

From my perspective

Of all the changes occurring within our health care system, perhaps the ones that affect surgeons the most are the cultural shifts that seem to be shaking the very foundation of our profession. Examples of some of the cultural transformations that are currently taking place include the corporatization of American medicine, the heightened attention that is focused on serious errors in hospitals with a resultant emphasis on improving patient safety, and the professional liability crisis.

One of the most profound cultural transformations is taking place in our training institutions. Work-hour limits and a new emphasis on the team approach to delivering care will change forever the way in which we practice surgery. This cultural shift affects not only surgery, but all of the medical disciplines as well.

Work hours

Two articles in the October 28, 2004, issue of the *New England Journal of Medicine* address weekly work hours.* Not surprisingly, the authors note that extended work hours lead to increased failure to provide error-free care. Although critics of the studies discussed in the articles may have a point when they claim that the reports applied faulty methodology, the authors do add to an ever-increasing body of knowledge indicating that house staff should be rested and informed if we are to reduce morbidity and mortality in hospitals.

During recent visits to academic medical centers, I have found that our residency training programs clearly are developing systems to effectively implement the 80-hour work week as mandated in July 2003 by the Accreditation Council on Graduate Medical Education (ACGME). To assist these training institutions in that process, the College has a help page on our Web site, which allows program directors to share their experiences in attempting to implement the mandated changes (see <http://www.facs.org/education/rap/index.html>).

*Lockley SW, Cronin JW, Evans EE, et al: Effect of reducing interns' weekly work hours on sleep and attentional failures. *N Engl J Med*, 351:1829-1837, 2004, and Landrigan CP, Rothschild JM, Cronin JW, et al: Effect of reducing interns work hours on serious medical errors in intensive care units. *N Engl J Med*, 351:1838-1848, 2004.



With the development of better systems, technological advances, and the electronic transfer of information, we can craft a more effective way of training rested and informed residents.

Although I am confident that training programs are making a smooth transition to the work-hour limits, a more fundamental question remains: What type of surgeons are these redesigned programs producing?

The new culture

The admissions committees of medical schools and residency programs have never been able to effectively determine the motivations of individuals seeking a career in surgery. Furthermore, an individual's interests and desires may change during the course of the surgical education experience. Some trainees start and remain highly motivated, with a deep and innate commitment to their job and their patients. Others may lose their enthusiasm along the way, while others may have entered training for an entirely different set of reasons. This scope of rationales for embarking on a surgical career has existed from the beginning of formal training.

Traditionally, residency training has been based on the premise that surgeons and other physicians entered the medical profession because medical practice was almost a calling in life. As a result, one needed to become totally immersed in training and answer to the prevailing comprehensive ideology. Residents were told that they had total responsibility for each patient they treated. This system of complete immersion and absolute responsibility led to long days and sleepless nights. We ran on caffeine and adrenaline.

Today this doctrine has changed and, in some cases, so have surgeons' values. No longer is it "my patient," but it is "our patient." All members of the surgical team share responsibility for providing appropriate care.

And, because all members of the team also are required to work a limited number of hours, new opportunities for immense problems arise. Patient hand-offs are more prevalent, and they can potentially create major lapses in the continuum of care.

What to do

Who knows whether this new way of training residents—with more shared responsibility, limited work hours, and increased concessions regarding lifestyle issues—will work or not? One apparent certainty is that we will never go back to the old etiology that trained generations of surgeons and other medical professionals in the last century.

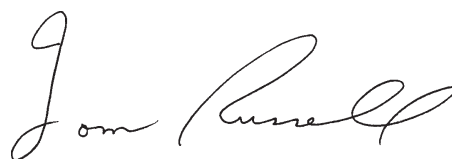
For a new cultural ethos to evolve, we must make fundamental changes in our approach to resident training. We can start by building a sense of mutual respect for the broad range of individuals involved in the care of our surgical patients, from nurses to allied health care professionals, from anesthesiologists to environmental service workers. As surgeons, we also must improve our communication and leadership skills, so these individuals will view us in a more positive light.

Additionally, we must foster in our residents the true core values of our profession. Professionalism and ethics must be instilled didactically, and not just through casual exposure. Being a surgeon (or any medical professional for that matter) is not a routine job. It incorporates

responsibility, service, and a real commitment to the patient.

Guiding ethos

None of us who trained in the "total immersion era" would want to return to that point in our careers. With the development of better systems, technological advances, and the electronic transfer of information, we can craft a more effective way of training rested and informed residents. By accepting and adapting to changes in the culture of resident training, we may very well be able to provide safer, more error-free care of our patients. This mission has been guiding the ethos of our profession. Our commitment to patient safety is a timeless and immovable force within our culture.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.