

# From my perspective

**A**t some point in all of our professional lives, we were the house officers in our chosen specialties at our respective training centers. Some specialty programs were more demanding than others in terms of time commitment. Indeed, some house officers were truly hospital residents, who literally lived in the training facility. We wore white coats and pants, and our lives totally revolved around our hospitals and the duties we had as surgical residents.

However, as the old saying goes, times have changed. Today's young surgeon has a different set of values, and society has voiced concerns about the ability of overextended residents to provide quality care. As a result, the profession has developed new work-hour restrictions for residents. In this column, I will reflect on some of the realities associated with our traditional training practices and on the changes occurring in this area.

## *The past*

In years past, the number of hours residents worked varied from program to program and week to week. Work weeks well in excess of the new 80-hour limit were common. In fact, the typical resident work week was oftentimes in the range of 120 to 130 hours. These long hours were prompted by a number of factors, including the insecurities and uncertainties of young physicians, who found that sticking around the hospital and being available much of the time helped to ease their fears.

Another reason for the long work hours was the enormous workload. Granted, much of this work was redundant and was created just so that residents would be doing something. For example, we can all recall endless rounding on our patients—rounds that were preceded by another set of rounds, which were, perhaps, preceded by another set of rounds by the medical students. The work seemingly never stopped.

Additional time was consumed with waiting for the team to finish in the operating room so that everyone would be available to make rounds. In those years, time was a cheap commodity, and a resident's time was a particular bargain.

The other major issue in the past was the unavailability of ancillary help in many of our hospitals. This situation resulted in house officers and students being the common means of transporting patients, drawing blood for laboratory stud-



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ies, and keeping watch over unstable patients. The list could go on and on.

In any event, working long hours and being available to do whatever task needed to be carried out was what our training programs expected of us, and we did our best to meet their demands.

## *Two problems*

In today's environment, it is unrealistic to place these sorts of demands on residents. Two factors have contributed to the movement toward reduced work hours for residents: (1) public concerns that residents who are overtired may be prone to error; and (2) the increasing emphasis on lifestyles issues among people in the common age range of the typical resident.

The public's concerns about lengthy resident work hours peaked nearly two decades ago with the highly publicized death of Libby Zion at New York Hospital in the 1980s. In response, the Bell Commission subsequently issued recommendations that were passed into New York State law that, among other mandates, capped residents' work hours at 80 hours per week.

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Over the years, questions have continually arisen about the effects of house officer fatigue in this and other cases, but one fact has become inescapable: many medical students find the time commitment associated with surgical training repellent. Their feelings have perhaps been most forcefully expressed in some of the recent low match rates for training programs in various surgical specialties. In large part, the dismal match rates can be attributed to the commitment and lifestyle that surgical training may entail.

Many of us have been somewhat dismayed by the heightened emphasis that residents are placing on the preservation of their personal time. Nevertheless, it has surfaced as a very real concern for young people today, and we need to listen to their views. Concerns about time, commitment to professional life versus commitment to their personal lives, and the oftentimes disrespectful behavior of some senior physicians are preventing young people from entering our profession.

### *Multidimensional responses*

The profession recently has developed necessary changes in the requirements for surgical training, which respond to these issues. After more than a decade of active and vigorous dialogue about work-hour restrictions, the Accreditation Council on Graduate Medical Education has determined that beginning next month, all residents will be restricted to the 80-hour work week now in place in New York, with some specific exceptions for certain programs that request additional time. The debate has ended, and the new standards are an imminent reality.

It is of the utmost importance that training programs comply with these new mandates. Failure to do so could result in the passage of federal legislation restricting resident work hours. In fact, two bills already are pending—one in the House and one in the Senate. This is an issue best addressed by the profession rather than by the government.

Certainly the new rules will create problems. The shift changes, the patient hand-offs, the delegation of responsibilities, and so on, will need to be addressed. Clearly, we will need to shift the emphasis from providing individual care to accentuation on working with teams and within multidimensional systems. We will need to develop protocols regarding hand-offs, and recognize that guidelines will

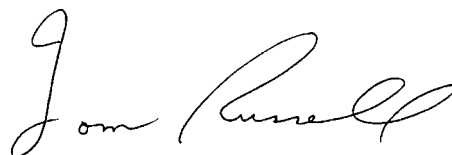
become progressively important as we enter this new phase of medical and surgical training.

As the new system of resident training is implemented, we need to inform the administrations of our teaching hospitals about the reasons for these changes and insist that they get the message that residents can no longer be treated like cheap labor. There must be an appropriate and favorable ratio of educational experience to, frankly, the performance of services without educational value. Hospital administrations must understand these concerns in order to hire the appropriate ancillary staff who can perform the new range of tasks. The days of residents transporting patients, drawing blood, and doing work that does not necessitate a medical degree are over.

The results of the changes in resident work hours and duties may be very powerful and potent. It is up to us to make certain that we attract the best candidates into the surgical specialties in the future. This responsibility must be embraced and supported not only by our profession, but by hospital administrations as well.

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**Editor's note:** To help program directors and other interested and concerned individuals deal with the myriad implications of this change in surgical training, the College is developing a special area of its Web site to address issues of importance and concern. A new Web page on resident hours of duty will be posted later this month on the Division of Education pages. Regular updates for program directors and practical information for addressing the restricted hours of duty will be presented, along with strategies being used by various training programs. The purpose is to facilitate the exchange of ideas and effective approaches. Richard Bell, MD, FACS, and Debra DaRosa, PhD, will serve as editors for the site and will work with an editorial board composed of Gary Dunnington, MD, FACS; Timothy Flynn, MD, FACS; James Hassett, MD, FACS; and Marc Wallack, MD, FACS.



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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmf@facs.org](mailto:fmf@facs.org).