

## **PHYSICIAN RESIDENCY TRAINING WORKLOAD ISSUES: HOW MUCH IS TOO MUCH?**

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Physician residency training in the United States has been heavily scrutinized. Specifically, the scheduled workload of residents in training, impact of same on the training of young doctors, and considerations for patient safety have emerged as pressing issues. AAMA members need to have a solid understanding of these issues, both for the residents in training at their own hospitals, and for physicians who they will recruit upon graduation.

The evolution of physician education during the past 75 years has not kept pace with the explosion of diagnostic and treatment tools that have been developed. The time period during which this expanse of medical knowledge is expected to be absorbed has not increased in any real amount over the same period. Considering that the amount of available residency training time is fixed, this has led to an increasing proportion of time and effort being focused entirely on medical pursuits. The lack of time remaining for rest and personal pursuits has been cited as harmful in the human development of the individual physician and compromising to their health and safety. The authors also have serious concerns about patient safety in this excessive workload environment. These 'resident' physicians have been sleep-deprived and have been found to have an increased incidence of depression<sup>1</sup>, motor vehicle accidents<sup>2</sup> and complicated pregnancies<sup>3</sup>.

At one time hospitals supported the education of physicians directly through stipends, room and board. With the coming of managed care, this relationship was ended and resident physicians, to some hospitals, became cheap sources of labor. These circumstances have also contributed to the harmful proportional shifts in time. The amount of time worked can become almost unbelievable, approaching 130 hours a week.

In 1957, group of residents established an organization known as the Committee of Interns and Residents (CIR). Organized efforts to curtail excessive work hours were pursued, with the first notable success in 1975. This group of residents, through collective bargaining was able to negotiate contractual limits of working overnight shifts to no more than one night in three.<sup>4</sup>

The resistance of medical culture did not allow any further significant advances until 1989. In 1989, the New York State Department of Health (NYDOH) enacted the '405' Regulations to the New York State Health Code. This Code was the culmination of the Bell Commission Report which implicated the training and overwork of residents as being contributory to the tragic death of a patient in a New York City hospital. Code 405 established work limits of 80 hours per week with a limit of 24 hours per shift and at least

one 24-hour period per week off for personal time. It is important for healthcare administrators to understand that the authors are not talking about “on call” hours here. These are actual on duty, intensive work hours in extremely busy teaching hospitals.

The recognition of this problem, and adoption of changes in working limits is not limited to the United States. In 1993, the European Union (EU) adopted the EU Working Time Directive that limited the workweek to 48 hours which will become applicable to house staff as of 2004<sup>5</sup>. In 1999, Australia adopted the National Code of Practice which limits work duration in much the same way<sup>6</sup>. As recently as 2003, resident physicians in Puerto Rico successfully lobbied to have limits modeled after Code 405 legislatively enacted<sup>7</sup>.

These international moves have had little effect on the national American medical culture. Even in the state of NY, which had already established legal precedent, there were gross violations of Code 405. In 1999, the Independent Peer Review Organization (IPRO) was hired by the New York Department of Health to enforce compliance with Code 405.

The financial crisis in US healthcare has, for some years, drawn attention away from resident training issues. The united move by three concerned organizations (Public Citizen, American Medical Students Association (AMSA) and Committee of Interns and Residents) recently refocused attention on the resident training issue. A petition was filed with the Occupational Safety and Health Administration (OSHA) citing the three potential areas of harm previously mentioned as areas of physical and mental risk that were significantly reduced with adherence to limitations of the excess work hours. The enactment of OSHA regulations would, in effect, nationalize Code 405.

The attention now drawn to this issue began a series of legislative and administrative moves. The first, late in 2001, was proposition of HR 3236 by Representative John Conyers in the US House of Representatives. This reinforced the push for national legislation for work hour limits. Soon after, in February 2002, Assemblymen Impreveduto, Munoz and Ahearn proposed state legislature in the NJ State Assembly (A.1852). Senators Vitale and Sweeney also introduced a companion bill in the NJ Senate (S. 1712). These state initiatives were deemed needed as the national moves had met with much resistance from the traditional medical community and its influences. This flurry of initiatives created momentum for movement in the US Senate. Meanwhile, the American College of Graduate Medical Education (ACGME), being the accrediting body of all residencies, announced changes in their guidelines on June 11, 2002. These guidelines now contained language requiring work limits similar to those in Code 405, the OSHA petition and HR. 3226 that programs must have incorporated by July 2003 in order to be accredited. This quashed much of the vigor in the national push to address the work hour issue. Some assumed that the issue was now addressed. The timing of this announcement could not have been better planned. On June 12, 2002 Senator John Corzine of NJ proposed the companion bill to HR.3236, S.2614 in the US Senate.<sup>8</sup>

Critics of the ACGME guidelines argue that they do not have enforcement mechanisms necessary for implementation and that the only accountability penalties that

can be imposed are a hold on reaccreditation or closure of the program. It remains to be seen if the critics are right.

The debate rages on. The authors of this paper are not writing in support of any particular legislative remedy or solution. We are writing to educate the membership of AAMA, a leading organization of healthcare managers, about the importance of the issue and the implications for American healthcare. The understanding and involvement of healthcare executives is needed in order to assure the safety of patients treated by residents in our hospitals, and also to ensure that the young doctors leaving residency and coming to practice at our hospitals are sound clinically, personally and professionally.

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