BELL COMMISSION REQUIREMENTS: DOCTORS OR FACTORY WORKERS?*

R. GORDON DOUGLAS, JR. and (*by invitation*) JOSEPH G. HAYES,**
RICHARD B. ROBERTS, and CHARLES L. BARDES

NEW YORK

INTRODUCTION

The climate for medicine in New York State during the past decade has been stormy at best. Quality assurance, hospital reimbursement, and most recently, house staff supervision and working hours have been under attack. The ensuing policy changes have left medical institutions across the state in distress as they struggle to meet the requirements for new financial and human resources. Both of these resources are affected in the debate over house staff scheduling.

Since the 1950s, the number of on-call days for house staff has dropped from seven days a week, to every other day, to every third day, and finally to every fourth day. These changes were made because of the increasing intensity of the daily workload, including rising numbers of admissions, shortened length of stay, increasing severity of illness, and expanding scope of diagnostic and therapeutic procedures.

In the past year, New York State has made a quantum leap in restricting house staff hours, a result of public perception that tired, over-worked, and under-supervised interns and residents were making frequent errors that resulted in poor patient care. The Commissioner of Health appointed a group, known as the Bell Commission, to study this problem and to make specific recommendations, which were then embodied in the state hospital code. The new regulations became effective July 1, 1989 (1).

THE BELL COMMISSION

In addition to increased supervision of interns and residents, the most significant code revisions affecting internal medicine training programs were work-hour restrictions which limited house staff to an 80-hour work

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* From the Department of Medicine, The New York Hospital-Cornell University Medical College.

** Please address requests for reprints to: Joseph G. Hayes, M.D., Department of Medicine, The New York Hospital-Cornell University Medical College, 525 East 68th Street, Room L-129, New York, New York 10021.

week (averaged over four weeks) and an absolute maximum of 24 consecutive hours on call, followed by at least eight hours off duty. The state provided some financial support (less than requested) to hospitals to increase support staff, such as IV teams and floor clerks, and to improve the condition of on-call rooms.

While it is easy to accept increased financial support, and moderate changes have fulfilled the requirement for increased supervision, the working hour restrictions presented a serious challenge to chairmen and program directors trying to provide high-quality patient care and comprehensive house staff education.

We know from recent surveys how little time interns spend with patients and how much of their time is involved with charting, scheduling tests, starting IVs, and similar procedures (2). In most programs, interns traditionally have been responsible for three tasks: working up new admissions, taking care of their own patients, and covering patients belonging to other interns and residents. In a few institutions, other systems evolved to allow interns to concentrate on new admission work-ups while night floats assumed some or all of the patient care tasks. Recently, some programs have installed new admitting teams to handle work-ups after 10:00 or 11:00 p.m. In any case, the intern was available the day after admitting for transfer of information (referred to hereafter as "turnover") and for teaching conferences and rounds.

THE PROBLEM WITH THE 24-HOUR DAY

The Bell Commission's 24-hour on-call limit presented many problems, as shown in Figure 1. The three traditional intern activities are shown together with time lines indicating working hours for three house officers. With a 24-hour on-call day, Interns 1 and 2 cannot overlap. Instead, a third house officer must come in early, resulting in a double turnover from Intern 1 to Intern 3, and from Intern 3 to Intern 2. Moreover, the intern misses all training on the day after duty and is unable to follow the progress of his or her patients at a time when the full clinical picture probably is beginning to emerge.

Although this system would meet the letter of the law, the fact that the admitting interns could not talk to each other, requiring a double turnover, seemed impractical and possibly dangerous. The system created significant opportunity for errors and omissions, not to mention its negative educational effects on teaching interns about continuity of care.

An alternative plan was devised based on a 16-hour on-call day (Figure 2). In this system, the admitting intern takes all admissions until 9:00 p.m. and leaves at 11:00 p.m. for a full eight hours off duty. Float A (either an intern, resident, or a float team) then admits all new patients

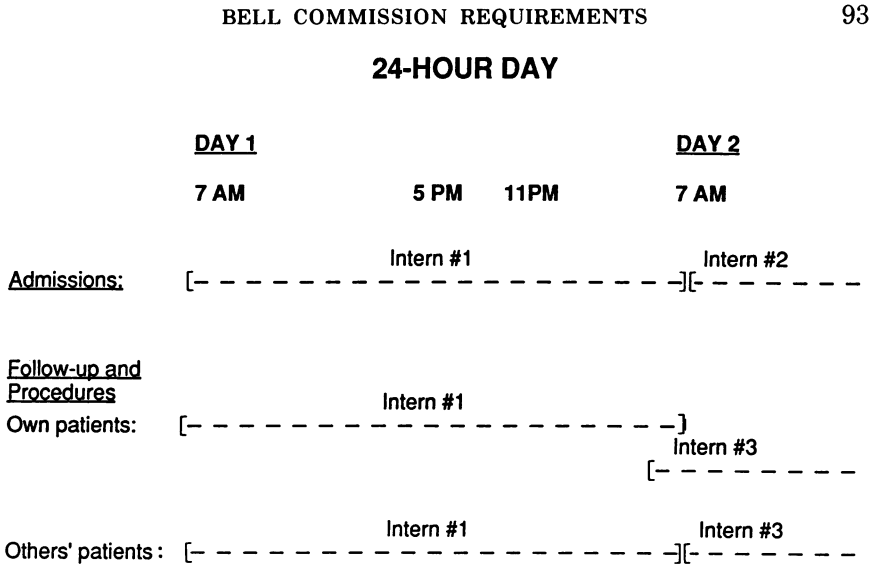

FIG. 1.

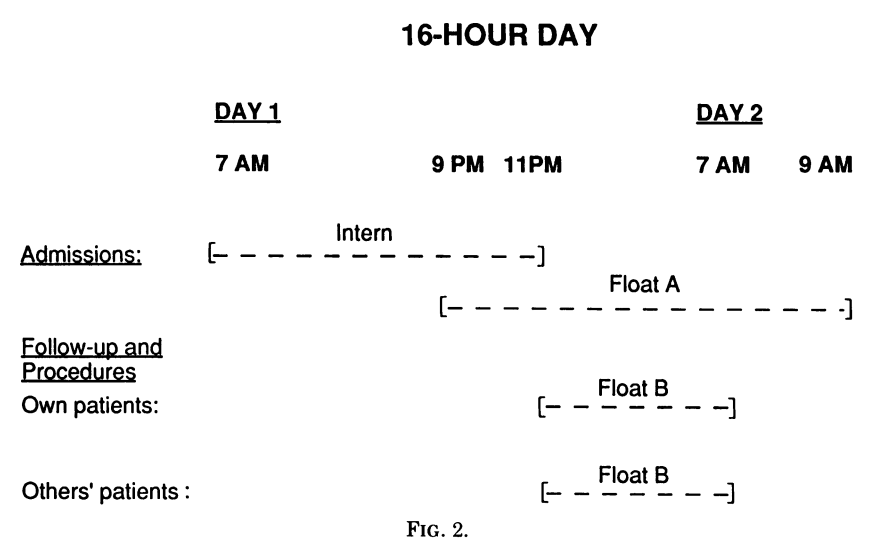

FIG. 2.

after 9:00 p.m., and either this person or a second float (labeled Float B) cares for other patients.

This option fulfills the work-hour requirements. Also, the admitting intern is available for all teaching and conferences, as are the float teams, who stay on duty until 10:00 a.m. However, the plan requires additional house staff unless interns admit every third night instead of every fourth,

an unpopular notion among interns. This system also has a serious impact on continuity of care (note that double turnovers are required), especially in the early hours after a new admission arrives, when important clinical changes may be occurring.

EVALUATIONS OF THE 16-HOUR DAY

In February 1989, the Department of Medicine at The New York Hospital-Cornell Medical Center experimented with the 16-hour day on approximately one-half of our general medical service, not including special care units. As indicated previously, we felt that this was a reasonable approach. However, we found great difficulty putting this system into practice in a busy medical service. Most admissions come in later, rather than earlier, in the day. When the admitting intern has only one or two admissions during the day (a rare occurrence), a shift system works well. But when the workload includes four to six admissions, as is often the case, the system begins to fall apart. Work-ups are initiated but cannot be completed. Instead, the admitting intern must sign out to the covering intern, and follow-ups on white counts, chest x-rays, and electrocardiograms are performed by someone who knows very little about the patient. Interns find that they have not written their notes by 11:00 p.m. Even though there are house officers on duty to take new admissions and to handle floor problems after 11:00 p.m., only the admitting intern can write the notes for admission work-ups.

Prior to this experiment, our house staff had developed into compulsive, complete internists, and we discovered that they did not react well to the mentality of "shift medicine." In comparing the reactions of interns who participated in the new system with those who remained on a traditional 36-hour on-call schedule, it was obvious that interns found the new system was highly stressful. They were uncomfortable with their inability, due to time constraints, to finish their notes and follow through on patient work-ups during their shifts. They also felt that the multiple turnovers allowed more room for error and affected the continuity, and possibly the quality, of patient care. Nurses agreed with this assessment, documenting an increased number of errors and miscommunications. However, nurses had no difficulty with the concept of interns working shifts, provided adequate turnover was accomplished. Attendings had difficulty determining who was on call and addressing problems with interns who barely knew the patients.

A psychiatry intern rotating through the medical service at the time, unbeknownst to us, wrote a letter to the editor of JAMA, that clearly expressed the interns' concerns (3).

> . . . I am suffering under this new system, as are the patients. When, at 11:00 p.m., I sign off of a case that was just beginning to reveal itself, and then do not show up until 7:00 the next morning, something essential is lost forever. In those 8 hours, the treatments have often had their most important effects and the patient has either 'turned the corner' or 'started to crump.' Lost to the process is the input from those physicians who have done the most thinking about the patient's illness, as well as the learning that comes from being there, hands on, as events take their course.
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> These scheduling changes, intended to enhance the quality of patient care, in fact, distance the intern from the patient. Shortly after a patient has disclosed his or her problems to the primary physician, that physician leaves the hospital. Moreover, the changing of shifts at 11:00 p.m. multiplies the number of times a physician signs over a case and increases the opportunities for miscommunication. Cliches like 'continuity of care' gain real meaning here.
>
> Under the trial schedule, there is no effective way to pass the baton. The one intern aware of the nighttime developments completes a 24-hour shift as the rest of their team arrives for 7:00 a.m. rounds. Traditionally, the intern has joined the team for morning rounds and worked through the next 12 hours. Under the Bell Commission's rules, the intern cannot join in rounds without violating the '24-hour rule.' The new team is deprived of the intern's knowledge of the patients, and the intern is deprived of the learning experience gained in rounds. Although the intern cannot take part in rounds, he or she would be allowed, under the rules, to go home for only 8 hours, come back and work another 24 hours, and repeat the cycle once again for 72 hours of work in 90 hours. Ironically, the rigidity of the commission's rules prevents hospitals from attempting to reconcile the need for a gentler schedule and continuity of care. Perhaps cooperation between the commission and the hospital could lead to rules more loosely tailored to this goal.

Following this failed experiment, we returned to our traditional every-fourth-night, 36-hour on-call schedule, and together with other chairmen and program directors lobbied the state for an extension from 24 to 27 hours.

HOUSE STAFF SURVEY

In May 1989, we surveyed our interns to assess their perceptions of the traditional 36-hour system, using the questionnaire shown in Figure 3. We received 21 responses from interns on duty on the general medical floors of The New York Hospital. Those on special care units or rotating to other hospitals were excluded. The survey results indicated that interns cared for an average of 11 patients scattered over 2.5 floors due to extensive boarding, and admitted 3.2 patients (range: 1 to 6) per on-call day (prior to the survey, we had initiated a backup system which prevented interns from getting more than five admissions while on call). On average, including the on-call night, interns were sleeping seven hours per day and had 2.5 hours of leisure per day.

Interns reported that they attended 89% of the conferences and rounds. Four admitted to falling asleep during conferences, with three of these

INTERN QUESTIONNAIRE

DATE: ___/___/___. DAY_____.
NAME:_____. FLOOR:_____. FIRM:_____.

NUMBER OF PATIENTS ON SERVICE:_____ ALC:_____.
NUMBER OF FLOORS WHERE YOU HAVE PATIENTS._____.

STATUS TODAY: ADMITTING POST CALL POST CALL #2 POST CALL #3

NUMBER OF ADMISSIONS IN THE PREVIOUS 24 HOURS (7A.M.-7A.M.).____.
NEW ADMISSIONS:_____. BEDHOLDING:_____. TRANSFERS:_____.

DID YOU ATTEND TODAY? (circle) ATTENDING ROUNDS NOON CONFERENCE M & M

PROFESSORS ROUNDS GRAND ROUNDS INTERN LUNCH

OTHER EDUCATIONAL CONFERENCE

DID YOU FALL ASLEEP? YES NO

DID YOU LEARN ANYTHING? YES NO

DID YOU FEEL FATIGUED AT WORK IN THE PREVIOUS 24 HOUR PERIOD? YES NO

HOW MANY HOURS DID YOU DEVOTE IN THE PREVIOUS 24 HOURS TO:
LEISURE ACTIVITY:_____. SLEEP:_____.
READING MEDICAL MATERIAL:_____. READING NON-MEDICAL:_____.
RESEARCH:_____. OTHER:_____.

WHAT TIME DID YOU SIGN OUT? _____A.M. P.M.

DID THE COMPUTERS HELP WITH THE SIGN OUT? YES NO

WHAT IS YOUR PERCEPTION OF CONTINUITY OF CARE? (in the previous 24 hours)

POOR 1 2 3 4 5 EXCELLENT

WHY?_____

WHAT IS YOUR LEVEL OF SATISFACTION AT WORK? (In the previous 24 hours)

POOR 1 2 3 4 5 EXCELLENT

WHY?_____

FIG. 3.

episodes on the post-call day. About two-thirds reported that they learned something in conferences, while one-third did not. Fatigue was a complaint of slightly over half, and it was not restricted solely to the post-call day. Asked to rate their perception of continuity of care and their level of satisfaction on a 5-point scale, where 1 was poor and 5 was excellent, the mean responses were 4.1 and 3.7 respectively.

Just before July 1, 1989, Dr. David Axelrod, the Commissioner of Health of New York State, agreed to interpret the code requirements as allowing a 3-hour period to be added to the on-call period. The additional three hours, which are for transfer of information only (not direct patient care), may occur not more than twice in any week, and are included in the 80-hour work week restriction. This has removed the necessity for a 16-hour system, and the 27-hour day shown in Figure 4 is the system we

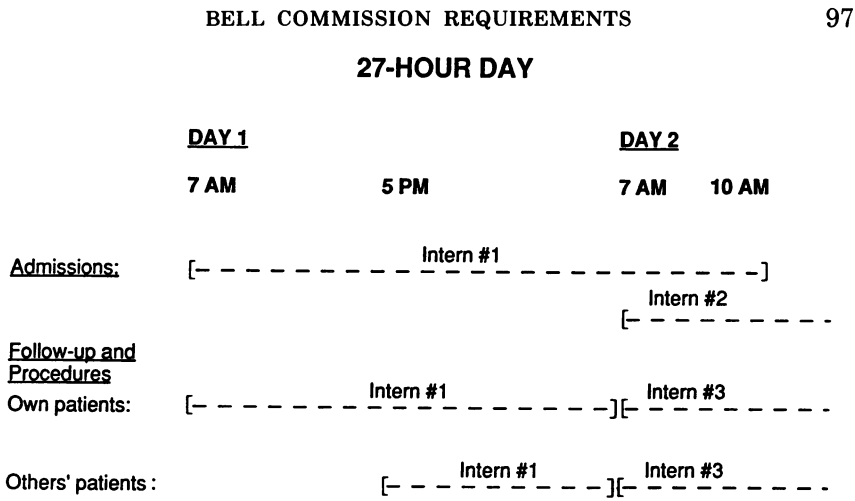

FIG. 4.

and many others in New York State have been using since July 1. In addition to providing opportunities for training on the post-call day, this system allows face-to-face turnover between admitting interns.

The new system has resulted in a high level of intern satisfaction. In October 1989, using the same questionnaire as before, we surveyed the new interns on their perceptions of the 27-hour day. This poll cannot be strictly compared to the May 1989 poll because of differences in levels of competence and efficiency of interns early and late in the year, respectively. Nevertheless, with 19 responses, the new survey shows a slightly decreased number of patients (10.6) spread over a larger area (3.4 floors). Interns are admitting more patients under the new system, with an average of 4.3 per on-call day. Although amount of sleep dropped to 4.8 hours and leisure time dropped to 1.8 hours, this is probably more a reflection of the time of year than the scheduling change.

Similarly, attendance at conferences has decreased to 57%, also felt to be a reflection of time of year. Only one intern reported falling asleep during conference. More than 90% of them felt they were learning at conferences, a marked improvement over the May survey. Perceived level of continuity of care, 3.8 on a scale of 5, and the overall level of satisfaction, 3.5, are slightly lower than the first poll. A May 1990 survey would be preferable for comparison because it would eliminate time of year as a confounding variable.

CONCLUSIONS

House staff working hours have a significant effect on level of satisfaction, education, and continuity of patient care. Many other factors influence these end-points as well, such as amount of ancillary services,

quality of teaching by attending staff, and willingness of residents to help overloaded interns (4, 5). Nevertheless, working hours are a major factor, and no change is trivial in this area. It is important that the profession, not the public or politicians, regain control in the design of training programs.

It is unlikely that the recent changes will be undone. Rather, they probably will spread to other locations as they are perceived as positive and desirable by medical students seeking internal medicine training. We must, therefore, develop methods to optimize education within this framework. One such method we have devised is a computerized sign-out program which helps prevent omission errors.

In addition to changes in house staff hours, the challenge to chairmen and program directors is to continue to change programs to incorporate more ambulatory and less specialized care, and to emphasize general internal medicine (6, 7). The inevitable but beneficial consequence of such a change will be a dissociation of education and service. Thus, other ways must be found for caring for hospitalized patients.

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DISCUSSION

Nolan (Buffalo): That was very nice and summarized well the scheduling difficulties. I don't want to address that. In New York State we've had many problems. I want to make several comments. One is that we did get that extension for the extra three hours which has made a lot of difference. A study done in New York State showed that the average number of scheduled hours before the Bell Commission was 84, so it wasn't much different from the 80-hour work week. With the three hours and the night float that we've been using in Upstate, we haven't had much difficulty complying with the regulations. It is interesting that the surgeons were exempted from this because they put so much pressure on the health department that they would close programs. Instead of an 80-hour work week, the surgeons have a 90-hour work week and anytime that they sleep when they are in the hospital, as opposed to internal medicine, they can add that to the 90-hour work week. The surgeons quote some study that showed that after 36 hours of being up there

was no change in manual dexterity of surgical residents and there was no evidence of intellectual impairment. I think New York Hospital is a lot different than big municipal hospitals in New York City. New York Hospital can attract as many good residents as they want. There are a lot of excellent attendings that can cover for uncovered house staff services when necessary, but the cost is enormous in the municipal hospitals in New York City. What's happened there is that although the state health department has given money to try to implement these changes, there are not the personnel available. There are not sufficient nurses. There are not the IV teams necessary, and there are not the attending physicians to cover these large wards in city hospitals, and the poor are suffering in New York City as a result. There is no question that the care has deteriorated. That doesn't mean that residents should be giving all the care in municipal hospitals, but to make these changes has caused tremendous disruption. The other issue in New York State and nationally is that when we talk about priorities for all the costs that we have in health care today, I think it is going to be very difficult to convince people to bear that enormous increase in ancillary help and in new attendings to take care of patients that are not going to be taken care of in our present training programs. It really is a cost issue in New York State. Not only is it a cost issue, but an issue of personnel availability. Where are these attendings? Where are these physicians assistants to take care of people who are now left uncovered by house staff in these big open city wards?

Griner (Rochester): Gordon, you've obviously dealt very well with a poorly designed set of regulations. As a member of the Bell Commission, let me remind the group that one of the principal issues the commission was dealing with relates not at all to residency working conditions, but to the lack of availability of attending supervision, particularly in the public hospital system in New York. For many hospitals in the New York metropolitan area, I think the problem still exists today. For many hospitals, there is no attending availability from 5 pm in the evening until 8 am in the morning or on weekends. That really was a central issue that the commission was attempting to deal with, and much of the problem with resident work hours has been a distraction from that fundamental issue.

Allen (Charleston): Gordon, those of you who exist in fine, large, highly respected programs have the leeway to deal with manipulation of house staff hours to try and address issues which are obviously critical in the minds of the public and in the minds of the politicians. I'd like to call to your attention and get your comments about those of us in less well recognized programs where we have the finances, where we have excellent patient populations for educational purposes, where we have a good staff of attendings, but to which it is becoming more and more difficult to attract qualified residents for training. We will begin to run the risk of having to sacrifice education on the alter of service. It seems to me, therefore, that a corollary concern deals with the evolution of ancillary methods of care delivery on a 24-hour basis. I would be interested in your comments and thoughts as they may lead us to how to segment our patient population relative to those qualified for or deserving of house staff care. What are your thoughts about the utilization of physicians assistants or alternative methods of covering inpatients?

Douglas: I think, Jim, has made some very important points. David Taunton basically set this up yesterday pointing out how unattractive internal medicine is becoming as a career. When you add factors relating to house staff training, it becomes unattractive for house staff training. Basically medical students see interns and residents in Medicine having less fun than interns and residents in Surgery and some other specialties and this affects their choice of career. I think what we have to do in the next decade, as I mentioned at the end of my talk, is to disassociate service from education. The hope, the silver lining behind the clouds, is that by the experimentation we've done in the past year maybe we've begun to do this. I think we should down size a lot of our programs. I think that we should remove house staff from the care of many kinds of inpatients. I think that we should enlarge the amount of ambulatory care in their programs. We are taking 43 interns next

year. I'd be happy with 20 and the chance to get to know them better. We could have a much more solid program, we could do a better job and the quality would be higher. How do you do that? We've had a fair amount of success in two areas. One is that there are a lot of things that go on in hospitals that you can get other people to do, tasks that interns traditionally do. We have about 10,500 admissions to the medical service now. When I went to New York Hospital in 1981 we had about 6,000. We've had a tremendous increase in the number of admissions with the same number of beds and same number of house officers. All that means is that everybody works harder. What we've done is we've eliminated all patients coming in for cardiac catheterization and all patients for chemotherapy from medical house staff management. They are taken care of by nurses mainly with a back-up of an attending physician or a hired attending who in our system is a moonlighting fellow. That has worked very well, I see other large segments of the inpatient population that are undesirable for medical education. I think that you could pick and choose. We have to get rid of the idea that all inpatients on the entire medical service have to be run by house staff. I think that is the driving force behind the system. I think it is one of the things we have to change.

Wolff (Boston): I thank you for that very clear exposition on what you are doing in New York. I have a couple of comments. I sit on a committee in Massachusetts that was set up in an attempt to avoid legislation. We have found a couple of things. One important aspect, as pointed out by Jim Nolan, is the fact that costs are going to be enormous. Is New York bearing the costs? Have they fulfilled their commitments to supply the money? Secondly, the surgeons in the teaching programs in Massachusetts have responded that even 90 hours a week is not enough and they are going to extend their residencies by one or two years. I'd like to know whether that is the experience of others. Thirdly, what a lot of people in internal medicine somehow overlooked was that in the spring of last year, the residency review committee for internal medicine recommended that 80 hours a week become standard. I don't think they made it an absolute recommendation, but it seems that they are going in that direction. Thus, this program will not be restricted to a couple of states, but it could easily become nationwide.

Douglas: We got some of the money that was requested in New York State. It was about two-thirds of what was requested. In other words, hospitals turned in requests for a certain amount of money for more nurses, more IV teams, etc. Of course there is nobody to hire. We did get some money, again approximately two thirds of what we requested as needed to run the program. The remaining third falls on the hospital.

Scherr (New York): I compliment you on your initiative in setting up a data base upon which we can begin to evaluate what is really turning out to be a major change in how we conduct graduate medical education. There is very little data on working hours and other activities in regard to internal medicine residencies. Your start is an excellent one and more is needed. Currently the Accreditation Council for Graduate Medical Education is considering this issue. The residency review committee in internal medicine has instituted similar analyses in regard to the impact of these changes. No data have been forthcoming yet, only perceptions. In regard to perceptions, it is not only the public that readily misinterprets the functioning of graduate medical education, but also, as you point out, the current medical students and those in first, second and third years of graduate training. I wonder if there are any lessons to be learned from the surgeons, not necessarily for their political agility but how they have managed to keep their residents in tow in a very strict hierarchal fashion without any pretentions about it being an apprenticeship and how their objectives of their training program are different from ours. You know in your own institution how the surgeons function and it might be helpful to hear about that.

Douglas: Our surgeons have a general as their chief and you either do it his way or you don't go to the operating room. A very simple formula. They do exactly what he asks them to do. Our residents and interns talk back to us, argue, and formulate ideas. They serve on

committees and we listen to them and all that sort of thing. They help us formulate their plans and their working hours.

Johnson (Ann Arbor): At the University of Michigan, we have one of the relatively few residual house staff unions outside of a few enlightened centers elsewhere. It is interesting that they re-emerge every three years and somehow put together a negotiating team. We are just entering that process. They laid on the table immediately the New York regulations as we anticipated. We noticed they had the earlier versions, though, without the revisions. It turns out that they appear relatively flexible about the hours. They seem more concerned about the so-called ancillary support services, the IV teams and the availability of the variety of support activities on a 24-hour basis. The general essentials speak in very general terms of the importance of these. I wondered if you are able to provide all those services and if that is an issue in New York now.

Douglas: Two things are related to that. One is that it surprised me but hospitals in New York State who addressed the fact that they were changing hours this year did well on the match last year and those that sort of ignored it didn't do quite so well. That's obviously a gross generalization for the whole state but it is true. We got this influx of money and I was sure the hospital was spending it in some other way because they have a way of doing that. However, recently, just to show you how correct you are, Joe, within the last two weeks they were able to extend the IV team service. They used to work from seven or eight in the morning until about 3:30 in the afternoon and they are able to extend it to 8 pm. This has had a greater influence on house staff morale than any other thing we've done. The other thing they are able to do for the first time since I've been there is that they began to provide Meals on Wheels. Our house staff was not fed at night and the cafeteria was closed so the Department of Medicine had to provide or bring in food. You can get that in New York. It is pretty easy to get pizza or Chinese or Japanese or anything you want. But it was a tremendous cost to the Department of Medicine. I finally got the hospital to pay for the dinners. They provide a balanced diet and it is better than the meals they had before. Those two things have had a greater impact on house staff morale than anything else we've done.

Reynolds (Baltimore): I offer my thoughts on this subject from several perspectives. I am currently an intern at Hopkins so I am experiencing directly the impact of long intern days and nights. Several years ago I was president of the American Medical Student Association and during my term of office, the organization spent nearly a full year researching the topic of resident work hours and talking to students, interns and residents before we wrote our position paper on the subject. In the beginning, the debate was framed around the optimal length of resident work hours, or shift workers as you define it. However, we learned that the real issues of concern to students and physicians in training were the educational content and environment of residency, the need for good ancillary support services, and the impact of chronic fatigue and an increasing patient population of HIV positive patients, nearly all IV drug abusers on the public wards in inner city hospitals. These are the patients whose IV's fall out in the middle of the night or day and you have to put in a central line because they have no more peripheral access. You are exhausted having been up 24 or 36 hours. Furthermore, most of the medical therapy of 2–4 weeks of IV antibiotics is not going to change their life. So interns and residents today face the stress and challenges of caring for a different patient population than the people here cared for during your years of housestaff training. I think Dr. Stobo has done an outstanding job with the residency program at Hopkins. We know he cares about the educational component and thus, looks for ways that allow interns and residents to do physician activities, not those of ancillary services. He created a job called data coordinators to help achieve this goal. The data coordinator frees up 2–3 hours of time for each intern which can then be used to take care of patients and go to conferences. I would encourage you to move away from the concept of shift workers and move closer to focusing on residency as the final or

next to final phase in the educational path of a physician. I think that if you do that you will satisfy everyone's needs, most importantly, the patient.

Douglas: Your comments are right on target, Preston. The issue in New York State that I want to make clear, though, was that we had no control. This was coming from the Commissioner of Health who said your interns are going to work twenty-four hours and they are going to go home. The reason we did the experiment with the sixteen-hour day was precisely to counteract that, to get people off the hour thing and this was very clearly communicated to Dr. Axelrod in writing and in person by a number of us and also other chairmen of medicine. Jim Nolan, through the ACP, had a very active role. We were able to convince them at the last minute that it was a totally unworkable situation. Part of it was a reaction of our house staff to the experiment with the sixteen-hour day. I think that what it did was, by getting that extra three hours, let us get back on the focus of where we should be and that is on house staff education and providing these additional services for the house staff so the focus can be education rather than service.

Christy (New York): With regard to the way surgeons approach this matter, I think the answer for the difference lies in the total and fundamental difference in the surgical versus the internal medicine personality both with regard to the mentors and the students. Second, at a large inner city New York City hospital, namely Presbyterian, whatever modification they are using (which I imagine is similar to yours, Gordon) has resulted in universal complaint from the teaching attendings that the house staff, chiefly the interns, don't know their patients nearly so well as under the old dispensation because of this matter of their going off duty just when the case is ripening.

Ferris (Minneapolis): I enjoyed your presentation, Gordon. It is important in your title to appreciate that our residents are not factory workers and they don't feel that way. As Dr. Reynolds just mentioned, if you bring them into decision making, they are as responsible about patient care as any attending. At Minnesota, we have introduced a night float system to accommodate the eighty-hour work week. Now, after a year or two, they are beginning to wonder about the night float system. They miss not making rounds in the morning. They feel like hired help on night float. When it comes to the difference between internists and surgeons, you have to remember we are upset about fewer medical students going into internal medicine. Surgeons don't seem to be. Interest in general surgery has gone down as much as internal medicine, but they have a guild-like feeling about this. Fewer surgeons means more cases. Residents are working harder today than we did, the patients are sicker and they do have considerations about home life and life style that we didn't seem to think about.

Duma (Richmond): Gordon, you touched on moonlighting in your program. How did the commission suggest you deal with those house staff who were moonlighting in addition to your regular program? How did you assess the factor of fatigue in regards to moonlighting? How many people were moonlighting and how well was it policed? How is the commission and how are you dealing with it?

Douglas: There are a lot of parts of the Bell Commission requirements that I didn't show you. Moonlighting is absolutely verboten. You've got an eighty-hour week, a three year program and you cannot moonlight. Those are the regulations in New York State. I am absolutely certain that my interns and my JARs are not moonlighting. I cannot make the same confident statement about my senior assistant residents. They've been told not to moonlight. They've been told they can't moonlight, that malpractice doesn't cover them and all that sort of thing and we don't hire them to moonlight.

Duma (Richmond): Has there been any suggestion by the legal profession that prohibiting them from moonlighting during off-hours may be unconstitutional?

Douglas: I address a lot of things with our lawyers but I haven't talked to them about that aspect of things.