Editorial

James V. Felicetta, MD
Editor-in-Chief

Have We Overdone Workhour Limits?

This editorial you're about to read is likely to make me seem like an old fool, hopelessly stuck in the dark ages. You'll probably conclude that I'm out of touch, irrelevant, and a hindrance to the advancement of medical practice. But I feel strongly enough about today's subject that I'm willing to brave the abuse that may well come my way from my younger and more enlightened colleagues.

The issue that has me up in arms relates to the unforeseen consequences of the recent national push to reduce working hours of house staff in medical training programs. I'm concerned at the prospect that further reductions, beyond those currently in place, are being debated seriously by the Accreditation Council for Graduate Medical Education.[1]

Of course none of us truly want to go back to the bad old days. When I was a resident in internal medicine in the mid 1970s, overnight call was every third night at the university hospital (a major hematology/oncology referral facility) and every fourth night at the affiliated facility. There were no limits to the total number of admissions we could receive on a night of call. It was not unusual for an intern to complete the workup for 12 (or more) very ill patients in a single night. I vividly recall asking myself, rather bitterly, one night what educational benefit my masters could possibly attribute to the admission of a fourth patient with acute leukemia to my service that evening. The fatigue factor was very, very real in those days, and it clearly had a negative impact on the amount of time and energy available for reading about disease processes.

So, yes, there was a crying need for reform. But I submit that the pendulum already may have swung too far in the opposite direction and, indeed, is threatening to swing even further. Although we do have better rested house staff now, we may have put at risk both the quality of patient care and the quality of postgraduate medical education.

As I talk to colleagues around the country (admittedly, mostly of my vintage), the recurring theme I hear is the risk of compromised patient care due to overly frequent and inadequate patient handoffs. The house staff simply do not seem to know the patients under their care nearly as well as we of an earlier generation did. And how could they? So often the patient they're caring for was admitted by a different house officer. The patient's sudden deterioration was handled by yet another cross-covering intern, and now the patient is about to be handed off to a new team so that the resident can have his mandatory day off. Indeed, a recent survey suggested that patient errors related to suboptimal handoffs are at least as frequent as those presumed to have occurred from excessive fatigue on the part of house officers.[2] In this environment, the attending physicians who supervise interns and residents must be far more vigilant these days.

And let's not forget the very harmful effects further reductions could have on resident education. Most programs have had to dial back the total number of formal teaching sessions substantially, simply because attendance would put the residents over the workload limits. I recently heard about one enthusiastic intern at a prestigious program who was told he could no longer stay behind at his medical center to read an online medical textbook because doing so was ruining the workload report!

The education of house staff is not something that can be achieved in just a handful of minutes. There was real value in the long, hard hours that earlier generations of physicians devoted to acquiring their skills and clinical judgment. Reasonable workload limits are certainly necessary, but let's recognize that there are just as many risks involved with cutting house staff hours too much as there are in not restricting them at all. ●

Author disclosures

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