to such constraints is to view medicine as just another job rather than a profession and thus to push for regular hours and better work conditions.

We also know that regulation is a clumsy tool. The 80-hour/30-hour limits are well-intended but arbitrary responses to a theoretical threat of medical errors caused by fatigue. But I would argue that they reflect a social climate that no longer tolerates young physicians' having to work long hours at relatively low pay. Today's generation expects a level of amenities that previous generations did not (8). As Glines (3) foreshadows, downward pressures on residency hours will probably continue, perhaps cloaked in the rhetoric of quality of care, but also reflecting the increasing unwillingness of today's young physicians to sacrifice an exhausting present for an uncertain future.

Paradoxically, residency work trends are declining when other professional workweeks have been stable (although admittedly much shorter) and when Americans are increasingly viewed as workaholics compared with their European counterparts (9). These trends raise questions about medicine's status as a profession. Is it indeed special? Should being a physician require some sacrifice, such as (sometimes) putting patients ahead of family? Is the practice of medicine compatible with a full family life? Should young (and older) physicians expect regular hours? What does that say about income expectations?

I believe that the status of medicine as a profession will be challenged and the furor over the 80-hour/30-hour rule is one example of changing cultural expectations, including the increasing desire of physicians to do shift work and choose specialties that allow a more controllable lifestyle (8). But, as Skeff and colleagues (2) and Glines (3) remind us, much can be done to improve the residency experience, whatever the work schedule. If the new ACGME restrictions catalyze such changes, that will be a good thing. We also must attend to the important details of who will cover and who will pay for the lost hours previously provided by residents.

Finally, we must do everything possible to assure the best care: better systems for documenting and preventing errors, involving patients in their own care, and malpractice reform.

My own view is that regulating the resident house officer workload stands pretty far down on the list of ways to improve quality (10, 11). But because the regulation is a

simple "fix" for a complicated problem and lifestyle issues are increasingly important, we should be prepared for further attacks on the medical residency system. How medicine chooses to balance young physicians' increasingly urgent calls for a decent lifestyle with its ancient tradition of service will say a lot about what kind of a profession it will become.

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