Perspective: **Limiting Resident Work Hours Is a Moral Concern**

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Abstract

The author outlines the cross-cultural and widespread expectation that the moral character of physicians is built on dual possession of skill and compassion. The details of the moral makeup of physicians are often hotly debated in the biomedical literature. Despite a lack of consensus regarding the required aspects of character, the author demonstrates that little debate exists that at a minimum physicians should possess not only knowledge but also a willingness to care for and comfort patients. The primacy of the patient in the physician's life is reflected in the panoply of oaths taken by new physicians despite great variability in other aspects of these oaths. The author details recent worrisome reports demonstrating the erosion of medical trainees' empathy and compassion by long work hours. Further, the continued linkage of these attitude changes and fatigue to poor medical outcomes is a call to action. Changes enacted by the Accreditation Council for Graduate Medical Education to reduce resident work hours are insufficient to achieve the goal of improved patient care while promoting moral development among resident physicians. The debate regarding resident work hours is often framed as an idealistic discussion of placing patients first. However, residents are used as an inexpensive labor force, and efforts to curtail this usage would have a significant economic impact. Economic concerns play a larger part in decision making than is generally discussed. The author calls for further alterations of resident work schedules to improve patient care and ensure the preservation of the moral ethos of medicine.

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"Beep, Beep, Beep . . . ." My first night call as a physician, and I had just laid my head down after a long first day. Feeling well rested after the short time off between finishing medical school and starting my internship in pediatrics, I welcomed this moment. I was a doctor. I would now care for and comfort people, restore hope, and heal when possible. I had entered medical school because I felt medicine was not just a job but a vocation.

Edmund Pellegrino[1] described the physician's role in medicine as "that special claim [that] lies less in expertise than in their dedication to something other than self-interest while providing their services." I was an intern and knew little, but I was dedicated to do all I could to learn the medical arts and care for my patients. I thought that I was prepared for the deprivation of personal needs this task purportedly required. Looking back after completing a pediatric residency and then a fellowship in neonatal intensive care, the compassionate and caring person certainly still resides within me. However, an examination of conscience reveals to me that at times a tired, grumpy, less than professional physician who thinks of doing the minimum possible for patients in order to rest also resides within me. A 4 AM page later in my training more often than not had me wondering what on earth I was still doing at work. I no longer leaped up with the zeal I possessed like that first night on call. I found myself tired, scared, and miserable, and it seemed as if no one cared for my needs. At the start of my day, when I knew I may still have 24 to 36 hours left until I went home, my ability to go the extra mile decreased, in order to conserve strength.

Now that much of my time is spent training future physicians, I get considerably more rest, and late night pages are taken from home instead of some foreign bed in a hospital. I have since come to wonder—why are physicians trained by this method? This leads to a deeper question: are we interested in moral physicians? Does the current system of medical education encourage a loss of morality? Some may wonder whether this represents a moral question. In this paper, I will examine an array of traditions and show that a widely accepted presupposition exists regarding the moral character of the physician. Furthermore, I will provide evidence that one of the declared goals of medical education is the preservation and enrichment of the moral character of trainees. I will then turn my attention to the institution by which physicians are trained in the United States and reveal that organizations, which claim to promote these moral traits, are in fact simultaneously making decisions that hinder the goal of moral development among trainees. In the conclusion, I will suggest a way forward.

Skill and Compassion Are the Cornerstones of Morality in Medicine

The idea of morality can be conceived from many standards. Morality generally means conduct that conforms to the accepted conventions of society with regard to both right and wrong.[2] It is often troublesome when attempts are made at clarifying what constitutes right and wrong, thus making this a difficult term to use. Ethics is a systematized valuing of practices and beliefs aimed at determining what are right or wrong actions. In our value-diverse society, defining what is the right moral conduct

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for physicians can be particularly difficult. Arguments can easily be derailed by the presuppositions the participants bring with them to the conversation. I do not think it would be possible to construct a framework that would allow consensus on a common definition of morality for physicians. However, in medicine there are a few characteristics that are so universal that little ethical inquiry is required to establish their accepted morality or rightness. The two characteristics which spring to mind most readily are that physicians must possess skill in their field and that they maintain compassion and empathy for their patients. For the sake of clarity, skill and compassion are often linked as discussions of professionalism and humanism. However, these discussions frequently do not elevate these two key traits above the panoply of other traits a physician may possess that are merely desirable. Skill and compassion form the foundation from which all the goals of medicine derive their purpose and can be realized. Some take the point of view that compassion and empathy are nice but not required. I ask, then, if compassion and empathy are not part of the moral necessities of the physician, would society view a physician bereft of these as lacking morality? In the next section, I will show that these are not just desirable traits in a physician but that they are expected and required by society.

The Medical Oath: The Physicians' Moral Pledge to Society

Society identifies the Hippocratic Oath—or some variant—as the embodiment of the guiding principles of the physician. Kao and Parsi[3] reported that all accredited allopathic medical schools in the United States administer some oath to their medical students and that about half use the Hippocratic Oath for this purpose. The idea that reciting a few words will empower or embolden a physician in training to do right seems odd at first blush. Is this practice naive? Kao and Parsi note that the oaths differ significantly in content and prohibitions, reflecting the varied ideals of those modifying the original oath or constructing new oaths. What is interesting is that all U.S. medical schools have an oath, and all appeal to the need for both technical skill and compassion for patients. The universality of this oath-taking process in our diverse and multicultural society reflects our desire for a medical community that is ordered in a principled, ethical, and moral manner. The cornerstones of this morality are always skill and compassion. Oath taking in medicine has no real prohibitive strength, but it is a reminder to the consciences of new physicians of the very privileged place they occupy in society and of their need to understand the vulnerable position their patients willingly inhabit for care.

The tradition of oath taking for newly trained physicians is not unique to the United States. Why is it almost universal that society asks physicians to take note of and make the principles of the oaths part of their lives? The moral expectations common to all societies are reflected in this practice. There are many differences among the various religions and philosophies that exist throughout the world. What is widespread among these traditions is the idea that caring for the ill or weak is at the heart of a moral society. Leon Kass,[4] in the introduction to the volume *Being Human* published by the President's Council on Bioethics, notes that efforts to understand what it means to be human and what constitutes human flourishing are at the heart of any serious inquiry as to the role of medicine and its relationship to society. The early philosophers strove to place medicine in a moral context. In *The Republic*, describing an ideal city, Plato[5] acknowledges the need for physicians and goes to great lengths to establish their role in society. He finally articulates that they cannot just be skilled in healing but also must "minister to better natures, giving health both of soul and of body." The Judeo-Christian tradition similarly places the physician in a moral context and eschews the physician's placement in the category of mere occupation. Pope John Paul II[6] reflected this in an address to the World Medical Association in 1983 and admonished the gathering to avoid the separation of medicine and morality and, further, to "rediscover their profound unity." In summarizing his view of the Jewish medical tradition, Elliot Dorff[7] reminds us that "sick people are not simply physical organisms . . . if a physician cannot give his patient medicine for his body; he should make sure that medicine is given him for his soul."

A strong tradition exists in the Western world that places physicians and their actions in the moral framework I have constructed, but what about other world traditions? Damien Keown's[8] examination of the Buddhist tradition reveals that, indeed, the morality reflected in Buddhism and "the practice of medicine have much in common," with both striving for removal of physical and emotional suffering. In S. Cromwell Crawford's[9] examination of the fundamentals of Hindu bioethics, he notes that one of the guiding principles of Hindu medicine is that the physician should possess character, purity of behavior, devotion, and compassion for all. The goal here is not to provide a litany of examples but, through these examples, to illustrate that by most philosophical constructs medicine is more than a body of knowledge; it is a moral enterprise. The simplest and most universal form of that morality is often embodied in the obligation to maintain both skill in healing and compassion for the weak and ill.

The body responsible for establishing U.S. standards for postgraduate medical education, the Accreditation Council for Graduate Medical Education (ACGME), reflects the general acceptance of this definition of medical morality. The ACGME's enumeration of core competencies for residency education note that medical knowledge and skill are required but also that resident physicians are to demonstrate "compassion . . . and respect for others [and] responsiveness to patient needs that supersedes self-interest."[10]

Burnout Threatens the Caring Impulses of Empathy and Compassion

Why, then, when I completed my training, did I not still feel the same compassion and sense of duty that I once did? Compassion remained but in a much attenuated form. Was it me? Recently, in *Academic Medicine*, Newton and colleagues[11] demonstrated an appreciable decline in measures of empathy among medical students as they progressed through medical school. Although it is unclear what precipitated the loss of empathy, the authors postulate that the stress of medical education and the competitiveness of medical practice are partially to blame. It is noteworthy that this study followed undergraduate

medical students; most physicians would acknowledge that the most difficult point in medical training is just after medical school graduation—that is, residency. Postgraduate medical training represents the point at which few breaks occur, longer hours begin, both night call and clinical rotations are nearly ceaseless, and, importantly, the level of personal responsibility is ever increasing. Fahrenkopf and colleagues[12] recently published a report demonstrating high levels of depression and burnout among medical residents. They further correlated increasing numbers of medical errors with depressed and burnt-out residents. Fahrenkopf's findings are mirrored in published work from other research groups.[13,14] Taken as a whole, studies suggest that medical training is not only difficult but that it also contributes to physicians' loss of empathy. Many may argue that this is a required by-product in the quest to develop competent physicians in a highly technical field. Unfortunately, as discovered in the studies above, burnout and loss of empathy are intimately linked with medical errors. This begs the question: is the acquisition of medical knowledge and skill at odds with maintaining compassion?

Work Hours Changes—Too Little of a Cure?

In 2003, the ACGME established a policy of no more than 80-hour workweeks for medical residents, no shift longer than 30 consecutive hours, and at least one full 24-hour period off per week.[15] Previously, there were essentially no restrictions on resident work hours, and workweeks routinely extended beyond 100 hours. Medicine has been slow to respond to significant evidence that long hours hinder patient care. Only after the Institute of Medicine's landmark report *To Err Is Human*,[16] which identified resident exhaustion as a cause of numerous medical errors and a subsequent threat of federal regulation governing work hours, did the ACGME act.[17] Why? And was the response sufficient?

Medical educators sometimes confront competing and conflicting goals. The goals that are often preeminent are taught not through policy statements but through the actions of those teaching. This is frequently referred to as the "hidden curriculum."[18] Those no longer in training often idealize residency as a time when true dedication to learning and patient care was demonstrated. This was done through long hours of toil on the hospital wards and clinics. Often, the implied lesson teaches that admitting quickly, seeing more clinic patients, discharging patients home, fudging work hours to stay longer, and being in the operating room are the valued traits. These activities teach skill. Taking time away from these is seen as only harmful to a physician's development. The documented loss of empathy among trainees is significant and powerful evidence that we are not imbuing in our residents a love of medicine which manifests as compassion and empathy for their patients. Instead, our system of education sets up a confrontation between the personal needs of the trainee and the medical needs of the patient. Compassion is universally accepted as a key element of the moral make-up of the physician. Why, then, do we treat it as a dispensable commodity and allow for its erosion during training?

Are Medical Educators and Staff Physicians Protecting Education or Lifestyles?

It is clear that economic and lifestyle concerns play a large role in American medicine's reluctance to address the effects of protracted resident work hours. Frequently, refusal to alter this system is characterized as an attempt to protect resident education. This may be the case; however, education is frequently not the only issue at play. Mitchell and colleagues[19] reported their analysis of further reduction in resident work hours recently in the *Archives of Surgery*. Interestingly, they concluded that decreasing resident work hours further would require "large amounts of human and fiscal capital." This conclusion cuts to the heart of why medicine is resistant to changing the system of training: it would be costly because it would require a larger work force. Residents contribute significantly to the operations of teaching hospitals. Nearly half of all inpatient admissions in the United States occur in teaching hospitals with residents doing much of the work in the care of these patients.[20] With a decrease in resident staffing following the 2003 work hours changes, a number of publications have noted the detrimental effect on faculty lifestyle.[21,22] A seemingly simple solution might be to increase the number of residents, ultimately leading to a larger workforce. However, medical school slots and postgraduate medical education training slots are federally subsidized, and this in turn dictates how many physicians are trained in the United States.[23] This workforce is calibrated to meet the medical needs of society but is balanced against a number of competing interests, one of which is physician salary. The Council on Graduate Medical Education was authorized by Congress in 1986 to provide an ongoing assessment of the physician workforce and to make recommendations to the Department of Health and Human Services secretary and to Congress as to policy that should be pursued.[24] The council's efforts are a major determinant of the number of training spots available in the United States. A look at the minutes from the most resent meeting held by the council on May 9, 2008, shows that physician earnings are one critical consideration in their policy recommendations. At that meeting, Dr. Sean Nicolson, professor of economics at Cornell University, made a presentation that was summarized as detailing

> the Federal involvement on issues related to the numbers and/or specialty mix of physicians, and presented arguments for government involvement in these issues. He detailed the findings of past studies which indicated that prospective physicians respond to changes in expected earnings. . . . He concluded that, while not the primary factor in influencing specialty choice, money does matter.[24]

It is important to note the vested interests of physicians. There is a great fear that increasing residency spots to ameliorate the problems with excessive resident workload could have a detrimental effect on physician pay and specialty mix.[25,26] An expanded pool of physicians could mean lower wages and could drive a continued trend toward specialization in lucrative fields. These changes could also impact medicine's ability to attract the best and brightest. These are valid concerns, but they do not negate the argument that the current system has severe flaws, which can hurt both trainees and patients. It is also true that many of these issues are beyond the control of the average, practicing physician. However, this fact does not mean we are just passive observers of this process. Most physicians belong to professional societies

whose sole purpose is to advocate for the views of the group. Making our colleagues and advocacy groups aware of our concerns is the first step we can take. When standards of living are guarded to the detriment of the ill and weak, it is hard to argue that the current system preserves our moral values.

Daily Sleep Should Be a Priority for All Residents

Countless staff physicians decry the alterations in work hours enacted by the ACGME. The complaints often leveled are that these changes turn physicians into factory shift workers, with the unspoken presupposition that factory workers cannot perform their jobs with dedication and commitment.[27] Further work hours restrictions are seen as escalating the odds of medical errors, with increased numbers of transitions of patient care, despite a lack of any empiric evidence to back this claim.[28] And, most physicians, including myself, worry about the impact on clinical exposure during training.

The reality is that this is a zero-sum game in which a reduction in work hours for residents will mean an increase in work hours for someone else. I agree that medicine is not factory work in which the production line can be stopped when the whistle blows at the end of a shift. However, to ignore the human needs of patients and physicians seems inexplicable. Significant evidence exists that patients are injured by medical errors that occur because of exhaustion and that these errors are compounded by desensitized, nonempathic physicians. Further, it is clear that even current restrictions are not enough to prevent this harm. I believe that we in the United States have not gone far enough in restricting work hours. Medicine, despites its current love of evidence-based practice, has ignored compelling research that protracted periods of sleep debt, circadian disruption, and sleep deprivation are more than minor irritants and severely limit human performance.[29,30] Ignoring the findings of sleep science places patients at risk in ways that would be intolerable if similar evidence existed regarding harm from a medication or treatment.

It would be nearly impossible to completely eliminate sleep disturbances and fatigue from medical training, but that does not mean it should not be our goal. Sleep and rest are essential human functions. The need for sleep cannot be overcome by force of will. Look out at any gathering of residents in a conference or morning report and, assuredly, someone will be asleep despite his or her best efforts. The primary goal of any changes made should be to ensure that, at a minimum, we no longer tolerate any system that does not allow for daily sleep. Adjusting schedules to decrease extended (24–30 hour) shifts should become a priority. Understanding and focusing on the issues of sleep and human performance should not be seen as pursuits of the weak but as a common concern to all.

Medicine Is a Moral Pursuit

My presupposition is that medicine is a moral enterprise. This sentiment is shared across a large swath of traditions both religious and philosophical. Unfortunately, despite this, the American system of medical training ignores evidence of undermining key components of the moral character of physicians at the start of their careers: empathy and compassion. Those of us in medicine can site examples of colleagues who withstand these rigors and seem to do right and well at every turn. However, the average physician rarely is able to consistently maintain him- or herself as a moral exemplar through the process of training.

The cure is not simple and not without side effects. As physicians, we constantly balance the risks of our treatments against the benefits of possible cure. To preserve the humanity and morality of our trainees, we must recognize first their humanity and, therefore, their human needs. Sleep, time with family, and time for leisurely pursuits are not frivolous. These things allow for an appreciation of life. Being in full possession of an appreciation for life helps us see the pain and suffering that may be occurring in others. This is especially salient when we accept as our purpose and oath in medicine the alleviation of pain and suffering. Technical skill is important, but being fully in control as to when and where to apply that skill is the art of medicine. Driving empathy and compassion from our field makes us more like automatons than shift work ever could. To fix the American system, we need to further reduce work hours because the current standards do not meet the means they hope to achieve. This may result in unwanted problems, but these are far less detrimental to our ultimate goal than persisting in our current flawed system. We will need to find workable solutions to the risks imposed by further restriction. The preservation of the expected common moral character of physicians requires that we acknowledge the empiric evidence that exists and change how we operate.

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Disclaimer

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Teaching and Learning Moments

Understanding

> Life is a succession of lessons which must be lived to be understood.
>
> —Ralph Waldo Emerson

"But you don't understand, just tell me. Yesterday I was there, today I'm here. You don't understand."

Mr. Jones (not his real name) was a 65-year-old man with metastatic lung cancer admitted to the nursing home for palliative radiotherapy and possible chemotherapy. Cigarettes, long a staple between the second and third fingers of his right hand, had discarded their friendship and turned on him. He needed help, but lived alone and could not survive on his own. His sister brought him to the hospital, then the nursing home; she related that 72 hours prior to admission he had developed confusion, and she could no longer care for him. His medical chart indicated a probable diagnosis of brachial plexus involvement secondary to tumor invasion, and, aside from scheduled hydromorphone, he was also receiving gabapentin for neuropathic symptoms and salsalate for boney involvement.

"Hi Mr. Jones, I'm Dr. Rousseau."

"You don't understand, I'm trying to tell you, you don't understand."

"What don't I understand?" I asked.

"I'm trying to tell you, you don't understand." His face frowned with the wrinkles of frustration.

"I'm trying to understand, Mr. Jones."

I proceeded to tell him where he was, who we were, what we were doing, and what we were going to do. But to no avail—after mumbling some incoherent words which escaped my ears, he repeated his refrain, "You don't understand."

As the days passed, I began to ponder Mr. Jones's words, "You don't understand," and one day while tossing aside the paternalistic cape that we often wear as physicians, I realized he was right: I don't understand. Although a loved one died last year and left me emotionally destitute and clearly more understanding of illness and loss, I was not the sick one; yet even with my personal and professional closeness to disease, I had not experienced what Mr. Jones was experiencing. And though yes, he was delirious and not totally aware of the veracity and certainty of daily events, I clearly did not understand what he was going through. Granted, this was not the intent of his words, but as I thought about it, the underlying truth became evident: as physicians, we oftentimes do not understand what our patients experience and sequester within the confines of confronting their withering mortality. We don't understand the fading of tomorrow's light, the torment of regrets, or the loneliness of sickness, nor can we be expected to unless we have personally experienced the lessons of humility and the absence of morning.

But I also believe that physicians can still go to the precipice of a patient's illness or loss and offer a consoling empathy, a magical presence, a comforting silence, a promise of nonabandonment—tools of caring in a world of hygienic technology. And by giving of ourselves—through empathy, presence, silence, and nonabandonment—the real meaning of medical practice can be suddenly illuminated, forcing us to acknowledge what our work means in terms of hidden personal meanings[1]: healing in the truest sense, even in the presence of death.

I think Anatole Broyard[2] said it best in his wonderful book, *Intoxicated By My Illness: And Other Writings on Life and Death*, written while he was confronting metastatic prostate cancer: "To the typical physician, my illness is a routine incident in his rounds while for me it's the crisis of my life. I would feel better if I had a doctor who . . . would . . . be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way." Effective, yet forthright and sublime in its simplicity.

Or, as Winston Churchill once observed, "I do not ask how the wounded person feels. I simply become that wounded person."

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