Working less, training harder

To the Editor:

Eighteen years ago, the death of a young woman under the care of overworked and sleep-deprived medical residents at a New York teaching hospital initiated an unprecedented reform movement in American graduate medical education.

Galvanized by public outrage and determined to improve patient care, as well as eliminate Draconian working conditions for physicians-in-training, a state commission headed by Bertrand Bell, MD, held open meetings with medical educators, residents, hospital administrators, and representatives of area medical schools. The results, adopted by the New York State Legislature in 1989, were considered extraordinary in their depth and scope: a set of sweeping mandatory rules, the first of its kind in any state, limiting the number of hours a medical resident may work continuously (24) and during a week (80). The rules stipulate a minimum of one 24-hour period off each week. Despite numerous efforts over the years by humanists, medical educators, and residents to extend these provisions nationally, the rules remained exclusive to New York.

Recently, the Accreditation Council for Graduate Medical Education, which accredits 100,000 residents at teaching hospitals across the country, agreed to impose the same reforms on residency programs nationwide.

This is welcome news as it coincides with the introduction of federal legislation—also the first of its kind—that would limit resident work hours nationally. The American Osteopathic Association and the American Medical Association this year also adopted resolutions similar to the New York provisions. But there is much more to this issue than meets the eye.

Much has changed in healthcare since March 4, 1984, when Libby Zion was admitted to a hospital with fever and agitation. Her death 8 hours later of an undiagnosed illness was a watershed in the movement for resident work condition reforms. Although there are now better regulatory controls and oversight rules in place to prevent some of these errors, addressing resident fatigue has often been an elusive matter.

At first, both primary care physicians and surgeons in New York rallied against any reforms at all, claiming that it would be difficult for residents to absorb the realities of caring for their fragile and needy patients if their working hours were fixed according to an arbitrary schedule. Although primary care physicians ultimately relented, surgeons continued to propose loopholes, arguing without convincing corroborative evidence that surgical residents require longer hours to develop finely tuned judgment and technical skills. Currently, surgical residents in New York are permitted to work beyond the stipulated hours provided their rest time is adequate overall and interruptions infrequent during the additional hours of duty.

As the patient population has become older and sicker despite (and because of) medical advancements, the work that residents typically perform has become harder and increasingly complex. A patient admitted with myocardial infarction in the 1950s typically stayed in the hospital for up to 6 weeks, the only therapeutic option available. Today, the same patient would receive a dose of aspirin, an antihypertensive medication, a cholesterol-lowering agent, and a clot-busting drug, and he or she may undergo a procedure to manually remove plaque from clogged arteries. The patient would then be discharged within 1 week. Today’s patient would also require careful round-the-clock monitoring for abnormal heart rhythms or other signs of instability. That the Accreditation Council for Graduate Medical Education and the American Osteopathic Association are now seeking to apply the work rules across all types of residency programs, medical and surgical, is certainly welcome.

The development is not without potential problems, however. Teaching hospitals will have to hire ancillary personnel for duties such as drawing blood, placing intravenous lines, and patient care itself at a time when Medicare reimbursement to hospitals has been on a downward trend. A more alarming worry is that the resident who previously worked 36 consecutive hours every 2 or 3 days will now come on duty every 12 hours but will not know enough about the patients he or she has been assigned to follow up because they were admitted by a different shift of residents.

This practice of cross-coverage can lead to delays in tests because of resident oversight and an increase in preventable errors such as prescribing medications without knowing a patient’s history of allergies to medications. The incoming resident may also be prone to ordering additional tests, instead of trying to decipher a colleague’s medical progress note or going through the reams of laboratory results that already exist in a patient’s chart.

It seems that New York’s experience with resident work hour limitations has not led to an inordinate adverse impact on patient care during the past 13 years compared with the rest of the country. Let’s hope that the application of similar rules at every teaching hospital, with interns and medical and surgical residents working fewer hours but training harder, will lead to better patient care as residents stay more alert and more attuned to their patients’ increasing healthcare needs.

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Editor’s note

Every July, the AOA House of Delegates and the AOA Board of Trustees meet to iron out policy issues. At this year’s meeting, the Board addressed the issue of standardizing resident and intern work hours.

Based on recommendations from the AOA Bureau of Professional Education and the AOA Council on Postdoctoral Training, the Board of Trustees worked to finalize this issue within existing AOA policy standards, agreeing to the following new policy:

Letters
Consider Medicare drug benefit plan for healthcare reform

To the Editor:
A common assumption is that the trend of health maintenance organizations (HMOs) and other health insurance companies exerting increased control over how physicians practice medicine on the basis of cost-containment is a new idea. The concept of managed care has roots that date as early as the 1800s when contract practice physicians provided all healthcare to a family, a plantation, or the indigent members of a community for a fixed annual fee.

Besides having arisen as a result of cost issues, managed care entails a history of a lack of organization between hospitals, medical practices, insurance companies, public health agencies, and government. In 1969 and in 1970, both the Republican Party (President Richard M. Nixon) and the Democratic Party (Senator Edward M. Kennedy) proposed a national managed care program that was eventually replaced by the HMO concept proposed by Paul Ellwood, Jr, MD. Dr Ellwood’s concept focused on a health maintenance strategy carried out by the private sector.

In 1993, the healthcare reform task force established by President Bill Clinton published its report, which had the effect of increasing managed care activity in the private sector in anticipation of universal coverage.

These events demonstrate that managed care is not a new idea but one that harkens back to the beginning of the social transformation of American medicine.

In addition to analyzing the growth of managed care, one must consider characteristics of the 19th century medical system which are similar to those of the current system in that they work against collective action or mobilizing public opinion. There still exists a faction of sectarianism, whether specialist versus primary care, physician versus nonphysician extender or alternative provider, and even Republican versus Democrat. Further, the US medical community has professional organizations to represent separate interests rather than a few relatively powerful organizations that represent the whole. In many areas of the United States, managed care still clings to the sick-care style of medicine rather than a population-based preventive-care style that the original HMO concept espoused. Competition rather than cooperation, also known as “coopetition,” still seems to be a bigger driver than fiduciary responsibility and the control of resources to benefit patients.

Finally, class struggles still exist between healthcare providers, hospital healthcare activities, and medical teaching institutions, so a fully collaborative atmosphere is not always present.

To achieve collaboration, providers, healthcare institutions, and government need to form a vertical alliance to meet societal needs. The medical community needs to think more globally and participate in government activities to directly force legislation for cost-effective healthcare. Effective, nonperverse managed care should embrace the goals of medicine—promotion of health and prevention of disease; relief of symptoms, pain, and suffering; cure of disease; prevention of untimely death; improvement of functional status or maintenance of compromised status; education and counseling of patients regarding their conditions and prognoses; and avoidance of harm to the patient in the course of care—especially in the current high-tech atmosphere.

Managed care has long recognized the high cost of medical intervention deemed futile and understands the concept of therapeutic relentlessness, the principle that considers medical treatment ethically manda-
tory to the extent that it is likely to provide greater benefits than burdens to patients. Cooperation between all factions is needed if we as a society are to solve this current crisis. At the current rate, the number of uninsured persons in the United States will increase by approximately 1 million per year if this cooperation is not forthcoming. Neither our society nor our healthcare system will fare better in the alternative government-administered, single-payer system currently used in Canada.

Rather than pointing fingers, society must look at the factors most likely to drive healthcare spending in the future and critically evaluate increasing consumer expectations. Besides considering the rising cost of new drugs and technology, society must consider the needs of an aging population. In addition, administrative expenses arising from the growing complexity of the fragmented US healthcare system need to be carefully assessed.

It is believed that these drivers will account for two thirds of projected annual increases in healthcare spending during the next 10 to 30 years. It is because of this projection that society should consider a universal, free-market system that fully covers preventive services yet has first-dollar copayments for all other services adjusted to income to curtail unnecessary expenditures and overutilization. Defined contribution is a must so as to keep employers and the economy healthy. It will allow a resurgence of freedom of choice, as well as require healthcare providers to consider global costs as they relate to maintaining a healthy nation.

These ideas are a modest but rational starting point that depends on more cooperation than any other factor. Physicians, medical institutions, insurance companies, and government need to get down to the business of planning economically disciplined patient care for the survival of a universally healthy country.

With the new spirit of cooperation in mind, one must look at an issue at hand: the Medicare drug benefit debate. Although debate is necessary for any intelligent decision making, the solution requires nonprofit cooperation. It is in this light that I propose that this great society seriously consider the Republican-backed drug benefit plan currently in the House of Representatives, regardless of one’s party affiliation.
The proposed plan appears to be economically disciplined and affordable. Remember, the national healthcare budget must make a best-faith effort to remain balanced to prevent extracting monies from other equally essential healthcare programs for the elderly. The US House of Representatives passed the Medicare Modernization and Prescription Drug Act (HR 4954, passed June 28, 2002), which appears to be well thought out and economically disciplined so as not to bankrupt the current Medicare healthcare system or cause undue hardship to other Medicare programs. This $350 billion Medicare drug benefit—the first to be passed—allows freedom of choice and dramatic reduction in personal drug costs to the consumer.

Unlike the Senate Democratic trillion-dollar alternative, HR 4954 would not cause undue hardship to other Medicare programs. The plan establishes a modest deductible, a generous shared first-dollar government payment up to a scaled cost, and a 100% first-dollar government payment over a predefined and reasonable total cost per year. It also waives any defined patient contribution for those Americans earning less than 150% of the federal poverty level. This plan is supported by major physician and nursing organizations (American Osteopathic Association, Association of College of Physicians, American Society of Internal Medicine, American Medical Association, American Association of Nurse Anesthetists, American Association of Ophthalmologists), insurance companies (American Association of Health Plans), pharmaceutical companies (Novartis Pharmaceutical Corp), and manufacturing organizations (National Association of Manufacturers) in the United States which indicates a new and necessary spirit of cooperation.

Finally, let’s take on the concept of rising drug costs. The greatest single factor in rising pharmaceutical expenditures is greater prescription drug use, not higher drug prices. Eleven percent of the 15% increase in drug expenditures comes from increased use of pharmaceutical products, and only 4% comes from increased drug prices. Prescription drugs are becoming the most cost-effective, least invasive part of the healthcare system. In many cases, the newer, expensive prescription drugs keep patients out of the hospital, prevent surgical procedures, and keep society productive.

Getting a prescription drug to market takes 8 to 12 years, may involve application paperwork of 100,000 pages or more, and cost the pharmaceutical industry $300 to $800 million dollars to develop through all phases required by the Food and Drug Administration. Now consider that out of ten prescription drugs brought through the system, only three produce revenues that match or exceed development. Also consider that when a pharmaceutical company registers the drug in anticipation of development and prior to the process above, the patent life begins, and 8 to 12 years of the patent are expended prior to release. To society’s benefit, the top 20 pharmaceutical companies spend in excess of $30 billion each year to develop new medicines. Therefore, pharmaceutical companies need to stay profitable to attract the investment needed to sustain innovation and provide the benefits society enjoys.

In short, this is a complex issue, that will continue to generate debate. I would hope that the spirit of cooperation of all parties involved, whether it be the medical communities, the pharmaceutical companies, the insurance companies, or the political and governmental communities, will predominate so that the health of America will not be placed at risk. I would urge that we take appropriate action to remedy the problem before the disease of noncooperation ravishes the American way of life.

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Study of cranial strain patterns creates more questions

To the Editor:

In the discussion, the authors theorize that “lack of mobility of the occiput may affect the SBS [sphenobasilar synchondrosis].” Yet surprisingly, the prevalence of SBS compression in their study is low. There also does not appear to be a handedness effect, although the disease, as discussed, usually affects one side more severely.

We still have much to understand of the synergy that occurs in the mindful interaction of physician and patient bioelectric fields which plays such havoc with interoperator reliability. Despite the perennial problem of physician (and institutional) bias toward particular types of cranial findings, this is a significant early step in defining the prevalence of cranial patterns in various populations and how those patterns interact with various medical conditions.

Thanks again for a most stimulating article.

JOHN H. JUHL, DO
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Response

We thank Dr Juhl for his comments and interest in our article. Although occipitoatlantal and occipitomastoid bone dysfunctions were found to be more prevalent than sphenobasilar synchondrosis (SBS) compression, the incidence of the latter (16.7%) was still found to be higher than that of the control population (5%), albeit statistically insignificant. Further, SBS compression is manifested as a diminished restriction of all motions at the articulation formed by the occiput and sphenoid bones. Dysfunctions of one of these bones may affect its relationship with the other. However, dysfunction of the one bone does not automatically translate into a more global dysfunction as seen in SBS compression. These interactions may explain in part the lower prevalence of SBS compression seen in our study.

Dr Juhl’s observation that there appears to be no handedness effect is correct. Although Parkinson’s disease typically begins on one side, the affected side has no association with handedness; therefore, any effect would be expected to be distributed evenly across the study populations.

We agree with Dr Juhl that ground needs to be covered on the possible influence of internal and external factors, which could potentially affect interexaminer reliability. As part of a series of studies on cervical biomechanics, Capobianco et al explored the possible impact that palpation itself may have on the outcome of interobserver reliability studies. The role that bioelectric fields...
may or may not play on interexaminer reliability could be a study worthy of future undertaking.

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References

Painted Trees
Like painted trees
With the appearance of motion
Our blue gowned bodies
Position around the target
Red marks the spot
Small spurts of it are bug zapped away
Wafts of escaping smoke drift up in offering
To the big yellow eyes
I am mesmerized
When I look up
Your eyes over the mask intrigue me
Intent, absorbed, amused
They say so much
I want to wave my arms as I talk
But I belly up to the bar
Hands planted
Blue feet rooted

Small jobs come my way
Retract, cut the line, don't airplane
I am suction woman, I want to say
I am retractor girl
Sometimes you talk
Sometimes words become superfluous
Finally I sew my way across
Acres of flesh, cons of time
My round hook dipping
Snagging her a smooth tomorrow
It takes forever, harder than it looks
You start me again more than once
In the end my eyes are gleaming too.
Tomorrow I will examine my handiwork
With the smug satisfaction
Of one who has learned to be
A tree in a surgical masterpiece.

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