



Resident and Associate Society  
of the American College of Surgeons:

## Position statement on further work hour restrictions

by Jacob Moalem, MD; Luke Brewster, MD, PhD, MA;  
and Ted James, MD, FACS

*The following statement was developed by the Resident and Associate Society of the American College of Surgeons (RAS-ACS) and approved by the Board of Regents at its October 2008 meeting.*

**W**hile the adoption and implementation of the 80-hour workweek by the Accreditation Council for Graduate Medical Education (ACGME) and its Resident Review Committees have had disparate effects on the various specialties within medicine, these regulations have had their greatest impact on surgical training programs. The restrictions on resident work hours have sparked the widespread overhauling of rotation and call schedules; hiring of physician extenders; and proliferation of resident cross-coverage, particularly at night.

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Two years before the enactment of the duty-hour regulations in 2003, resident attendees at the American College of Surgeons Clinical Congress were surveyed about their opinions on resident work hours. Though the majority of residents at that time believed that some regulation of work hours would be beneficial, most believed that more than 80 hours would be required to train competent surgeons.<sup>1</sup>

We recently surveyed the RAS membership again, to assess whether their opinions had changed after a five-year “adjustment period.” Although surgical residents’ opinions on the subject reflected their adaptation to the regulations four years after the implementation of the ACGME’s regulations, their feelings had not changed dramatically. Representing 15 surgical specialties, nearly 600 respondents to the survey were evenly split on this issue: half thought that residents should work no more than 80 hours per week (in line with current regulations), and half still believed that more than 80 hours per week were needed for optimal surgical education. Only 3 percent believed that fewer than 60 hours per week would suffice to adequately train surgeons. Compared with their more junior colleagues, senior residents (postgraduate year four and higher) were more likely to think that more than 80 hours per week are necessary to train surgical residents. Moreover, nearly half of senior residents believed that the 80-hour work hour restrictions were, in and of themselves, a moderate or severe barrier to resident education (unpublished data). Clearly, surgical trainees, particularly senior residents, do not uniformly agree that the 80-hour workweek has been beneficial.

We have recently celebrated the 80-hour workweek’s fifth anniversary. In the time that has elapsed, numerous studies have attempted to relate the reduced work hours to patient outcomes. Some studies have demonstrated a decrease in attention lapses or medication errors in association with reduced work hours.<sup>2</sup> To date, however, no peer-reviewed study has demonstrated improved patient safety or improved outcomes in surgical patients as a result of the duty hour limitations.<sup>3</sup> In addition, there are no reliable national data that demonstrate a positive effect of the 80-hour work week on resident education or patient care.<sup>4</sup> Conversely, multiple recent studies have


raised serious concerns regarding the increased need for transfer of care responsibilities and decreased continuity of care that is necessary to accommodate the new work hour regulations.<sup>5-13</sup> Specifically, studies have demonstrated adverse effects of decreased continuity of care on medication errors,<sup>5,10</sup> communication errors,<sup>6,8,10,12</sup> resident–patient relationships,<sup>9,13</sup> and resident attitudes and professionalism.<sup>9</sup>

Beyond the impact on individual surgeons and patients, more global implications must also be considered. As the requisite knowledge base required of surgeons continues to expand, fewer and fewer trainees progress directly to practice. Thus, in an era when surgery is a decreasingly popular career choice among medical students<sup>14,15</sup> and the burden of educational loans is peaking,<sup>16-18</sup> many residents are lengthening their training period and accumulating debt during this pursuit of additional training. Lack of preparedness for the realities of independent practice is thought to have been a major contributing factor to more than 75 percent of U.S. graduating general surgical chief residents’ choices to pursue fellowship training in 2007.<sup>19</sup> Further shortening of work hours could only be anticipated to augment this alarming trend.

The mission statement of the American College of Surgeons is in line with the putative mission of every surgical training program in this country: It is “dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.” Quality surgical training and care is founded on a longitudinal, comprehensive curriculum, which applies the six core competencies outlined by the ACGME to the care of the preoperative, intraoperative, and postoperative surgical patient.

We believe that the increasing trend of graduating chief residents to pursue additional training is consistent with our survey results. As residents mature and the reality of independent practice becomes increasingly daunting, trainees thirst for opportunities to enhance their knowledge, skills, and readiness. With profound differences in scope of practice among medical and surgical specialties, and even among the various surgical specialties, we believe that perhaps uniform regulations should not be applied across the board.

As a subsidiary organization of the ACS, the RAS

fully supports any initiative designed to improve the care of surgical patients in this country, so long as it is evidence based and founded on a comprehensive study of all major contributing factors and possible ramifications. Although we readily acknowledge the concerns about resident fatigue and inefficiencies in our training programs, these issues should not be considered in isolation. We implore any regulatory body that is considering further restrictions on resident experiences to also consider the impact and consequences of such restrictions on (1) continuity of care, (2) burden on this country's health care system, and (3) the overall quality of surgical training—and thereby on surgical care. 

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