The Debate over Residents' Work Hours

BY PAUL S. TREUHAFT

People who work in medicine and follow the discussions of medical ethicists may have thought that the struggle between paternalism and autonomy was over, with autonomy the winner. Alas, this is an error, and some evidence of the struggle's persistence was recently reviewed in the *Baltimore Sun* and the *Washington Post*. In late August, both newspapers wrote about Johns Hopkins University's Osler Medical Service's recent loss of accreditation. The Accreditation Council for Graduate Medical Education removed the service's accreditation for a violation of the new standards for resident work hours that the Council had enacted this year.

The new work hour standards call for no more than an eighty-hour work week, averaged over a four-week period, with at least twenty-four hours off work per week. These new regulations result from a public debate, which began in 1984 with the death of Libby Zion from a drug interaction in a New York hospital, about the issue of whether staff fatigue imperils the health and safety of patients. A subsequent lawsuit argued that house staff fatigue was a contributing factor to Zion's death, although further analysis has satisfactorily established that the real problem was inadequate staff supervision. Since this lawsuit, the debate has been a fitful one. Poorly designed studies on the impact of fatigue on performance constitute one part of the data used in arguments, and firmly held opinions about the importance of near-constant attendance of resident staff at the bedside constitute another. Absent from the debate is an analysis of changing trends in the delivery of health care or the impact of advancing technology. In an insightful piece in the Annals of Surgery earlier this year1, Frank Lewis, the SecretaryTreasurer of the American Board of Surgery, argues that the debate results from a conflict between two observations that are both true, but not related. These observations are, according to Lewis, that house staff work very long hours, which most Americans feel are neither necessary nor appropriate, and the unsupported perception that patient safety is a critical issue in most urban hospitals.

A middle way is possible.

Residents do work long hours. They have done so ever since Halsted invented the modern surgical residency in Baltimore over one hundred years ago. Halsted's program was an outgrowth of his own personality and work ethic and the poorly managed surgical training of the times. His system produces fiercely individualistic and independent physicians who willingly submit themselves to a degree of overwork which much of American culture finds questionable for their doctors. These same physicians, however, often suffer from some of the same problems that afflicted Halsted—most notably depression and drug addiction. The key unanswered question is whether the training these physicians receive best serves the needs of modern American medicine.

The patient safety issue provokes another argument. Lewis, probably referring to the 1999 Institute of Medicine study, *To Err is Human*, argues that this is "old data that does not withstand critical and logical review, and is likely a significant exaggeration." Lewis does not give a detailed critical analysis, however. And data from the Leapfrog Group, a group formed by The Business Roundtable to study medical error and medical outcomes, tend to support the Institute of Medicine's figures.

We need to resolve the tension between a training system that produces fiercely individualistic physicians and a health care system that increasingly values a team-driven approach to care. In the end, Americans will have the health care system they value most highly, and the physicians who emerge to staff it will be the ones who best fulfill the social needs of the health care system. Just as Europe has found it possible to train skilled physicians with a seventy-two-hour work week, so we will find it possible to train skilled physicians with an eighty-hour training week. The training system will have to change, but this does not mean that all the good things in the old system need to be abandoned. Instead, the system can adapt while preserving elements of the old. If the change is evolutionary rather than revolutionary, a stronger health care system will result from the blend of the best of the old with the strengths of the new.

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1. F.R. Lewis, "Should We Limit Resident Work Hours?" *Annals of Surgery* 237, no. 4 (2003): 458-59.