Too Many Fences: A Supporter’s Criticism of Resident Work Restrictions

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“Any life truly lived is a risky business, and if one puts up too many fences against the risks one ends by shutting out life itself.”
Kenneth S. Davis

Ever since I was a medical student in the early 1970s, I have been in support of restrictions on resident work hours. Surgery was my first clinical rotation in my third year, and I was shocked by how long and hard the interns and residents worked. The chief resident on neurosurgery was on duty every day and night for 6 months! The residents were in a survival state of mind, and patients became burdens rather than people to be cared for: Empathy and compassion too often boiled over into resentment. I thought the residents had a multi-year prison sentence with a great lack of freedom over their lives. I did not like what this work experience did to them. I wanted none of that. After choosing family medicine, I searched for programs where the work hours were “civilized,” and learning was balanced with good patient care. Fortunately I matched in a program that used a pairing system on ward rotations in the first and second year so we could spend more time in the family medicine center caring for our continuity patients. Instead of being in the hospital every third night, we were there every sixth night, and we could read from home the nights our partners were admitting. I still got very good at starting IVs, even on children, and did lots of procedures, but I felt like I had escaped the prison sentence. I am not sure if I ever worked more than 80 hours a week. I suspect I did sometimes, especially when one of my patients had a 36-hour labor and delivery experience. These were draining but exhilarating. Other times I stayed at the bedside during a long dying experience, another profound and meaningful learning process. My work hours were generally 60 or more hours per week (that is still six 10-hour days), but I did learn that I could work the next day after staying up all night.

As research articles started to appear showing the patient safety problems from overworked residents, I cheered. Maybe something would be done about the barbaric process of residency training in America. Finally the evidence became overwhelming enough that the Accreditation Council for Graduate Medical Education had to act, first in 2003 and revised with much greater restrictions for 2011. The 2011 standards were prompted by a major report in 2009 from the Institute of Medicine. The evidence of danger to patients from sleep-deprived residents could no longer be denied.

Work shifts are now restricted to 16 hours for interns and 24 hours for second-year residents as long as there is “strategic napping” after 16 hours. Some do not think the new work restrictions go far enough and have called for 12–16 hour maximum shifts with 10 hours off duty between shifts. These authors cite the data from the airline industry and call for residents, and all physicians, to have work restrictions similar to pilots.

All this is well and good looking only at patient safety and the cognitive and other abilities of a single caregiver. But physicians are more than “shift workers,” and medical care is a team activity. Disease and illness are not scheduled like air travel. Patient experiences are often intense and last a long time. Residents and other physicians need to be capable of responding to patient needs in a variety of situations. If we train a generation of residents as shift workers, what will happen if we have a major disaster and physicians are called to work tirelessly for days? Will they be prepared for that? Training programs like Outward Bound show that we put far too many restrictions on our abilities...
based on limited experiences and when given the chance, we can perform in extraordinary ways. Experience with that is important for survival in difficult conditions.

There is a balance between the patient safety literature and physician work hours. If a hardworking person experiences a decline in their abilities after 12–16 hours, patients should not have to suffer for that. A resident could remain involved in patient care while a fresh resident or faculty member becomes involved in primary decision making. As I experienced the 36-hour labor, I was happy to have help arrive. The same is true with the dying patient or the one in intensive care. But I would not want to be sent home unfulfilled by not seeing the experience through. I felt sorry for the nurses who were sent home when their shifts were done just as they were helping patients the most. Continuity of care is a core value in family medicine. Sending residents home away from the patients and families they care for is bound to be disruptive to the development of relationship-centered care. Family physicians are not shift workers.

It is hard to find rank and file residents and faculty who support the current resident work restrictions. I find myself holding my tongue and being embarrassed by my support of these. Why all the explicit restrictions when general rules would suffice? The ACGME has published a side-by-side comparison of the 2003 and 2011 standards. The 2003 standards are more general and allow for some flexibility. The 2011 standards is an exhaustive list of restrictions, and most programs may not know when they are in violation. There are now too many fences around risk, and we are cutting out a major part of the residency training experience. I am still in favor of resident work restrictions, but we should rethink these in the context of teamwork. Resident involvement with patient experiences is paramount to good training. Patient safety should never be compromised, and standards for that are important. Require a fresh physician every 12 hours, but do not force residents to leave the very experiences they will need to work in after training. Putting patients first means having the best care and continuity with a physician.

Let’s not create a generation of shift workers ill prepared for situations that are bound to arise, here and in other countries.

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