Go Home, Someone Else Will Do It

Post Date: 10/28/2004  
Author: Ferdinand D. Yates, Jr.  
Issues: Healthcare

July of 2003 marked an important milestone (and perhaps millstone) for hospital residency programs, when the Accreditation Council for Graduate Medical Education implemented final changes for the 7,800 medical residency programs that it oversees. The council introduced guidelines stating that medical and surgical residents could work no more than 80 hours a week (with certain variations for some surgical programs) with a 10-hour break between shifts, and no resident was to be on duty for more than 24 continuous hours. The history of the issue dates back to 1984, when Libby Zion’s father brought suit against New York Hospital regarding the death of his daughter. The prosecution asserted that Libby’s death was due to substandard care and preventable medical error by a fatigued, overworked hospital resident who was too tired to perform her duties properly. Eventually allegations of malpractice were dropped, the doctors were not accused of wrongful death, and the plaintiff settled for an award of $375,000. The case initiated a veritable firestorm of allegations and insinuations regarding the competency of the medical residency system, juxtaposing it with the issue of preventable medical error.

Many physicians learned their trade under the age-old “see one, do one, teach one” methodology of teaching. This system of education should not only be maintained, but also endorsed; one can only learn so much medicine and therapeutic options from the written page. It has been said that “the hospital is a poor setting for learning the natural history of disease or how to care for the patients.” I posit, rather, that the hospital setting is a necessary part of medical training regarding certain aspects of disease progression.

In 2000, the Institute of Medicine reported that between 44,000-98,000 Americans die annually from medical error, and several studies have examined the problem. A population study done in New York (Leape et al., 1993) revealed that the two medical-surgical areas causing the highest percentage of adverse effects were operative error and drug-related issues. A study done in Utah and Colorado (Thomas et al., 2000) confirmed the same breakdown of errors leading to adverse effects. In addition, both studies identified the Emergency Department (ED) as a surprisingly low percentage of adverse effects (2.9% and 3.0% respectively). Interestingly, however, the ED
constituted the highest percentage of either preventable adverse effects, or cases with identifiable negligence (93.3% and 52.6% respectively). This data does not necessarily support the claim regarding the issue of fatigued overworked residents. There are a myriad of other possible explanations: complicated cases with difficult technical aspects, patients with multiple medical conditions, or an already over-utilized ED that has to deal with an overwhelming civic disaster. A fatigued resident is but one small cog in the wheel of medical care and distribution of services.

We must recognize the interfacing of the three principal parties (patient and family, physician, and hospital staff) and the interplay that arises from changing the system. Issues regarding fatigued residents notwithstanding, there are indeed other aspects to consider. Is adequate nursing and support staff in place? Is the volunteer staff being used appropriately? Can we get procedures done in a timely manner? What about pharmacy services? Can transcription services be more expeditious? Do we need to be concerned with the penmanship, abbreviations, and/or transcribed order? Fatigued medical and surgical residents are clearly only one part of the huge medical machine.

The primary justification for the changes in residency programs was from the concern that medical and surgical residents, when fatigued, were alleged to place patients at undo medical and surgical risk. I applaud these changes, as I know firsthand the difficulty of residency prior to these implementations, having been on duty far more than 24 continuous hours during my own pediatric residency. But by working the same ward for a week at a time while I worked on the intravenous lines team allowed me to provide continuity of care, learn good skills and recognize errors of judgment in my technique, and have the opportunity to learn more about the process of a medical disease. The fractioning of patient care (through shift work and the multiplication of medical personnel involved in a patient’s care) not only leads to a dissolution of knowledge, but also presents the possibility that continuity of care with appropriate follow-up may not be realized, not to mention leaving many patients unhappy and unconfident with the day’s proposed care when there isn’t a continuity of care. Under the newly proposed system, when the shift is up, the resident is often escorted to the door. The resident is not allowed to stay for rounds, case discussions, autopsy, or surgery?where typically, much learning is provided through the follow up, and continuity of care is discussed. The young doctor maintains pictures, lessons, and experiences that will last a lifetime.

The medical system of teaching, training, learning, and doing is a most unique opportunity. The system in place allows an inexperienced individual (a hospital resident) to touch an indisposed individual (the patient) at a weak moment for the purpose of personal gain for the former without any promise of benefit for the latter. Supposedly, the inexperienced individual is under the watchful gaze of the wise and experienced superior, though in the past, this was not an absolute guarantee. The new regulations attempt to correct this issue. How many times have any of us explained, to those who have placed themselves under our care, that the purpose of a ?teaching hospital? is to teach those who will follow as the next generation of health care providers?

More immediately, how do we, as practicing and caring physicians, maintain the trust of our patients as we (at the same time) pass on the Hippocratic tradition?to those who are following in our footsteps?that is germane to our profession? The hospital system has a rich history as a teaching environment. How do we police a bastion that has good qualities but may be in need of
Our professionalism is at stake with this issue. Guardians of care may convert to guardians of time. Doctors are very much in tune to the issue of patient autonomy. Doctors are also becoming increasingly accosted by the ?informed demand? that many patients bring to the examination room. The ethos of ?someone else will do it? may take on a life of its own. Doctors may truly find it easier and less demanding to acquiesce to patient demands rather than insist on a less glamorous alternative. ?As patients are increasingly recognized as consumers of health care and physicians as its producers, physicians are more willing to abandon a tradition of service for an industrial work ethic.? 2 The doctor-patient relationship truly is at stake, and one must consider how these subtle changes will effect communication and quality of care. As these changes take place, we need to consider the following:

1) We must be careful not to allow a personal agenda or personal bias rule the day. ?Libby Zion?s intern at the time was simply too inexperienced to properly care for the patient, to recognize when someone needs more that a posey and Demerol? 3 ?she was not incapacitated by the lack of sleep;

2) We must interpret medical data in an accountable and reliable way that does not infer either misinterpretation or inadequate interpretation (understanding the medical error is caused by more than just fatigue!);

3) We must be willing to change if new information presents itself (scientific research should always acknowledge legitimate new information);

4) We must measure the success of the new policy (the Bell commission should be preparing a follow-up study of the newly-implemented policies);

5) and we must be willing to admit that a new policy may not be accomplishing all that was hoped (there are many reasons for medical error, and it is possible that multiple issues will affect the desired corrective process).

It is said that every action has a reaction. Change may indeed be worthwhile; however demanded change may not be either appropriate or correct. We must not only be caring and protective, but vigilant and ethical. Our medical professionalism is at stake

References


Holzman, Ian R. and Scott H. Barnett, ?The Bell Commission: Ethical Implications for the


3 Lawrence Martin, M.D., from ?The House Office?s Survival Guide: Rules Laws, Lists and Other Medical Musings.?

This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivs 3.0 United States License.

Source URL (modified on 07/26/2011 - 14:15): https://cbhd.org/content/go-home-someone-else-will-do-it