Residents and medical students in the 21st century:

Better, worse, or just different?

by Zsolt T. Stockinger, MD, FACS, Michael S. Ellis, MD, FACS,
and Norman E. McSwain, Jr., MD, FACS,
New Orleans, LA

About a year ago, the New Orleans Surgical Society met to hear Louisiana surgeon and then-president of the American Medical Association, Donald J. Palmisano, MD, FACS, discuss the professional liability crisis gripping American medicine. During the informal reception afterward, the discussion turned, as it often does these days, to another perceived crisis in American surgery—the move to the 80-hour workweek and the training of surgery residents in general. As one can imagine, the spectrum of views offered on this subject was diverse, ranging from rebellious to resigned, from uncaring to understanding. Most of the discussants agreed that the current crop of surgery residents is a different breed than we were when in training. Of course, we had heard practicing surgeons say the same of us, and, most likely, the current residents will make the same comments about their successors, if they aren't already. Nonetheless, we bemoaned the fate of American surgery, reminiscing about surgical training during the previous millennium.

At one point, one of the authors happened to mention that he had organized the first house staff organization at Charity Hospital, around 1973. At the time, working conditions were bad (sighs all around), hours were long (understanding nods), pay was inadequate (shrugs), and demands were made—and met (gasps). His experience demonstrated the potential power of organized medicine, but as the story unfolded, it begged the question of whether residents really were different in those days.

Changing priorities

Today's medical literature is rife with articles about the impact of the 80-hour workweek[1,2] and the changing priorities of medical students as they select careers.[3-6] Perusing just a few recent publications shows that medical educators are concerned about the possible negative effects of the rules on both residents and patients.[2] Apparently even some surgery residents, while enjoying the improved lifestyle afforded by the new rules, feel that they negatively affect patient care.[2] There are concerns that current trainees (students and residents) have an unrealistic view of the work hours and call schedule of practicing surgeons.[7,8]

But how does today differ from yesterday? To answer this question, we decided to turn to the Service Employees International Union's Committee of Interns and Residents—the largest house staff organization in the country, representing trainees in seven states or territories. Founded in 1957, this group was instrumental in achieving the one-in-three call schedule and other needed benefits. Perusing their Web site *(www.cirseiu.org),* one finds that today's hot topics include the 80-hour workweek (of course), maternity leave, collective bargaining, and overtime pay. "A limit on resident work hours means healthier patients, healthier residents, and a healthier medical community," sayeth the Web site,[9] although one-quarter to one-third of residents themselves, in at least two studies, have said they believe that work-hour limitations will negatively affect patient care.[2]

Meanwhile, three young physicians have filed a class-action lawsuit against the National Residency Matching Program (NRMP), attacking the FREIDA residency database, the American Association of Medical Colleges' survey of house staff stipends, the Accreditation Council on Graduate Medical Education, and the match itself. In the complaint, the physicians argue that these activities are anticompetitive and restrict salaries,[10] despite the fact that the NRMP has two medical student board members and was founded in part by medical students because of the gross inequities in the resident selection process before its inception in 1952.[11]

Today, medical students' chief concerns regarding selection of specialty are controllable lifestyle[3-5,12] and intellectual challenge.[12] General surgery in particular has been knocked for its "lacked breadth in expertise, limitations over stress, control over one's time, regularity of schedule, adequacy of leisure time, and income commensurate to workload."[4] Other specialties considered to have a "poor lifestyle" are also decreasing in popularity.[3,5,6] Yet despite this trend, most general surgeons say they would choose this same specialty again.[8]

Our concerns as residents

By coincidence, while we were discussing submitting this article to the *Bulletin,* a third-year medical student rotating on the surgical service asked what our program offers to encourage young people to complete their residency here. In our day, to paraphrase President Kennedy, we asked not what the program could do for us, but what we could do for the program.

In 1973, the Charity Hospital house staff placed before the administration the following eight demands:

1. A "crash cart" on every floor. At the time, there was one for the entire hospital.
2. Privacy screens for patients. All patients were, and still are, housed in barracks-style wards.
3. Some sort of cooling system for the patient wards. Not even floor fans were available.
4. Bedside commodes for patients.
5. Air conditioning in the resident call rooms. Residents would sleep on the roof of the hospital, because of the unbearable heat of the New Orleans summer.
6. A place to park.
7. Health care insurance for house staff.
8. A raise of $50 per month, for a monthly of income of $225.

As you may notice, four of these items were directly related to patient care, two were related to working conditions, and only the last two directly affected the residents' pocketbooks. To discuss work hours would have been inconceivable, and to discuss lifestyle meant that one actually expected to have a life. Surprisingly, all of these demands were ultimately met.

What's different

So what is different today, 30 years and a generation after the demands set forth in 1973? Are the physicians and surgeons of the future more self-centered, demanding to have actual *lives* while we were content to have *jobs*? Do the surgeons of the future actually dare to differentiate between having a life and a job, when we thought the two were synonymous? Is it possible that we cared more about our patients, while they care more about themselves? Are we training surgeons or shift workers?

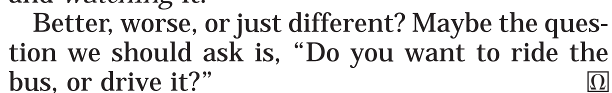
Or is it possible that patient care has changed to the point where residents no longer need to fight for patients' rights? Are we now finally confronting the fact that one-third of a resident's time is spent performing activities with marginal educational value,[13] and that with better communication between physicians and nurses, residents can sleep more and be paged less?[14] Can anyone honestly say that he or she would have preferred less sleep, fewer days off, and less time with their families while in residency, regardless of in which decade it was?

What it means

In other words, are we finally allowing our trainees to say that there has to be a better way? Halsted did it, a century ago, and reformed American surgical education as a result. As Halsted reformed surgical training a century ago, so we must now.[1] The challenge will be controlling the revolution, not preventing it. Our role as surgeons will be to shape the reformation within the confines placed upon us. It will mean showing our medical students that the surgical specialties are desirable career choices.[8] It will mean training efficient, knowledgeable, and caring surgeons who, to borrow a phrase from the military, "fight smarter, not harder." It

will mean placing renewed emphasis on the idea that, as surgeons, we are *responsible* for our patients, only now instead of being at the bedside always, we will ensure the appropriate continuity of care. It will mean teaching residents that there is a difference between being *aware* of the clock and *watching* it.

Better, worse, or just different? Maybe the question we should ask is, "Do you want to ride the bus, or drive it?" Ω



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Dr. Stockinger *is an active duty U.S. Navy surgeon at Naval Medical Center, Portsmouth, VA; he recently completed his trauma surgery fellowship at Tulane University/Charity Hospital, New Orleans, LA.*

Dr. Ellis *is an otolaryngologist and clinical professor of surgery, Louisiana State University School of Medicine. He was a founder and first president of the Charity Hospital Association of Residents and Interns, New Orleans, LA.*

Dr. McSwain *is professor of surgery and general surgery residency program director, Tulane University, and director for trauma services, Charity Hospital, New Orleans, LA.*