Resident work conditions under the microscope

This edition of *CJS* has a commentary by Imrie and colleagues[1] from the Royal College of Physicians and Surgeons of Canada referencing the report *Fatigue, Risk and Excellence: Towards a Pan-Canadian Consensus on Resident Duty Hours*[2] that has recently been released by the National Steering Committee on Resident Duty Hours. A large group of engaged physicians and other experts have reviewed literature on the effect of resident duty hour restrictions in relation to patient safety, resident wellness, training and educational outcomes and the educational needs of surgeons. The working group highlighted evidence suggesting bad outcomes in care delivery and training — particularly for surgical specialties — when total or consecutive hours of resident duty are mandated. Restricting the number of hours, which in reality may be a reflection of an increase in the number of handovers in patient care, seems to have resulted in some bad outcomes. Imrie and colleagues comment on recent studies that reported more complications in high-acuity surgical patients and increasing failures in certification examinations with rigid resident hours.

The actual conclusions of this report, as I interpret it, are that a tired doctor may not necessarily be a bad doctor, that there are no conclusive data to show that restrictions on consecutive resident duty hours are necessary for patient safety, that there is no clear evidence that resident duty hour hours have an overall cross-medicine impact on academic performance, and that there is evidence suggesting suboptimal patient care and educational outcomes in surgery resulting from the restriction of resident duty hours. There have been observations that resident wellness suffered owing to longer hours under previous training schemes and that any changes in hours need to incorporate "other" metrics. The National Steering Committee on Resident Duty Hours report is timely, as we enter a phase of determining what is appropriate training or even what defines a normal practice after residency. We are certainly struggling at our national association with the definition of what constitutes a full-time staff member. We are hard pressed to show what constitutes an average call schedule or operating room rotation across Canada. It does seem that most staff surgeons are putting in long hours and doing a fair amount of call.

We are not the only people interested in what defines a normal workload for physicians. Medical working conditions remain a hot topic in the popular media. A recent (Aug. 20, 2013) blog post from the *New Yorker*,[3] "Why doesn't medical care get better when doctors rest more?," by Dr. Lisa Rosenbaum examined her personal experience. In the article, she, and indirectly her physician mother, recount their take on the enforced resident hours and the attendant physician errors they are experiencing. She examines some of the same literature as the National Working Group on Resident Duty Hours and reaches the conclusion that patient wellness has to come first, because that is what happens in practice after residency. Closer to home, *Maclean's* ran a story on a similar subject with an emphasis on the fact that changing the hours worked might have increased errors.[4]

We definitely need to look at how these observations and this landmark report should change the way we design training programs, especially in surgery. I think adding yet another novel layer, such as competency-based training, on top of restricted resident hours will not mitigate the shortcomings of the current system. But something has to be reconfigured. It may be that we need better studies and that the current results reflect inherent bias. However, we need to step up and do something quickly because it seems the patients may be paying a price for our new programs.

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