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The Disappearing Doctors

Reduced residents’ work hours sound fine until the residents—now a legion of shift-worker physicians—are rushing out the door or aren’t there.

by Janet R. Gilsdorf

The pediatric infectious diseases (PID) team assembles in the hallway for rounds here at the children’s hospital where I have worked for twenty-five years. I’m the attending physician during the next two weeks, and the other team members include the PID clinical fellow, two pediatric residents, a medical student, and two pharmacy students.

“Where’s Diana?” I ask. Diana, a second-year pediatric resident, is doing a month-long elective on pediatric infectious diseases. On Monday afternoons and Wednesday mornings she is at her primary care continuity clinic. Today is Tuesday. She should be here.

“She was the night float on hem-onc last night, so she’s home now,” the PID fellow says, using hospital shorthand for hematology-oncology. “She’ll be at her continuity clinic tomorrow morning and then here tomorrow afternoon.”

“Well, where’s Don?” I ask. Don, a third-year pediatric resident, is also taking an elective with PID this month.

“He had to cover the ICU [intensive care unit] today because of some glitch in the schedule. He’ll be here tomorrow morning and then gone to his continuity clinic tomorrow afternoon.”

Missing Residents

Both residents working with the PID team are elsewhere today. They aren’t available to examine their patients, to learn about new symptoms from the parents, to review the results of the most recent lab and radiographic tests, to review the nursing assessments for the past twenty-four hours, or to make recommendations for ongoing care for their patients. The PID fellow tried to do their work today as well as her own.

Residents like Diana and Don—young physicians learning to be clinical specialists—have long been the mainstay of medical care in teaching hospitals. Because residents traditionally worked in hospitals in the name of receiving education and because altruism is a hallmark of doctors, physicians-in-training have provided a

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considerable amount of clinical care while working long hours for relatively short pay. What’s going on here? Why aren't Diana and Don on PID rounds as they were supposed to be? It's the result of cockamamie resident physician work schedules that look more like Bingo cards than a comprehensive system for providing coordinated medical care or educating future medical specialists. The erratic schedules are the unintended consequences of the new rules on resident work hours.

In 2003 the Accreditation Council for Graduate Medical Education (ACGME), which accredits U.S. medical training programs, instituted rules for resident work hours, sometimes called “the eighty-hour workweek”; the new rules limit residents’ duty hours to no more than eighty hours a week. These rules govern the working conditions of the 100,000 young doctors-in-training in teaching hospitals across the United States and were developed both to protect patients from potentially unsafe medical practices by sleep-deprived physicians and to improve working and learning conditions for residents. The work rules, among other stipulations, limit both the number of consecutive days in a week and the number of consecutive hours in a shift that a physician-in-training can work; in addition, the rules require rest periods of at least ten hours between shifts.

Nobody wants procedures or important decisions to be made by exhausted, blurry-eyed, muddle-brained doctors, so the intent was to form medical teams that would work in rotating shifts, thus providing the physicians with adequate time off. As a result, several times a day, responsibility for patient care shifts as it is passed from team member to team member. Although several studies suggest that compliance with the new work rules reduces wandering attention on the part of the residents, might reduce actual or near-miss car accidents involving exhausted residents who’ve worked extended hours, and appears to reduce serious medical errors in ICUs, other studies are ambiguous about the outcomes of the rule changes. Furthermore, the validity of the methods and analyses in these studies and the generalizability of the results are open to discussion. In short, the total impact of the new rules on physician performance and learning, as well as on patient care and safety, remains largely unknown.

Sprinting Through Care

S o we begin our rounds without Diana and Don. Today, like every day, we’ll design therapeutic strategies for very sick children who have rare or complicated or difficult-to-treat infections. Many of these children have compromised immune systems caused by an accident of nature or by chemotherapy for cancer or by immunosuppressing drugs to prevent a transplanted organ from being rejected. As we walk through one of the wards, a first-year resident stops me in the hallway.

“Dr. G, could I ask you a question?”

“Sure.”
“We have a patient with hypogammaglobulinemia and a protein-losing enteropathy. Should we continue his IVIG and trim-sulfa?” The resident has just described, in these few words, a patient with low antibody levels, most likely because too much protein, including antibodies, is passing into his stools. She’s asking if the child should continue to receive intravenous immunoglobulin therapy to replace the antibodies and if the child should continue to receive the antibiotic trimethoprim-sulfamethoxazole.

“Well, that’s complicated,” I answer. “For starters, how old is the child? Why does he have a protein-losing enteropathy, and how long has he had it?”

The resident shuffles the papers in her hand. “Um, I really don’t know him very well. I’m just cross-covering because his primary resident is ‘post-call’.” Translation: She’s filling in for the patient’s resident physician who was on duty overnight and, because of resident work hour rules, is unavailable today.

“I can’t begin to answer your question without knowing the details,” I say. “Why is the patient on the trim-sulfa, anyway?”

“Don’t know.”

“Will you be calling in our team to consult about this patient?” I ask.

“I don’t think so. The senior resident told me to ask you about it.”

“Well, I can’t make recommendations about stopping treatment until I understand the whole situation. Put in for a consult and we’ll figure it all out.”

Is she a bad resident for asking me for a recommendation on a patient I don’t know? No; like all residents, she has been given responsibility for the care of a very ill patient during the current eight- or ten- or twelve-hour shift, but she didn’t take care of him yesterday and probably won’t take care of him tomorrow. She doesn’t know the full story of this patient’s recent illness, doesn’t know the long-term plans, and wasn’t part of the previous decision making to design the patient’s current treatment. This resident is filling an open shift in the schedule, and her goal is to place a check in the box beside the item on her list that says, “Ask PID about stopping IVIG and TMP-SMX.”

Is this a bad hospital? No; stop-gap measures designed to provide physician care to all patients around the clock, seven days a week, are found in every teaching hospital in the United States. By limiting the number of work hours of each resident, however, the new ACGME rules have effectively decreased the hospital’s resident physician workforce by 25 percent—in other words, a full quarter of them have gone missing.

The problem is that losing 25 percent of the workforce hasn’t been accompanied by hiring additional physicians. As a regulatory agency, the ACGME issues mandates to ensure that young physicians receive excellent clinical training; it usually doesn’t approve adding increased numbers of residents to a training program just to plug a hole in a hospital’s need for clinicians.

A hospital’s inability to increase the number of resident physicians isn’t the only barrier to improved staffing—most hospitals can’t afford increased numbers of
residents anyway. At the same time that the new rules have come into effect, the resources to pay for medical care are vanishing. Medicaid and Medicare payments for health care services are decreasing, and insurance payments are following this lead. Furthermore, more and more patients—forty-seven million currently—have no insurance, which means that they don’t pay—because they can’t pay—the bill. Although so-called physician extenders (such as physician assistants and nurse practitioners) might take on some of the tasks of the missing physicians-in-training, nursing practice isn’t medical practice; even advanced practice nurses or physician assistants haven’t had the comprehensive training required to be good doctors. In addition, many physician extenders command salaries similar to those of physicians-in-training yet work only forty hours a week; hiring them as replacements would mean a 100 percent increase in costs.

**Keeping An Eye On The Clock**

*We continue our rounds and enter the staff room, where an intern, seated at a laptop computer, is feverishly keyboarding a progress note that documents the current status and treatment plans of one of his patients.*

A senior resident enters. “What are you doing here?” she asks the intern.

“Finishing up my notes.”

“You can’t do that. You’ve got to get out of here.”

“But, the notes...”

“I’ll do them for you. Make a list.”

“I also wanted to check the rash on the kid with Kawasaki disease...”

“You can’t. You’ve got to go home.”

Apparently the intern in the staff room is up against the limits of the work rules and has been told to leave the hospital. There’s no wiggle room. The ACGME requires training programs to report the actual hours spent in the hospital; it leaves it up to the training programs to figure out how to get the work done in the time allotted. If the intern continues on duty beyond the dictates of the rules, our training program might be cited for noncompliance. The penalty for too many citations: probation for the training program or possibly withdrawing the program’s ACGME accreditation. A training program on probation or without accreditation has an extremely hard time attracting excellent resident physicians.

We proceed to the next ward. There we meet another resident who, earlier, had submitted a request for a PID consultation.

“Let’s talk about the boy admitted last night with the neck mass,” I say to her.

“Yeah...tell me what to do with him,” she answers.

“Rather than my telling you what to do, let’s think it through together so you’ll understand how to do work-ups of kids with cervical lymphadenopathy.”

“I don’t have time for that. Please, Dr. G, just tell me what to do.”
Unintended Consequences

Besides ensuring excellent medical treatment for patients, the ACGME work rules were intended to keep residents alert so that they could fully engage in the work and education needed to become fine physicians. The rules, however, are backfiring. Residents no longer are able to observe the timing of a patient’s response to an intervention; they can’t follow the tempo of a fever or the bloom-and-fade cycles of a rash even when, as responsible physicians would, they sincerely want to. Their heads are crammed with the facts they’ve learned during medical school, but they can’t see firsthand the course of a birth or a gall bladder attack or the phases of recovery from a surgical procedure and then integrate those facts into informed decision making. Instead of producing physicians with high professional standards who see their patients through to the end (of labor, of an operation, of an illness, of a life), the current system is creating a legion of shift-worker physicians who leave when the clock strikes a certain hour rather than when the job has been completed.

In evaluating their training programs, residents often ask for increased autonomy. They realize that in the future they’ll be solely responsible for the care of their patients, and they worry that without a certain amount of autonomy during their training, they won’t be adequately prepared for independent decision making. Yet with their current here-today-and-gone-tomorrow schedules, they can’t be given increased autonomy—they won’t be around for the next step or haven’t been around for the last step. They don’t have the big picture.

The children’s hospital where I work contains what I consider the world’s most precious treasure: children who are the future of our society. The other great treasure in my hospital is the young physicians of tomorrow who will carry forward our medical values, traditions, and practices. The reason that the doctors at my children’s hospital are disappearing or aren’t there when they’re needed is, simply, inadequate resources to compensate for the restrictions of the new work rules and the resulting workforce reduction.

It’s always about the money. In terms of the new ACGME regulations and providing medical care for children, we (meaning our society) can’t seem to figure out the money part. Yes, to some extent, we might be able to work “smarter” with new technologies and information systems. Yes, we need to figure out how to streamline communication among the many team members. Indeed, we need resources to create real teams.

As we consider how to allocate medical and educational dollars, the question becomes, What’s more important than healthy children and well-educated physicians? We know the answer: Nothing. But when the next question is, What are we doing to meet the challenge of having enough doctors for enough hours in all of our hospitals, we also know that answer: Nothing.