

CIR, AMA-RFS, and CMA-RPS Sponsor Conference Hours Workshop Draws Residents from Across California

"Thank you for a wonderful Sunday." With that last comment from a California intern, the November 2, 2003, workshop entitled "How Can Residents Make Hours Reform Work?" came to an end. The day-long, problem-solving session was held at Harbor-UCLA Medical Center in Los Angeles, jointly sponsored by the CIR, the AMA-Resident Fellow Section (AMA-RFS) and the California Medical Association-Resident Physician Section (CMA-RPS). The event attracted about 40 residents from 14 California hospitals, as well as housestaff and medical school leaders from Chicago, New Jersey, Boston, Washington, D.C., Arkansas, and Kansas.

After an early morning welcome by Dr. Tony Blaine, CMA-RPS president, CIR President Ruth Potec, MD, traced the resident activism that created enough pressure to finally convince the ACGME to institute new resident work hours limits, which went into effect July 1, 2003. Dr. Maurice Sholas, AMA-RFS President, prepared participants for the day's work, explaining that the morning session would focus on "What keeps us in the hospital so long?" and the afternoon on sharing 'best practices' for reducing resident hours (see box, facing page) and on how hospitals and programs are responding four months into the new ACGME rules.

Have the ACGME hours limits been a positive change? The answer from workshop attendees was a resounding "yes." Participants reported returning to the hospital refreshed after leaving post-call; getting regular days off; uncovering hospital inefficiencies; learning to do better sign-outs; seeing a nationwide increase in surgery applications; and recording patient satisfaction improvements when hospitals hired physician extenders.

Are there problems with the way the new rules have been implemented that need addressing? Again, the answer was an overwhelming "yes" from workshop participants.

"We all think that we are supposed to work all the time and never leave the hospital. We all feel guilty," said CIR Regional Vice President Arun Chopra, MD, a Pediatric Critical Care Fellow. "The truth is we need to change the way everyone practices medicine. These new pressures on attendings will force them to press for change. And those changes will require more money in the system. It's exciting to be in this room today. We're witnessing a real change in the culture. We'll look back 20 years from now and say,



"We were a part of making that happen."

Charles Mashek, an AMA-RFS delegate, agreed. "It's exciting that residents are coming together from all across the country in a way we never did in the past. There are no quick fixes. We're going to have to find a way to make it work. But no more just talking about it—we're doing it!"

Residents Talk About What Works (And What Doesn't) for Hours Reform

Whether hours reform is deemed a success or failure will depend on how hospitals choose to put the new guidelines into practice. Here are some of the most recent data, shared by residents from a variety of hospitals—on the roadblocks and winning strategies for hours reform.

Hospitals Need to Allocate New Resources—Almost all of the residents reported that their hospitals had not provided additional funds to bring their training programs into compliance with the new hours rules. One resident from Olive View Medical Center echoed the remarks of many during the day when she pointed out that, "Resident resentment comes when a program thinks that just by shifting work to other house officers or devising a 'creative schedule,' the hours problem will just go away. No, the problem doesn't go away. Either the work load has to be reduced or more people have to be hired to do the work."

Residents' Views Must Be Included—but often are not. A show of hands revealed that only about 50% of the residents were involved in devising plans to meet ACGME compliance at their hospitals. About 30% said only chief residents were involved, and 20% reported zero resident involvement. As a result, some participants reported that the original scheduling changes made for July 1 in their programs had to be altered because residents were unhappy and/or the changes caused more problems.

Success Depends on Strong Leadership from Chief Medical Officers and Program Directors. "When the program director says, 'You must do this—it's not a choice,' then things change," noted one Loma Linda Medical Center resident. Or as another participant put it, "If the Chief Medical Officer isn't on board—you are screwed."

Focusing on Hospital Efficiency Wins Support and new resources for hours reform when residents can show improvements in patient care, and overall efficiency. One resident described how Anesthesia residents in his hospital were routinely starting cases at 8 a.m. instead of the scheduled 7 a.m. Investigation revealed that the residents had to wait until the cafeteria opened at 7 a.m. to get breakfast (knowing that they would probably be stuck in the OR and miss lunch). The cafeteria began opening at 6:30 a.m. and then cases began on time.

Ancillary Services, Ancillary Services, Ancillary Services—They shorten a resident's

Best Practices—Thinking Outside the Box

Here are some of the best practices participants of the November workshop described to their colleagues. CIR members have a big advantage, with greater ability to be part of the decision making at their hospitals when it comes to implementing best practices.

Procedure Team—A designated surgical team which responds quickly to the need for patient procedures. Team members rapidly improve their skills and their log book numbers, while remaining residents save valuable time in their day; patient care needs are often attended to more quickly.

Elective Surgery Cases Assigned by Resident Schedule—Elective cases are booked based on the surgical residents' on-call schedule, so that residents will be able to maximize their time in the OR doing the cases they need for their training; by concentrating hours, residents are more rested and better able to learn at other times.

Day Float System—Tuesdays through Fridays, the Day Float Team takes the first admits of the morning, so that the other residents don't have to come in to work until 10:30 am.

Night Float Expanded to 7 Days—Night float gets one guaranteed day off a week, when the resident on Rheumatology elective is pulled on Thursday nights. Saturday and Sunday nights, the night float only has to come in if and when the ward team 'caps' (this could be at 4 am).

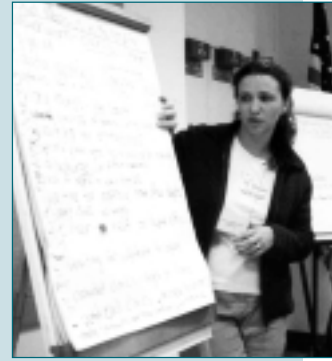
Rounding With Post-Call Resident First—Hospitalists rounds first individually with the post-call residents; then with the rest of the team. This helps to get the post-call resident out as early as possible and give some extra time for the other residents to do work before rounds.

Rounding with Attendings between 9-11 PM—Granted, by moving away from the traditional morning rounds, this constitutes a major change in attending physician culture. But residents who have tried it say there are several advantages: increased hospital efficiency (by allowing the team to get a big jump on the next day's discharges); and evening out resident workloads and teaching time so that more is accomplished during non-prime-time hours.

Rounding with a Laptop Computer—Providing each team with a laptop computer that can be wheeled from one patient to another in order to write discharge notes and orders at the bedside greatly speeds up the paperwork that residents are deluged with.

Schedule < 80 Hours—Base schedules on 60 hours per week, not 80. By not cutting the schedule so tight, residents then have the flexibility to attend conferences, stay for a case or to follow an interesting patient.

Hire a 'Resident Assistant'—Residents at D.C. Children's Medical Center took a cue from Johns Hopkins and convinced their hospital to hire two resident assistants to help housestaff with discharge paperwork, ordering tests, etc.



"After rounds, all the housestaff used to dive for the phones to call Radiology and order the necessary tests," explained Arun Chopra, M.D., CIR Regional Vice President, who was part of the CIR bargaining team that negotiated the new jobs. "All of us were on hold, waiting in line for the radiology tech to answer our call and take our orders. Then we had a realization: one person could do the job of 12 residents better than 12 residents could do this one job."

Hiring Ancillary Staff—Hospitals are urged to hire more ancillary staff to take the work burden off residents—for example, more transport workers, phlebotomists, a person to do visual acuity exams in the Ophthalmology clinic.

Hiring Physician-Extenders—The Cardio-Thoracic program at one hospital hired physician extenders, and now service runs more smoothly, patient outcomes are improved and residents have more time for the OR, studying and patient care.

Website Improves Education/Patient Care—One Family Medicine program put every grand rounds PowerPoint presentation for the last three years on the department's website. They also included the top 20 diagnoses at the hospital; click on each one and the residents get the top 10 best articles on the subject. Patient handouts, in twelve languages, are also easily printable from the website, which saves resident time and improves patient care.

Monitoring Hours? Set Up a Hotline—Some GME offices have set up a hotline for residents to call if they have concerns about working too many hours on a particular rotation, but feel they are getting no support from their program.

day, improve a resident's education (when residents are allowed to focus on physician tasks) and improve the efficiency and quality of care delivered to patients.

Education Must Be Protected—The general consensus was that the move to limit hours had accentuated, and perhaps even accelerated, the already alarming problem of reduced resident education. Participants reported feeling pressured post-call

to miss conference, feeling that attendings now rush through rounds and morning report and that residents don't get to 'do as much' and have less 'ownership' of their patients in the rush to get things done and get out of the hospital.

Many spoke of the need for medical educators to start 'thinking outside the box' more effectively to organize medical education. Said one Santa Clara Valley Medical Center resident, "We need to wean attendings away from thinking the 30 minute lecture is the only way to teach."

Attendings, Med Students Working Harder—When hospitals do not identify additional resources to relieve the work burden on housestaff, that burden gets shifted to others. Both the American Medical Student Association and AMA-Medical Student Section participants reported that medical students are now expected to work harder and longer. Virtually all participants reported the frustration of junior attendings, worried that their own workload and hours had increased, while their time to teach had decreased.

"This system takes idealistic people, stomps on them and spits them out," said one resident leader who has recently become an attending. "In clinic, I see a patient every five minutes, with 10 minutes for paperwork. By the end of the week, I am no damn good."

No Confidence in ACGME's Ability to Monitor Compliance. At least one resident attending the workshop reported that at his hospital, resident threats to call the ACGME had indeed produced results! But actually making the call with the accrediting body was another matter. Participants universally pointed to an inherent con-

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tradition—residents are afraid to report violations for fear of bringing down their own program, or the wrath of their housestaff colleagues, attendings and program directors, none of whom want to lose accreditation. Although the ACGME has reported receiving only seven complaints in the first three months of the new rules, AMSA's website has logged three dozen complaints, e.g. reports of forged hours records and the 'scam' of home call, that on paper takes a house officer out from under the 80 hour requirement, but in reality can keep them up all night answering calls.

Evaluating the Impact on Patient Care—Some residents worried that patient care has been negatively affected by the hours changes, but no one seemed to think that this should be blamed solely on the hours limits, nor were the problems unsolvable. "Sign-out has always been a problem," said one resident. "The hours limits force us to do a better job, and that's good." Several participants called implementation of the hours limits a "work in progress" and one resident from LA County + USC Medical Center urged the group to keep problems with implementation in context. "Working more than 80 hours a week is just wrong; wrong for our patients and wrong for us. Let's not forget that."



Photos above, facing page: residents came from hospitals throughout California to discuss strategies for successful hours reform, and how to avoid obstacles that can sabotage the process. Right, co-sponsors of the event, left to right, Maurice Sholas, MD, PhD, AMA-RFS Chairperson; Ruth Potec, MD, CIR Pres.; and Tony Blaine, MD, MBA, CMA-RPS Pres.



PHOTOS: (TOP) RUTH POTEC/AMA; (BOTTOM, LEFT TO RIGHT) SANDY SHAGOC, AMY HALICZER; (RIGHT) AMY HALICZER

"Do-It-Yourself" Hours Reform Kit

Wish you could have been at the workshop but were unable to attend? You can recreate the experience and begin making changes at your hospital. Here's how: CIR has an abbreviated "Do-It-Yourself Kit" on our website. Go to:

<http://www.cirseiu.org/docUploads/Do-It-Yourself.pdf>