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Fighting Resident Fatigue

FIGHTING RESIDENT FATIGUE

It has been a wider passage for medical residents to power through the night working around-the-clock to see how diseases progress, but attitudes about the wisdom of this are changing to the work hours of residents needs to be revised. This is the Clinicians Roundtable on ReachMD XM 160, The Channel for Medical Professionals. I am your host, Dr. Lee Friedman and joining me to discuss fighting resident's fatigue and changing the medical residency program, are Dr. Kenneth Ludmerer, Professor of Medicine and History at Washington University in St. Louise and also Dr. Daniel Munoz, a fellow in cardiology at Johns Hopkins University. Both of our guests were members of the Institute of Medicines work hours' committee, which recently published a report that suggested changing medical resident's schedules would help to ensure patients safety.

DR. LEE FRIEDMAN:

Welcome Dr. Ludmerer and Dr. Munoz.

DR. KENNETH LUDMERER:

Thank you.

DR. DANIEL MUNOZ:

Thank you.

DR. LEE FRIEDMAN:

Now, you were both on the work hours committee of the institute of medicine that has made some recommendations about residency work hours. Dr. Ludmerer were there any basic principles in place prior to your committee meeting?

DR. KENNETH LUDMERER:

Prior to the committee meeting, there were principles in place namely the limitation of the workweek to 80 hours by the so called ACGME, the accreditation council for graduate medical education. This regulation went into effect in July 2003. There were also certain regulations put in place at that time regarding the length of shifts that requirement for a day off per week, things of that sort. Our task was to evaluate to the best we could. The consequences of the 2003 regulations and to make any additional recommendations that we thought might be appropriate.

DR. LEE FRIEDMAN:

Dr. Munoz were there things that were felt to still be lacking after these 2003 guidelines?

DR. DANIEL MUNOZ:

Well, so the genesis of our committee and probably the reason why it was performed is because congress commission did formation and asked the Institute of Medicine to form a committee to look at these issues. So, certainly there is evident concern on the part of certain members of congress and also myriad of advocacy organizations and so we were asked the question of, as Dr. Ludmerer mentioned, whether we needed to make further changes or make further recommendations to try to really optimize resident's schedules and with an eye towards of patients safety.

DR. LEE FRIEDMAN:

Dr. Ludmerer did you still find that there were compromises of patients safety and errors being made due to resident's fatigue?

DR. KENNETH LUDMERER:

There certainly was evidence of resident fatigue. We should stress to the public that evidence that patient's safety was influenced by this was essentially non-existent. So, we are operating on the basis of fairness possibility to maintenance. The public should know that evidence that resident fatigue per se is a safety hazard is close to nonexistent and is only one of many, many, many factors that influence safety in the hospital such as the quality of staffing, quality of medical records, availability of x-ray, things of that sort, so it's a tiny part of the safety problem. If it's a part at all. On the other hand, common sense is that you don't want to be abusive, we know from sleep physiology studies that there are predictable points where performance falls off and committee wanted to make some recommendations that were humane and that were consistent with what we know about the needs of human body.

DR. LEE FRIEDMAN:

That's very interesting and very important that the data outside does not really show a significant risk for patient safety, but on the basis of those other things you outlined that these recommendations were made. Dr. Munoz, you just started your fellowship. Are you through with your residency, can you relate some of the issues that residents face because of the long hours in terms of humane living conditions and learning and other issues.

DR. DANIEL MUNOZ:

I can and I should say that you know my personal anecdotes are no more powerful than the anecdotes that any resident or anybody who has gone through residency has and so and I can relate and I think that I can say that I had a terrific experience in residency and it was intense and it was vigorous and it was at times tiring, but particularly as a cardiology fellow now removed from residency. I cherished residency because of everything I weren't and you realize that once you are out during either fellowship or out practicing in the community you really do rely upon the richness of the educational experience that one receives as a resident. It really is a special and unique part of becoming a mature thoughtful Clinician and so I think you know one of our challenges here and one of the contacts that we had to approach this with was, you know, we wanted to draft recommendations that maintained the rigor and the richness of residency and the educational experience while also making it humane and safe for both residents, but also perhaps most importantly for patient.

DR. LEE FRIEDMAN:

Good points, very good points and Dr. Ludmerer what were some of the specific recommendations that your community has made at this point?

DR. KENNETH LUDMERER:

In terms of hours, our recommendations are similar to the 2003 recommendations and that they recommend that a workweek in the hospital not be longer than 80 hours, the lengths of time in the hospital that we recommend for residence is unchanged from 2003. Major innovation is that we recommend a 5-hour nap period if residents are going to remain overnight and work the next day. The big change in the novelty of this report in my opinion is that it's a comprehensive educational document. It's a great mistake to evaluate the residency experience on the basis of the hours in hospital alone. If you want to evaluate residency, as you know, you have been through it, you have to evaluate the total experience as Dr. Munoz points out is it a rich educational experience, what is the quality of education. You have enough patients, but not too many patients. One problem today is that resident's or human form out many patients to be responsible for and is reasonable to expect any human being to be responsible for. We recommend limits and the number of patients. We recommend better supervision. We also recommend much more help in terms of the traditional so called scut work, the chores, the IVs, scheduling, things of that sort, so that the residents can concentrate on the professional duties. This report is a major educational document in this regard because it looks at it's entire experience of residency and it is dampening as it is to look at hours issue when the committee feel that is 1 component of the total package.

DR. LEE FRIEDMAN:

Well put that at least from my experiences, I look back perhaps I did gain some experience watching a particular medical process of congestive heart failure or diabetic ketoacidosis through the night, but then if I didn't get that sleep, the richness the ability of me to learn the next day to appreciate the care of other patients was certainly compromising, as I would fall asleep in teach rounds and very well said.

If you have just joined us, you are listening to The Clinicians Roundtable on ReachMD, The Channel For Medical Professionals. I am your host, Dr. Lee Friedman and with me is Dr. Kenneth Ludmerer, Professor of Medicine and History at Washington University in St. Louise and Dr. Daniel Munoz, a fellow in cardiology at Johns Hopkins. We are discussing how to change the residency experience.

Dr. Munoz, there are some very exciting recommendations that you have made practically speaking I would imagine there are some barriers to implementing these though.

DR. DANIEL MUNOZ:

There are and we came really face-to-face with those in our lengthy deliberation. I think that one thing is crystal clear to those of us on the committee I think that should be crystal clear to those in position of power and influence when it comes to academic medicine and over side of academic medicine residency training is that there is no free lunch and that for the recommendations, the comprehensive recommendation package that we have laid out of the committee for those to have the beneficial positive effect that we intend there is going to have to be an investment and investment doesn't just mean in terms of dollars, but in terms of a culture change in terms of people power and in terms of a real sharpening and a real focusing in on what the residency experience should be for the resident and what it should for patients and their families, who expect and deserve the best of care and so these recommendations don't come free and I think one of the things that we grappled within that we feel I think very strongly about the committee is that the recommendations are to be taken seriously and the investments needed to ensure that they have the intended effect should be taken just as seriously and that one without the other has a potential to do more harm than good and it goes back to the oath we take as physicians to first do no harm and we are to be in the business when we are talking about a system, its complex and is important as the residency training system here in this country, we need to make sure that whatever changes we make are done with the most care and the most thoughtfulness and the appropriate injection of resources and investment.

DR. LEE FRIEDMAN:

I think there is a regular awareness in the medical community about the hours as both of you have said that there is much more truth in that and this has exciting almost paradigm shift that you are proposing. Dr. Ludmerer are there things that we can do so to start raising awareness and changing the attitudes to make these recommendations able to be implemented.

DR. KENNETH LUDMERER:

Well, I think so and I certainly hope so. It involves the financial outlay because of residents still do the work of the hospital someone has to, are required to hire more nurses, blood drawers, to hire other medical personnel, so that residents do not have to see all the patients and I think that to the degree the public is aware that there is an investment we estimated about 1.7 million dollars to support this to let their representatives know and also to encourage all payers that this is for the common good. We don't see this is a responsibility of Medicare and Medicaid along, which were the major finances of residency education. Today, we feel that this is the responsibility of everyone, who pays for medical care because everyone receives the benefits so that <_____> insurers have a role to play as well.

DR. LEE FRIEDMAN:

And Dr. Munoz has anything to add so we can start to do to encourage the people to take a good look at the whole residency process?

DR. DANIEL MUNOZ:

Well, I think this report does that and I think to echo what has been said, what is critically important here is that we realize and I think our report says that hours is about 1 component and that for there to be the improvement in the system that we all would hope an desire for, hours is one thing, but so are the other things that Dr. Ludmerer has tested upon as far as supervision and education. I think 1 way for it to be easily crystallize in all of our minds, as you know Dr. Friedman and Dr. Ludmerer you all have been in medicine as long as I have and I am entering the profession, but one thing that everybody can relate to is that we are all fathers, sons, family members of someone who might become ill and what might we want if we are taking our loved one to an emergency room or to hospital at an academic teaching center. We want any resident or a doctor in training who is involved in the care of a loved one to first of all know their stuff be educated and be primed on the latest and greatest medical care that we have at our disposal. We want them to be appropriately supervised and have easy calls for assistance or help or supervision from there senior residence and from their attending physicians

and we want them finally to be rested in fresh and ready to tackle the diagnostic and therapeutic challenges and hearing and caring for someone and so I think we are one step away from being patients ourselves and I think it's easy to really try to imagine how we would want the system to work if we are on the patient's side and I think that's what this report in our package of recommendations tries to get on.

DR. KENNETH LUDMERER:

If I may add something, there is an in-build on what Dr. Munoz says, there is another dimension to this critical issue of finding solutions and this is a dimension I believe that is particularly important to this audience, which is a physician audience. We in medicine have responsibilities as well. We have to change our culture, this particularly plays out in the area of supervision and important recommendation of the committee is more better supervision. This can be done only if medical faculties value teaching and will not penalize the physicians for spending time as attending physicians in teaching, which very frankly many medical schools do today, now published <_____> environment and residency program directors and faculties have the additional responsibility of creating an environment in which residents are not intimidated or freed to call for help. In the past, as most doctors know, there has been this idea that someone who calls for help is just weak and indecisive that is erroneous and dangerous attitude and we have to work to change the cultures of residents don't fear recriminations if they call for help.

DR. LEE FRIEDMAN:

Very good and I have here in front of me a website www.nap.edu and there is apparently a place we can also get a copy of the report, so I want to very much thank Dr. Kenneth Ludmerer from Washington University and Dr. Daniel Munoz from Johns Hopkins for discussing with us this very important and to me exciting report about how we need to have a kind of paradigm shift and how we look at the residency experience both for the sake of the residence in our patients and in our profession and they make some very I think important and interesting recommendations in their report and I encourage everyone to please look into this further.

This has been the Clinicians Roundtable on ReachMD XM 160, The Channel for Medical Professionals. Thank you very much for listening.