



Why resident hours must be flexible: One young surgeon's view

by Jacob Moalem, MD

When the Accreditation Council for Graduate Medical Education (ACGME) implemented its duty hours regulations (DHR) in 2003, it did so with a promise to study the impact of this revolutionary change five years later. That study is ongoing, and the ACGME has solicited input from every conceivable source. They have hired three independent contractors to review the scientific literature for papers on the impact of DHR, reached out to every stakeholder organization for written position statements, and have commissioned a team of sleep scientists to summarize the most current evidence on the impact of sleep deprivation. With the recent release of the Institute of Medicine (IOM) report, *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*, the ACGME's efforts are particularly timely.¹ The most restrictive features of the IOM report are summarized in the box on page 15.

In June 2009, the ACGME sponsored a Duty Hours Congress as a way to gather feedback regarding the IOM report. Seventy-seven stake-

holder organizations submitted written responses to the IOM report, and 67 of these, including numerous specialty societies, hospital and accreditation organizations, and medical student and resident organizations, presented testimonies. I was privileged to speak on behalf of the Resident and Associate Society (RAS) of the College, based on our previously published position statement.²

The consistency of opinions among the vast majority of presenting organizations was staggering. There was widespread opposition to further reductions in work hours, and support for removing the rigidity in scheduling, both of which are called for by the IOM. Every organization, except for the Committee on Interns and Residents and the American Medical Student Association, agreed with these positions.

Representatives from pediatrics, internal medicine, radiology, psychology, psychiatry, and pathology all urged the ACGME to fight the implementation of the restrictive elements in the IOM's new recommendations.

The main reasons cited for opposing the IOM's recommendations were the dearth of evidence demonstrating an improvement in patient safety since the introduction of the DHR, and the growing recognition of the prevalence of errors due to miscommunication during patient handoffs.³ Most presenters also highlighted concerns regarding the effect that strict adherence to the hours has had on professionalism among residents.⁴ All presenters agreed that a mandatory five-hour nap was unworkable, but that resident safety was paramount. There wasn't a debate concerning the fact that residents should be provided adequate sleeping facilities, and transportation home for the times that they are too tired to drive safely.

While the call for flexibility was unanimous, there was some variability in how the various

stakeholders defined “flexibility.” Most presenters simply asked for a reduction in the rigidity of scheduling recommended by the IOM. They sought the elimination of the “no averaging” clauses, and of the four consecutive night maximum recommended by the IOM for night duty. Many surgeons, though, called for a different kind of flexibility—the elimination of the duty hours restrictions for chief residents.

Many surgeons discussed the need to provide chief residents with scheduling flexibility so that they could participate in rare cases and emergencies whenever they arise, and to avoid a potential conflict between their educational experience and after-hours education. Another important reason they cited for scheduling flexibility is the requirement to prepare trainees to operate and respond to emergencies at all hours, which is something surgeons are expected to engage in upon graduation.

Certainly, senior residents should never be forced to choose between having to go home and their desire to work on a rare case. Moreover, I agree that there is an element of training that affects the physician’s ability to cope with sleep deprivation, but I disagree that those are the most pressing reasons for flexibility and exemption of senior residents from hours regulations.

I believe that the most important reason to give chief residents autonomy over their work schedule is the preservation of their very role, which for decades has been unique. A surgical chief resident’s function is, and should remain,

more akin to that of junior faculty member. As such, they are personally responsible for the welfare of all of the inpatients on their service. If a patient takes a turn for the worse, it is the chief, regardless of whether he or she operated on the patient, who is charged with overseeing the restoration of that patient’s health. This is not the time to look at the clock; it is a time of commitment to patient care and of invaluable learning opportunities.

Another reason that surgery chief residents need, and deserve, different standards of training has to do with the fact that, immediately upon graduation, they are thrust into leadership roles, both in and out of the operating room. Beyond direct patient care, chief residents are charged with educating and training medical students and junior residents.

With increasingly stringent hours regulations, chief residents are being stripped of important leadership development opportunities—such as leading the surgical team on afternoon teaching rounds—which are now almost nonexistent. Moreover, we have seen a sharp decline in teaching cases, in which chief residents take their junior colleagues through cases under the watchful eye of an attending surgeon. Finally, in many residencies, administrative responsibilities have been deemed “noneducational,” and have also been reassigned to staff.

I believe that in the past five years we have seen the gradual erosion of the surgery chief resident role into that of a senior resident who comes in,

Highlights of the IOM recommendations (December, 2008)

- Maximum shift length: (a) 16 consecutive hours or (b) 30 hours, including a non-regulated 16-hour working period, followed by a required five-hour protected sleep period between 10:00 pm and 8:00 am. The remaining nine hours can be used only for transition and educational activities.
- In-house call frequency: Maximum on-call frequency every third night, averaging no longer allowed.
- Minimum time between shifts: 10 hours after day shifts, 12 hours after night shifts, 14 hours after any extended duty period.
- Maximum frequency of in-hospital night shifts: Four-night maximum, with a required 48 hours off after three or four nights of consecutive duty.
- Mandatory time off: Four days off and one 48-hour period off per month, one day off per week, no averaging.

Source: *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*.¹

Resident and Associate Society to hold Town Hall Meeting

The debate concerning restrictions on resident duty hours has heated up in the wake of the recent IOM report entitled *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*, with strong and impassioned arguments on both sides of this controversial issue. The Resident and Associate Society of the ACS will hold a Town Hall Meeting on this issue Tuesday, October 13, 7:00–7:45 am. All attendees of the 2009 Clinical Congress in Chicago, IL, are invited to participate in the session and to share their opinions with two of the most influential people in this debate: Thomas J. Nasca, MD, chief executive officer of the ACGME, and Thomas V. Whalen, MD, FACS, Chair of the Residency Review Committee for Surgery and a Regent of the College.

operates, and goes home at the end of the day. This is an abomination that is enabled, and even encouraged, by us, the faculty who—against our own beliefs—insist that our residents go home when we believe that the right thing is for them to be in-house, caring for patients in need.

Educators have emphasized the importance of a heightened team approach to residency education.⁵ While many of the duties in the daily function of the team can and should be handed off to the on-duty residents in order to comply with hours regulations, the leadership of the team should not be so readily transferable, and must remain in the hands of a resident who is intimately familiar with the patient.

I strongly believe that most surgery residents aspire to the model that I have described, and yearn to function in the capacity of the “old time” chief residents. The system must be changed to enable this, but so, too, must our faculty’s expectations and demands. Giving the chief autonomy over his or her schedule must work both ways, such that just as the chief should have the flexibility to remain in the hospital to care for a sick patient, he or she should be free to leave when the patient case load allows. In addition, we must continually seek to develop and refine educational tools to make resident training more effective and efficient.

It is our collective responsibility to restore the surgery chief resident to his or her vitally important role. Granting chiefs autonomy over their own schedules will go a long way toward this goal, and the faculty should redouble their efforts to instill in them the deep sense of responsibility that is so crucial to a successful practice in medicine. □

References

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