

Resident Duty Hours

The ACGME Perspective

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On July 1, 2003, new program and institutional requirements that regulate the duty hours of residents went into effect. They are the product of changes in the health care system that have challenged three cherished beliefs: that the primary purpose of residency is education; that the type of work performed by residents is appropriate; and that medicine's credibility is enhanced when physicians work long hours without rest.

The amount of work done in caring for hospitalized patients has increased over the last several decades, due to tremendous advances in biomedical science and technology. DRGs and other financial incentives to shorten the length of stay mean that there is less time in which to do the needed work, and the financial pressures on hospitals mean that support staff have been reduced. Doing more in less time with less help results in residents admitting and discharging patients, recognizing disease with great facility, but lacking the time to recognize the patient.

The new standards can be found on the ACGME website: www.acgme.org. They limit duty to 80 hours per week averaged over 4 weeks, require 1 day in 7 free from all educational and clinical responsibilities, limit continuous duty to 24 hours with up to 6 additional hours for transfer of care, and limit in-house call to no more frequent than every third night. Home call is per-

mitted but if the resident is called in, the time in hospital counts towards the 80-hour limit. The ACGME will rigorously enforce the new standards. A resident complaint procedure has been established and is on the website.

This culminates a 2-year process in which the ACGME worked with the larger community of organized medicine to develop these standards. For many specialties the changes are minor, but for others compliance requires major redesign in the educational and clinical delivery model. No additional funding has been provided to make these changes. Why was yet one more unfunded mandate added to the list?

In the late 1990s, the Residency Review Committees (RRC) and Accreditation Council for Graduate Medical Education (ACGME) noticed that roughly 25-35% of programs reviewed were in violation of existing duty hour requirements that were then in effect. Program requirements are developed after an extensive vetting process and serve two functions: they act as a minimal standard for accreditation purposes and they represent a formal value statement by experts in the specialty about what the ideal program should look like. Any gap between the profession's stated values and its behaviors weakens the profession and is disturbing.

Soon thereafter, state and federal legislative bodies began to introduce proposed legislation that

would regulate resident duty hours. Encouraged by groups of student and resident activists, public advocacy groups, and resident unions, this legislation was shaped to reflect the New York 405 regulations and would take a function traditionally regulated by the profession and turn it over to the government. Other industries (airlines, trucking, railways) had a long history of having work hours regulated by the federal government. Other countries (Europe, Australia) regulated health professional duty hours—not just residents, but nurses and faculty as well. Other countries restrict duty hours to anywhere from 48 to 56 hours per week.

At the same time, the science of sleep medicine made it very clear that acute and chronic sleep deprivation affects human performance. Although individual variation exists, all humans become impaired after sufficient sleep deprivation. Patient safety requires rested and alert health professionals. (An extensive bibliography on resident duty hours and the sleep science related to acute and chronic sleep deprivation can be found at www.acgme.org.)

In summary, these requirements came about because residents are doing more work in less time with less help. Further, the changes in healthcare delivery were compromising professional values and weakening the foundations of professional self-regulation. New data from sleep science were impos-

sible to ignore. The government stands at the ready should we fail to regulate ourselves. Both the House and Senate have reintroduced companion bills to regulate resident duty hours; New Jersey and Delaware have proposals at the state level. However, for the time being the profession is given a chance to regulate itself.

It is not uncommon for residents to say, "It's really weird how they do things around here." It has been said that "the health care sys-

tem is broken and residents live in the cracks of the broken system—they are the glue that holds it together" (Paul Batalden, MD, personal communication, September 2000). Residents get things done when no one else can. Residents work in microsystems of care, inpatient units, ICUs, emergency rooms, etc. These small units of care, consisting of a few doctors, nurses, a computer, and other health professionals, are the functioning units where health care is

actually produced. In restricting resident duty hours, system issues will be uncovered. It is not likely that faculty will tolerate the system inefficiencies tolerated by residents. Properly applied, the duty hour requirements may provoke changes that strengthen the educational experiences of residents and improve the design of the microsystems of care. Should we fail, more draconian measures outside the profession's control will almost certainly ensue.

Neurology[®]

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Neurology 2004;62;E1-E2

DOI 10.1212/WNL.62.1.E1

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