Based primarily on scientific evidence about the adverse impact of fatigue on physician performance, the Accreditation Council for Graduate Medical Education (ACGME) imposed restrictions on resident work hours in 2003 and revised these regulations in 2010. Regardless of your opinion of these rules, they are now the established law of the land in every ACGME-accredited residency. As a result, there is every reason to believe that residents are less fatigued in the workplace. Whether these changes have made residencies less stressful for young physicians or patient care safer for the American people is harder to establish from the existing evidence. It is also hard to say if these changes will be good for the profession of medicine in the long run, but opinions abound at local and national meetings.

Into this debate, we now introduce new evidence that changes in the structure and culture of family medicine residency programs between 2000 and 2010 were associated with a measurable and significant decrease in resident clinical experience. In this issue of *Family Medicine*, Lesko and colleagues report a 17% decline in resident clinic visits when comparing data before and after the initiation of work hour limits in the University of Washington residency network.\(^1\) The authors are careful to note that other changes have also occurred during this period. Most of the programs converted to using electronic health records and began the process of transforming their practices into Patient-centered Medical Homes over the same decade. But data from private practices do not suggest that these two changes result in sustained declines in clinical volume, so it is tempting to consider work hour regulation to be a primary explanation for the findings reported in this paper. Of greatest concern are the 21% decline in clinic visits by third-year residents and the 22% decrease in the number of inpatient visits by residents during the same period. These are not small changes; they are as educationally concerning as they are statistically significant.

It is easy to simply blame the new rules for diluting the educational content of our residencies. To do so, however, is to miss the point. We cannot simply return to the “good old days” of residents who lived in the hospital and saw as many patients as they could during a 3-year whirlwind that most of us have trouble remembering with much clarity. Such training often produced practicing physicians who were burned out and who struggled to define appropriate boundaries between their personal and professional lives. Our attempts at professionalism training and Balint support groups have not prevented this from being a problem for too many of our graduates. In his accompanying commentary, assistant editor Joe Scherger accurately points out that the good old days were not really that good for doctors or for patients.\(^2\)

So, how can we retain the benefits of a safer and more humane residency experience while producing graduates who achieve competence based on a solid caseload of clinical experience? The first step is to stop denying that working fewer hours and seeing fewer patients does not result in graduates who have a weaker foundation of clinical experience when they enter practice. I suppose skeptics might argue that having 17% fewer clinic visits and 22% fewer hospital encounters might not adversely affect the competency of our graduates. Perhaps residents were seeing more patients...
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than they really needed to in the old system. Lesko’s study does not address the competence of graduates, only the experience of residents. Historically, our most established measure of competency has been graduate performance on the certifying exam from the American Board of Family Medicine (ABFM). Data from the ABFM indicate that pass rates have declined significantly during the same time period. There is also reliable data from ABFM diplomate surveys that the scope of clinical practice is narrowing for family physicians (personal communication with the American Board of Family Medicine). Hands-on experience may matter more for family physicians than for any other medical field. Narrowly trained specialists have to master a far smaller number of competencies than family physicians and usually have more time in which to master them. Family medicine has always been at the forefront of medical specialties in claiming that experience itself is a measure of competency. So we seem to have a consistency problem if we want to argue the opposite now.

Once we have all agreed that this is a problem, possible solutions can begin to take shape. There is still a lot of wasted time in a 3-year residency. Limited work hours means we must squeeze more experience into the time available. In addition, some believe that lengthening training is the answer. Others argue that we should reduce the number of skills mastered by each individual resident. Perhaps it is the competency of the team that matters rather than each individual on the team. Today, these are simply opinions, hypotheses to be tested. With modern clinical information systems, we have better tools to test such hypotheses than ever before. Every academic department and every residency needs to work on this problem, and we need to work together. It makes no sense to redesign residencies on a program-by-program basis if we want to retain a common portfolio of clinical skills for our discipline.

Most important, we must not accept a choice between humane training and depth of experience; we must insist on both. Less competent physicians in the long run is too high a price to pay for less tired learners in the short run. The stakes are high for family medicine, but they are even higher for the patients and communities we serve now and in the future.

References